An Evaluation of Partnerships for Early Childhood Mental Health

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This dissertation titled
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Abstract

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An Evaluation of Partnerships for Early Childhood Mental Health

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Early Childhood Mental Health Consultation (ECMHC) has been linked to increased teacher competence and efficacy, as well as increased social skills and decreased challenging behaviors for participating children (Green, 2009). Partnerships for Early Childhood Mental Health (“Partnerships”) is an ECMHC program in Southeastern Ohio. This study evaluated how well the program is addressing the objectives identified on the “Partnerships” Theory of Change Model. The researcher used a mixed methods approach to analyze existing program data within the framework of Stufflebeam’s (2000b) CIPP program evaluation model. Results indicate the program: (1) has addressed many of the identified needs of the preschool population it was designed to serve; (2) is more expensive on many measures than the average costs of other ECMHC models; (3) has a well-articulated design that is being reliably implemented by staff; and (4) has high satisfaction from participating teachers who report positive benefits for themselves and their children. The study contributes to the field of ECMHC by reinforcing current ECMHC literature. Because of its well-articulated processes, the “Partnerships” program may serve as an exemplar for programs in similar contexts, particularly those located in rural Appalachian settings. Finally, this study demonstrates methodology that other ECMH directors can use to conduct substantive evaluations of their own programs.
Dedicated to my husband, Douglas Shamblin, who always encourages all of my efforts; and my parents, Bob and Bonnie Arnold who gave me the gifts of personal resiliency, a love of learning, and a generous spirit.
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Chapter 1: Introduction

The United States is currently home to approximately 25.5 million children under the age of five (Forum on Child and Family Statistics, 2012). Some estimates suggest that at least 44% of these children are spending, on average, 36 hours a week in childcare and preschool settings (National Association of Child Care Resources and Referral Agencies, 2011). A major concern is that at least 30% are at risk of being asked to leave these settings because they have significant social/emotional/behavioral challenges (Ravner & Knitzer, 2002). One strategy that may decrease social/emotional and behavioral problems in young children is early childhood mental health consultation (Gilliam, 2008).

Early childhood mental health consultation (ECMHC) was first described in the literature by Cohen and Kaufman (2000) who defined it as “a problem-solving, capacity building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more caregivers, typically an early care and educational professional, and a family member (p.4).” Instead of direct intervention aimed at individual children with problems, ECMH consultants focus on building the capacity of early childhood staff and caregivers who then go on to work with all the young children in their care to support social emotional development and to reduce the impact of mental health issues (Cohen and Kaufman, 2000). ECMHC is being delivered by “professionals from a variety of disciplines including counseling, social work, psychology, and special education (Perry & Kaufman 2009, p.2).” ECMH consultants work with early childhood professionals with a wide range of training and skill—from child care providers who may have high school diplomas to special education
public preschool teachers who may have master’s degrees—but all have one thing in common, they are educators for children aged 5 and under.

ECMHC is becoming more prevalent. Duran, Hepburn, Kaufman, and Le (2009) conducted a national scan of ECMHC programs. They received surveys from 35 states, 29 (83%) responded that they had ECMHC services available in the state. Of these 29 states, 72% reported having consultation available statewide with the majority of these (72%) housing these services in mental health centers. Despite more than half of states sponsoring ECMHC services, only 17 had evaluation strategies in place to gauge implementation and assess effectiveness.

As ECMHC is beginning to expand across the United States, attempts are being made to establish research support for the field. Two major research syntheses have been conducted related to outcomes for ECMHC. Brennan, Bradley, Allen, and Perry (2008) identified 26 published and unpublished studies related to outcomes for early childhood staff. After reviewing all these studies, the researchers concluded that statistical meta-analyses were not viable because most studies lacked the necessary sample sizes and comparison groups needed. Instead, they decided to use matrix coding with apriori categories conducted by three different investigators. Study results found that across all the reviewed studies, there was some evidence that ECMHC helped increase self-efficacy, confidence, and competence in managing children’s challenging behaviors. Several studies suggested that ECMHC reduced staff stress related to challenging children and reduced staff turnover.
A follow-up review two years later by the same team (Perry, Allen, Brennan, & Bradley, 2010) focused on child outcomes for ECMHC. This time, the focus was on 14 research studies. These were selected because they had at least one of the following qualities: publication in a peer-reviewed journal, designed as a randomized control trial (RCT), or contained a comparison group. Again, the research group elected to do matrix coding with apriori categories by three different researchers because they felt that these studies lacked the sample sizes for statistical meta-analyses. Study findings found wide variation in consultation models and approaches. Despite this variability, ECMHC was consistently associated with teacher reports of reduced externalizing behaviors and improved social skills in children across all studies. There were mixed findings in regards to reduction of internalizing problem behaviors. Both reviews concluded that continuing to build the research base for EMCHC would require articulating the underlying theory of change for consultation models, developing instruments, and increasing the rigor of studies (Brennan, Bradley, Allen, & Perry, 2008; Perry, Allen, Brennan, & Bradley, 2010).

Over the last twelve years, Tri-County Mental Health and Counseling (TCMHC) has steadily been developing an early childhood mental health consultation (ECMHC) program to meet the needs of young children in Southeastern Ohio, called Partnerships for Early Childhood Mental Health (“Partnerships”). Through the preceding three years, with collaboration from participating school partners, the program has created a unique ECMHC model that has received attention from the Ohio Department of Mental Health
and garnered a national fellowship from the Robert Wood Johnson Foundation\(^1\) for the Program Director. While aspects of the model had been evaluated prior to this project, an extensive assessment of the program had not been conducted. Since ECMHC is not a standardized intervention approach, thorough evaluation of services at an agency level is important for making localized decisions and program alterations to meet specific community needs. However, the results of a comprehensive evaluation of the “Partnerships” program may have interest beyond Southeastern Ohio where the program is located. Given the variability of consultation models discussed in the literature (Brennan, Bradley, Allen, & Perry, 2008; Perry, Allen, Brennan, & Bradley, 2010), and the recognition that the “Partnerships” program has received, there may be value to others conducting ECMHC or to those considering implementing this practice. This is consistent with calls in the literature for EMCHC programs to add to the current literature by articulating their consultation models, conducting stringent evaluations of these models, and sharing the lessons learned (Duran, Hepburn, Kaufman, & Le, 2009; Hepburn, Kaufman, Perry, Allen, Brennan, & Green, 2007).

Stufflebeam (2000b) has developed a widely used, multi-step evaluation model called Context-Input-Process-Product (CIPP). It offers a process for conducting an exhaustive evaluation of a program and safeguards against overlooking critical aspects of outcomes. By engaging in the evaluation process using the CIPP model, the “Partnerships” staff and stakeholders hoped to learn if they had accomplished their stated

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\(^1\) The Robert Wood Johnson Foundation (RWJF) is a major philanthropic organization in the United States. Focused on public health, RWJF sponsors numerous grants, research projects, and fellowships devoted to improving health care for all Americans (www.rwjf.org).
program objectives, produced positive outcomes for participating teachers and children, and whether the program model is worth further investment.

Additionally, the author makes two contributions to ECMH research through this program evaluation of Partnerships for Early Childhood Mental Health: (1) lessons learned may be useful to the development and practice of other ECMHC programs, and (2) utilization of Stufflebeam’s (2000b) Context-Input-Process- Product (CIPP) program evaluation model will document its application to ECMHC programs.

**Purpose of the Study**

The purpose of this study was to conduct a summative program evaluation of Partnerships for Early Childhood Mental Health. Program evaluations can be classified into two types: (a) formative evaluation conducted during program development or used to make improvements, and (b) summative evaluation conducted after a program is completed to access impact and make decisions about continuation (Madaus & Kelleghan, 2000). For a program that is going to continue its existence, the two may be combined (Sciven, 1991). The “Partnerships” program will continue after the evaluation so formative elements were also incorporated into the study. However, the main focus will be on summative elements given that results will be used for decision making about impact and application of the results to the ECMHC field (Fitz-Gibbon & Morris, 1987).

The “Partnerships” program has established a comprehensive ECMH consultation model that consists of three levels of intervention. Level one, Universal Consultation, focuses on intervention in classrooms to promote resiliency of all children in a class. Level two, Targeted Consultation, focuses on reducing mild challenging behaviors within
a classroom setting for individually identified children. Level three, Intensive Consultation, focuses on assessment and treatment of mental health and developmental disorders for individually identified children.

In addition to clearly delineated levels of service, the “Partnerships” program has a well-articulated Theory of Change Model. A Theory of Change Model identifies short-term and long-term objectives, the strategies and processes to accomplish them, and the underlying assumptions on which the program is based (Anderson, 2011). To evaluate the program’s services in relation to the “Partnerships” Theory of Change Model, this study employed Stufflebeam’s (2000b) CIPP Program Evaluation Model. The CIPP approach considers a program’s Context, Input, Process, and Product (CIPP). Context refers to the program’s external landscape such as the needs of intended participants, barriers and assets to meeting these needs, and program threats and opportunities. Input refers to the material and manpower resources used to conduct the program. Process refers to the mechanisms used to complete the program’s purpose and is implementation consistent with the program design. Finally, product refers to the overall impact of the program (Hadley & Mitchell, 1995; Stufflebeam, 2000b).

Because it ensures that no program process or outcome is missed, Stufflebeam’s (2000b) CIPP model was the compelling choice for conducting the comprehensive evaluation of the “Partnerships” program. It met the formative and summative evaluation goals and the resulting rich description will allow other ECMH consultants to use this report to inform their own program development.
Significance of the Study

Early Childhood Mental Health is a relatively new field which synthesizes knowledge from counseling, social work, psychology, and special education (Ohio Department of Mental Health, 2009). With its formal existence spanning little more than a decade, the current literature base for ECMH reflects great variation in practice and gives little guidance for those interested in establishing new programs. One way to develop the existing body of research is for ECMHC programs to describe their underlying theory of change models, evaluate them, and publish the results (Brennan et al., 2008; Duran et al., 2009; Perry et al., 2010). By doing so, practitioner “scientists” from the field will help form a network of shared definitions, practices, measures, and methodologies to maximize the ability of current and future researchers to articulate best practices and demonstrate the effectiveness of ECMHC (Ravner & Knitzer, 2002). This current study not only assists with identifying adaptations of ECMHC that are beneficial for rural Appalachian settings, it provides a rich description for others considering implementing an ECMHC program. This study may also serve as an exemplar for applying Stufflebeam’s (2000b) CIPP Model in early childhood mental health. Most importantly, it will benefit “Partnerships” in its continuous efforts to improve and sustain.

Evaluation Design

Within Stufflebeam’s (2000b) CIPP evaluation framework, the researcher used a mixed methods (Tashakkori & Teddlie, 1998, 2003) approach to analyze existing program data. This included three main strategies: systematic review of available program documents, a synthesis of three previous reports containing statistical analyses
of outcomes, and new statistical calculations for unanalyzed extant data sets. The researcher utilized a multiple method strategy to add depth, scope, and dependability to findings (Stufflebeam, 2000b).

The Context component of the evaluation involved a comparison of annual program reports with existing reports of community needs assessments and grant proposals originally used to design and fund the “Partnerships” program. For this component, the researcher used a matrix coding strategy with apriori categories. An independent, external reviewer repeated this same strategy in order to corroborate the findings. The Input evaluation component contained a review of the program’s existing operating budget to assess cost effectiveness of the program. A major part of this component included calculations of consultant, classroom, teacher, and child unit costs of consultation. This work was then followed by a comparison to other state and national early childhood mental health programs. The Process component included a review the “Partnerships” Theory of Change Model and the “Partnerships” Program Model. These models were compared to the actual service delivery which was assessed with new descriptive statistical analysis of consultation logs (nine months of logs for three staff containing 304 entries) and teacher satisfaction surveys (from eight participating teachers). Two existing evaluation reports were also reviewed to determine critical components identified by teachers and program staff. The Product component of the evaluation involved three main strategies. Three reports of statistical analyses of program outcomes were assessed for causal validity and significant findings were synthesized. To date, no one had conducted this type of evaluation of these outcome
reports, or had attempted to combine the findings with other relevant program data to
determine total program impacts. The Product component also entailed new statistical
measures for existing, unanalyzed outcome data collected during the 2011-2012 program
year that included Teacher Opinion Scales, Preschool Mental Health Climate Scales, and
Teacher Satisfaction Surveys. Findings were further triangulated through a document
review of two qualitative evaluation reports. A complete description of each document
and data set used for this study is contained in Chapter Two. More complete details
about the study design and methodology are presented in Chapter Three.

**Evaluation Questions**

The major focus of this evaluation was on examining the effectiveness of the
model in addressing its stated objectives. Objectives identified on the “Partnerships”
Theory of Change Model are: (1) increasing the competence and confidence of
participating teachers to meet the social-emotional needs and reduce the challenging
behaviors of the children they teach, and (2) increasing resiliency for children whose
teachers participate in the program (Shamblin, 2011). In order to align with the CIPP
process, the following questions also guided the evaluation:

1. **Context:** How well did the program address the needs of Athens County
   preschool children and teachers identified during the program’s development
   and prior to its implementation? Going forward, how will the program address
   any unmet needs?

2. **Input:** What resources were used to implement the program; and what is the
   program’s cost effectiveness? How does the program’s per unit costs per class,
teacher, and child compare to other programs in Ohio? How does the program compare to any discussed in the literature? Going forward, what changes would enhance efficiency?

(3) Process: How does the program delivered by staff compare to the “Partnerships” Theory of Change and program models? Were all component parts delivered and what percentage of time was spent on each? What critical processes were identified by ECMHC staff and participating school personnel? Going forward, what changes are recommended?

(4) Product: Did the program help teachers feel more confident and become more competent in reducing challenging child behaviors? If so, how? Did the program increase the resiliency of participating children? If so, how? What is the overall impact of this program model?

**Role as Program Director and Internal Evaluator**

The researcher of this study is also the program director of the “Partnerships” program and was instrumental in the development of the existing program design. As such, she has a recognized vested interest in the outcome of this study. In addition, she supervises the program staff and oversees their implementation of the program services. In order to manage these dual roles and lend credibility to study findings, the researcher analyzed only extant data sources. Because the program has partnered with Ohio University’s Heritage College of Osteopathic Medicine on several federal grants, the program had ample documents and rich data collected under protocols approved by Ohio University’s Internal Review Board. Data analyzed for this study consisted of program-
developed documents as well as outcomes from standardized instruments developed by well respected early childhood mental health consultation experts. No new observations, interviews, or surveys were completed for this study because of the researcher’s dual roles. By focusing on existing program data, the researcher was able to avoid potential role conflicts while acting as supervisor to existing staff and to avoid ethical complications with current program participants. The work evaluated in this study had already been completed, the grants funding the activities had been closed out, and the documents could not be changed. Specific documents and data analyzed will be discussed in Chapter Two.

Note that since the researcher is the program designer and director, she is drawing on three specific, well-established research stances: internal evaluator, connoisseurship, and scientist-practitioner. This represents an advantage because internal evaluators understand aspects of the program that outsiders may not, are able to streamline the study design process, and can immediately apply the evaluation results (Brody, 2009). Additionally, as an experienced early childhood mental health consultant with over ten years of experience, the researcher was able to employ elements of Eisner’s Educational Connoisseurship model –In this qualitative process, the researcher enters as a participant observer, and much like a connoisseur of art, uses specialized skill and informed “critical eye” to critique a program (Eisner, 1976). Finally, in conducting this study, the researcher embraced her position as a scientist-practitioner—a stance that affirms that a person can engage in practice and research simultaneously as a set of integrated activities
to the enhancement of both (Stoltenbert & Pace, 2007). Further details related to the evaluation design will be outlined in Chapter Three.

**Limitations**

This study is primarily constrained because of the use of an internal evaluator and dual roles that she plays as researcher and program director/developer. In managing these roles, the researcher focused the study on an analysis of past program documents and data. In doing so, the researcher has been able to reduce staff tension, increase credibility of findings, and create a transparent research process. However, there was limited ability to collect missing information or to evolve the evaluation process. The researcher further assumed that program staff and participating teachers have recorded information accurately on program documents. This assumption appears to be supported given that teacher and staff data, which were independently generated, yielded complementary findings.

Program documents and data sets were complete and easily accessible. Outcome data analyzed was primarily limited by the scarcity of tools available for assessing the components of early childhood mental health consultation. Because ECMH is new practice, few tools exist for measuring child outcomes, and even fewer standardized ones. Tools for measuring teacher and classroom consultation outcomes, while described in ECMH literature, have not been standardized and are not widely available. For these components, the “Partnerships” program has used tools identified as “best practice” in “Early Childhood Mental Health Consultation: An Evaluation Tool Kit” (Hepburn et al., 2007). For child outcomes, the program has been using a tool commonly recognized by
the field, the Devereux Early Childhood Assessment (LeBuffe & Naglieri, 1999).

Specific program measures will be described further in Chapter Two.

Delimitations

This study was delimited to the “Partnerships” program. It is further delimited to existing documents and data created by program staff and school personnel from participating schools collected over the last two years of the program. The results are relevant for comparable early childhood mental health programs serving similar schools and students. Readers of the study may choose for themselves how well the study results apply to their specific circumstances and to the general field of early childhood mental health consultation.

Definition of Terms

For the purposes of this study, the following definitions are used:

*Early Childhood Mental Health Consultation:* “A problem-solving and capacity building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more caregivers, typically an early care and educational professional and a family member (Cohen & Kaufman, 2000, p. 4)”.

*Universal Consultation:* EMCH Consultation that is focused on helping a teacher or early childhood professional encourage healthy social-emotional development for all children in the class or other care setting.

*Targeted Consultation:* ECMH Consultation that is focused on improving behaviors of a specific child within a classroom or care setting.
**Intensive Consultation:** Mental health assessment and treatment for a specific individual child.


**Resiliency:** Internal characteristics that seem to safeguard individuals against the stresses of life and resulting in more positive outcomes in adulthood (Masten & Garmezy, 1985).

**Protective factors:** Personal characteristics developed in childhood that appear to increase resiliency; grouped into “initiative, attachment, and self-control” (LeBuffe & Naglieri, 1999, p.4).

**Initiative:** “A child’s ability to use independent thought and action to meet his or her needs (LeBuffe & Naglieri, 1999, p.4).”

**Attachment:** “A mutual, strong, and long-lasting relationship between a child and a significant adult such as a parent, family member, or teacher (LeBuffe & Naglieri, 1999, p.4).”

**Self-control:** “The child’s ability to experience a range of feelings and express them using the words and actions that society considers appropriate (LeBuffe & Naglieri, 1999, p.4).”

**Organization of this Dissertation**

This dissertation is presented in five chapters. This first chapter provided an introductory overview of the study including relevant background, the purpose of the study, the significance of the study, the evaluation design, the evaluation questions, the limitations, delimitations, and definitions of terms. Chapter Two is a review of the
literature and covers the following topics: reasons for investing in early childhood mental health, evidence supporting early childhood mental health consultation, program evaluation literature, and the CIPP model. The chapter closes with a description of Tri-County Mental Health and Counseling and the Partnerships for Early Childhood Mental Health Program. Chapter Three explains the methodology used to conduct the evaluation study. Chapter Four reviews relevant results. Chapter Five provides a discussion of the results, their implications for the program, and relevance for the ECMH field.
Chapter 2: Review of the Literature

For many adults, early childhood may stir warm memories of carefree days with little responsibility, few worries, and much innocent laughter. They may wonder why any preschool child would require mental health services. Even helping professionals are slow to realize the need for specialized services for this population and few training programs exist. Until the last decade, few tools or interventions were available for those mental health professionals focusing on young children (Fitzgerald & Barton, 2000).

This changed in 2005, with Gilliam’s landmark study of preschool expulsion. His survey of state-funded preschools across the United States revealed that two thirds of states allowed expulsion of preschoolers. Only eight of these states required any documentation of the circumstances surrounding the expulsion; and only four required that the expelled preschooler receive an assessment or intervention services (as required by federal special education guidelines). On average, the 4,000 participating state-funded preschools were expelling children at a rate of 6.7 in 1000 children. This was three times greater than the rate for any other grade level, K-12. With these startling results, Gilliam’s study brought young children’s mental health to the national stage.

What are the impacts to young children? Ravner and Knitzer (2002) found that self-regulation and behavioral health was highly tied to school success. Children with behavior problems in preschool are less accepted by peers and teachers, receive less interaction with teachers, participate in fewer learning activities, and have fewer opportunities to participate in enrichment activities. The number of preschool children with behavior problems may be greater than expected. The statistics range from 10% in
the general population to 27% in low economic population, and as high as 30% per report of preschool teachers (Ravner & Knizter, 2002).

Gilliam again came to national attention in 2008, when he highlighted a promising practice that addressed the national concern of preschool expulsion: Early childhood mental health consultation (ECMHC). First described in the literature by Cohen and Kaufman (2000), Early Childhood Mental Health Consultation (ECMHC) is “a problem-solving, capacity building intervention that takes place within a collaborative relationship between a trained ECMH consultant, other early childhood professionals, and primary caregivers/parents (p. 4).” The goal is to assist professional and primary caregivers so they can support social-emotional development, decrease challenging behaviors, and identify/intervene with any budding mental health issues for the preschool children in their care. Gilliam (2008) found that teachers with consistent access to early childhood mental health consultation were 50% less likely to remove a child from the care setting, but only 23% of teachers had access to this promising service.

These initial studies led to an increased interest in ECMHC. By 2009, 29 states had some form of ECMHC, 72% of these embraced statewide implementation, and eight used a single intervention. Of these programs, 72% were housed in mental health centers (Duran, Hepburn, Kaufman, & Le, 2009). With a rapid expansion that spans less than five years, the research base for the field of early childhood mental health and specific practices such as consultation is limited.

One challenge to researchers is that ECMHC is delivered in a variety of ways and there are many different models. Two attempts have been made to identify the common
components that are found in all ECMHC programs: “Promising Practices in Early Childhood Mental Health” (Simpson, Jivangee, Koroloff, Doerfler, & Garcia, 2001) and “What Works? A Study of Effective Early Childhood Mental Health Programs” (Duran et al., 2009). The two documents had different approaches which resulted in different criteria. However, commonalities were that ECMHC services were individualized and tailored to the unique needs and strengths of participants; comprehensive and included a variety of intervention levels; coordinated and encompassed multiple child serving systems; and built on strengths and resiliency enhancing positive skill development as opposed to problems and deficit (Simpson et al., 2001; Duran et al., 2009).

This chapter will review the existing literature supporting early childhood mental health from four dimensions: long-term impact of untreated early emotional and mental distress in the adult population, research syntheses of current brain science, economic return-on-investment theory, and current research evidence for the specific practice of early childhood mental health consultation. Recommendations to add to the evidence base through program evaluation will be identified, followed by a brief review of program evaluation literature, and an overview of a specific evaluation called the CIPP model. Finally, highlights of Partnerships for Early Childhood Mental Health Program and its parent organization, Tri-County Mental Health, will be described. The chapter will conclude by summarizing issues relevant to the evaluation of this program.
Why Invest in the Mental Health of Young Children?

Long-Term Impact of Untreated Early Childhood Mental Health Issues

Found in the Adult Population

A review of four significant adult studies suggests that untreated mental health issues, especially early trauma, can have significant mental and physical health effects even in adulthood. The most extensive study to date is the Adverse Childhood Experiences Study (ACES) (Feletti et al., 2002). In this survey research, approximately 14,000 HMO participants reported on their adverse childhood experiences which were then linked to their HMO claims. Adverse childhood experiences encompassed the following events: emotional, physical, or sexual abuse/neglect; growing up in a household with a parent who was substance addicted, mentally ill, suicidal, or a victim of domestic violence; and/or having a parent who was incarcerated. Of those participating, 66% had experienced at least one adverse event, 25% had experienced two. Those who had one event were 80% more likely to have experienced a second one. Most significantly, those who had experienced four or more adverse events were 460% more likely to deal with depression; and 500% more likely to have alcohol problems. While 60% of those who had experienced no adverse childhood events as children lived to age 65, only 3% of those with four or more events reached this milestone (Felletti, 2002).

This initial study was limited because it was based on retrospective self-reports. It was further limited to establishing a relationship between these retrospective, self-reported adverse childhood experiences and health/mental health outcomes but could not establish causality. Despite these limitations, this initial study serves as an important base for the
ongoing work being conducted by the ACES study group which has established a website to continue to gather data (Adverse Childhood Experiences Study, 2012). Results are published annually, through the Center for Disease Control and Prevention, and continue to demonstrate strong relationships between the presence of self-reported adverse childhood experiences and numerous chronic medical conditions such as autoimmune diseases, pulmonary disease, liver disease, lung cancer, alcoholism, substance abuse, obesity, depression, and suicide (Centers for Disease Control and Prevention, 2012).

Focusing specifically on childhood physical abuse and neglect, a smaller study surveyed 2,800 adults about their current health/mental health and their previous childhood experiences (Springer, Sheridan, Kuo, & Carnes, 2007). The researchers analyzed population survey data from the Wisconsin Longitudinal Study containing retroactive self-reports of childhood physical abuse/neglect, childhood access to mental health services, and current mental health and physical health status. Of those responding, 11.4 % had experienced some form of abuse or neglect in early childhood. Statistically controlling for numerous demographic factors (current age, race, gender, the presence of additional adverse childhood effects besides abuse, and family economic circumstances), physical abuse in early childhood was predictive of increased risk of depression, anxiety, aggression, physical health problems, and medical diagnoses. Like the ACES study, the researchers correctly identified the limits that reliance on retroactive self-reporting placed on their study. However, the study further supports the relationship between events in early childhood and adult mental and physical health outcomes.
McLaughlin, Campbell, & Pungello (2007) was the first to establish a potential relationship between intervention in early childhood and adult mental health. Children who participated in quality early childhood programming with mental health interventions were followed into adulthood. The early childhood programming was based on standards established in the Abecedarian project (a North Carolina early education project serving low-income children in a child-care model), which not only included low child-adult ratios, learning strategies individualized for each participating child, and developmental screening and surveillance, but also included ongoing mental health supports (Campbell & Ramey, 2007). As adults, the participation group had a 26% prevalence of depression compared with 37% of the non-participation group (McLaughlin et al., 2007). While the outcomes of McLaughlin’s study cannot be solely attributed to the mental health supports that participating children received, they do point to the possible positive impact of mental health supports provided within the context of early childhood education settings. As such, it provides significant understanding of the field of ECMH because it is this interplay between mental health and early childhood education which serves as the hallmark of the specific strategy identified as early childhood mental health consultation.

Guyer, Grason, Frick, Perry, Sharkey, and McIntosh (2009) furthered the support for a link between early childhood interventions and improved adult mental health and health outcomes. They conducted a meta-analysis of early childhood interventions for tobacco use, injury prevention, obesity prevention, and mental health. The analysis contained all articles for early childhood prevention strategies in these four areas that
were listed in PubMed, PsychINFO, National Health Service Economic Evaluation Database, the National Bureau of Economic Research working paper database, and EconLit. Strong literature support was found for promotion and prevention activities for reducing tobacco use and accidental injury. There was good support for obesity and mental health, as well; however, the existing studies for these two areas were smaller and more localized than for tobacco and accidental injury. More wide-scale studies are needed in order to have the same security that early childhood prevention activities for obesity and mental health are causally linked to improved adult outcomes (Guyer et al., 2009).

**Current Brain Science**

It is not surprising that researchers are finding links between untreated early mental health issues and long-term consequences into adulthood. Harvard’s National Scientific Council on the Developing Child (NSCDC) is a leader in synthesizing neuroscience for the field of early childhood. Major neurological findings released by this entity contain many discoveries directly relevant to early childhood mental health (NSCDC, 2004, 2007, 2008, 2010, & 2011). Among these are (1) the role that social emotional development and early relationships have on the developing brain; (2) the ways that young, developing brains are impacted by early childhood trauma; (3) the nature of emotional and mental health distress in young children; (4) the impact of prolonged anxiety on early brain development; and (5) the acquisition of executive functioning by the brain during the preschool years.
Early social-emotional development and early relationships are essential to brain development. The emotional experiences of babies take place within the context of primary caregivers. The emotional states of young children are complex and are dependent on their own emerging capacities to regulate these feelings. By the end of preschool, children who have good emotional regulation are able to anticipate, talk about, and empathize with their own and others feelings. When emotions are dis-regulated, executive brain functioning is decreased leading to poorer attention and decision making (NSCDC Report, 2004).

Because the brain develops within the context of caregiver interactions, it is vulnerable to the negative impacts of adverse childhood events such as those previously mentioned in the ACES study. Adverse childhood events lead to specific physical trauma responses, for example, increased levels of fight-or-flight neurotransmitters such as adrenaline. The developing brain is not meant to have a continuous exposure to these chemicals. When this happens because of chronic exposure to adverse effects, the developing brain becomes hardwired for hyper vigilance and hyper responding. This can impact a child’s abilities to attend, focus, have organized functioning, and make sound decisions --all critical to school success (NSCDC Report, 2007).

Young children experience the same intense emotions and mental distress as older children and adults. This distress can be as severe and impactful as that experienced by older children and adults, but often it is expressed differently. Different diagnostic and intervening skills are needed by professionals working with this age-group. Because young children are so heavily reliant on their caregivers, these activities must include
primary caregiving, and occur in natural environments. The consequences of not attending to these early distresses can be potentially long lasting. Young children experiencing extreme emotional and mental health distress have impacted executive functioning and decision making which sets them up for long-term challenges if left untreated (NSCDC Report, 2008).

Specifically, experiencing a fearful event impacts a developing brain, particularly the regions responsible for emotional regulation and learning. Young children learn to connect feelings of fear with the associated context. Unlearning fear is much more complex than developing a fear response. Once this neural pathway is created, it is difficult to extinguish. Persistent fear can distort how children perceive and respond to threats, even neutral ones. Children do not outgrow early learned fear responses, and they are not changed just by removing a child from a dangerous situation (NSCDC Report, 2010).

A child’s early relationships and care environments have a crucial role in the developing brain, especially executive functioning. Executive functioning is like the “control center” that allows all other brain systems to work in tandem. It includes memory, inhibition, and cognitive flexibility. In everyday situations, these three neurological systems work together to produce appropriate social responses. Consequently, executive functioning skills form the basis of a child’s ability to learn new information, focus attention, and control impulses—all necessary skills required for school success (NSCDC Report, 2011).
The totality of the reports from Harvard’s National Scientific Council on the Developing Child (NSCDC) points to the critical nature of social-emotional health to the young child’s developing brain. These findings from neuroscience have come to the attention of economists, who are beginning to articulate the fiscal benefits of investing in the social-emotional health of young children (Heckman, 2000; Rand, 2008).

**Economic Theory and Return on Investment**

As the knowledge of brain science becomes widespread, economists are also beginning to see the importance of investing in early childhood. A specific economic model, Human Capital Theory, has been used by those advocating for investment in young children (Heckman, 2000). Heckman, an economist, developed his theory through his review of numerous international policies, analyses of the research studies on the impact of social service and educational programs, and existing return on investment studies. The basic premises of his theory are that “(1) child development is a process that has specific time periods; (2) skills acquired in one period are critically dependent on the skills learned in the previous periods; (3) both nature and nurture play roles in new skill development; and (4) human capabilities include a set of productive characteristics such as cognitive skills, artistic ability, and health (Heckman, 2000, p. 3).” These four premises suggest that it makes sense to develop human capital in early life stages to get the best return on investment. Through his model, Heckman was attempting to build a unifying framework for early childhood educational and social policy and economic investment. It implies that economic investment in programs meant to increase the productive capacities of individuals, during the early years, will not only produce the
greatest impact for participating individuals, but will also produce the greatest monetary payoffs for society (Heckman, 2000).

Seeking to investigate Heckman’s theory, the Rand Corporation conducted a series of return on investment studies consisting of two meta-analyses (2008). The first review published research findings on twenty early childhood education programs and their outcomes. In this review, Rand identified twelve specific areas where government savings had occurred through these programs. These taxpayer savings primarily occurred because the early childhood programs were preventive in nature and lead to decreased costs for intervention programs in adolescence and adulthood. Specific examples include lower special education costs, reduced costs for social welfare programs serving adults, lower public health costs, and lower court and criminal costs. In its second critical review of available literature, Rand was able to document significant return on investments. Published literature of forty-eight early childhood programs, revealed an average return on investment (ROI) of $2.36 for every dollar spent, and a range of approximately $1.80-$17.07. Variations in these ROI findings were linked to program components. Some variations were associated with the length of follow-up: Higher benefit-costs were linked to programs with long-term follow-up such as the Perry Preschool Project which followed its original group of participants until the age of 40. Other variations were linked to the intensity of the program: small-scale intense programs have the greatest outcomes but are the most expensive to implement across a broad spectrum. There was also evidence that ROI decreases under specific circumstances. While universally administered programs have some positive ROI, the
ROI is highest when programs are designed and targeted to meet the needs of a specialized population such as children who are living in poverty, or those who have experienced physical abuse. Finally, variation was linked to quality; raising program quality increased positive outcomes, but make a program more expensive to bring up to state or national scale. Consequently, the major insight for ROI studies is the need to balance quality of programming with quantity of children to be served; and to target programming for the needs of specialized populations (Rand, 2008).

President Obama has recognized the importance of economic investment in early childhood to developing a skilled, future workforce for the United States. His “Zero to Five Plan” is based on the Rand documents (2008). His administration has increased the federal Head Start budget by 2.1 billion dollars and the Maternal, Infant, and Early Childhood Home Visiting Program by 1.5 billion dollars. Under the American Recovery and Reinvestment Act, the administration invested two billion dollars in the Child Care and Development Fund designed to increase the capacity of the early childhood workforce. Finally, a new program called the Race to the Top: Early Learning Challenge Program, charges states with transforming their early learning systems. The project is supported by a budget of $600 million dollars. All these endeavors emphasize a holistic approach to child development and recognize the importance of addressing social-emotional development in young children (www.whitehouse.gov/issues/education/early-childhood).

Rand’s ROI studies and Heckman’s theory are supportive of early childhood mental health, particularly consultation. ECMHC seeks to improve the quality of all
early childhood education settings through increasing the skills of teachers and caregivers, while building in targeted intervention strategies for children who need additional social-emotional supports.

**Early Childhood Mental Health Consultation**

**Effectiveness of Consultation**

Economists are calling for financial investment in early childhood, but is there specific research supporting early childhood mental health consultation as an effective strategy for addressing the mental health needs of young children? The answer is beginning to be “yes.” Since it was first described by Cohen and Kaufman (2000) and brought to attention by Gilliam (2008), the literature for early childhood mental health is growing. Over the past decade, early childhood mental health consultation has been linked to a reduction in child abuse, a reduction in challenging child behaviors and increased social skills, and increased confidence and competence of early childhood teachers.

One of the earliest published studies on ECMHC was conducted by the Center for the Study of Social Policy (CSSP) in 2001. CSSP found that four early childhood programs that had met their quality standards also employed early childhood mental health consultants. These were the only four centers associated with the center to do so. These four centers were surveyed regarding the components of their consultation program, including participating children and families. Based on survey responses, the center found a relationship between ECMHC and several outcomes known to reduce the risks of abuse and neglect to children. Specifically, CSSP concluded that ECMHC (a)
reduced externalizing child behaviors which place children at greater risk, (b) increased positive parenting behaviors so they use fewer punitive measures, (c) increased relationships between early childhood professionals and parents so that parents have a safety net, and (d) increased access to MH services for children or parents who need them (Center for the Study of Social Policy, 2001). Although these findings were limited by the scope of the project (four centers) and the type of methodology (survey research), this study served as a foundational study for future researchers.

The first randomized study of ECMHC supported CSSP’s findings that ECMHC reduced externalizing behaviors, particularly oppositional defiant and hyperactive behaviors, for participating children (Alkon, Ramler, & MacLennan, 2003). In this study, classrooms in 25 urban centers were randomly assigned to receive consultation services or to a wait-list control. Consultants worked with teachers to increase their skills and with individually identified children who needed behavioral supports. Throughout the one-year of services, observational measures, director and teacher questionnaires, and staff focus groups were conducted. The researchers identified that the reduction in the challenging behaviors were linked to an increase in social skills. Subsequent follow-up studies have supported these initial results for participating children (Han, Catron, Weiss, & Marcil, 2005; Perry, Dunne, McFadden, & Campbell, 2008; Williford & Shelton, 2008). Even when the consultation is only aimed at increasing teacher skills and confidence, the same outcomes have been obtained for children in participating classes (Morrison & Bratton, 2010). These studies seem to suggest that ECMHC does support
improved behavior outcomes for children, even though the focus of the intervention is on teachers and caregivers.

In this regard, ECMH has been linked to increased confidence and competence of teachers and parents. Brennan, Bradley, Allen, and Perry (2008) critically reviewed 26 published and unpublished research studies and program evaluations addressing the impact of ECMH consultation on early childhood professionals. For their search they moved beyond electronic search databases such as PsychINFO and ERIC, and included smaller websites such as universities, state departments websites, and Early Care and Education Referral databases directed at parents seeking childcare. Additionally, they contacted professionals considered experts in the field and asked for their assistance in obtaining internal and external reports for established consultation programs. This exhaustive search resulted in their final review of 26 programs. Following a critical review of these documents, the researchers concluded that across all studies there was some evidence that ECMHC supported increased teacher self-efficacy, confidence, and competence in dealing with challenging child behaviors; and some studies suggested that it improved staff sensitivity, lowered job-related stress, and decreased staff turnover. These findings are being supported in published follow-up studies. A pilot study of “Together for Kids”, a comprehensive consultation program directed at teachers and parents, found increased use of positive parenting practices, and increased teacher competency (Upsher, Wenz-Gross, & Reed, 2009). Even when consultation is not directed at parents, it appears that ECMHC may reduce implementation barriers associated with conducting other evidenced-based parenting programs such as the
Incredible Years Parent Program—an evidence-based positive-parenting training curriculum (Shepherd & Dickstein, 2009). Most recently, Louisiana’s statewide implementation of ECMHC in all of its public-funded childcare centers found that participating teachers demonstrated increased efficacy, confidence, and competence. As one might expect, the impact was greatest for new and inexperienced teachers (Heller, Boothe, Keyes, Nagle, Sidell, & Rice, 2011).

Although limited, the research on ECMHC is promising; ECMH appears to help children who have special social, emotional, and behavioral health needs through increasing caregiver abilities. However, if consultation results in improved teacher and caregiver efficacy, is it also impacting typical developing children—those with no identified special needs? This is a question that proponents of ECMHC are interested in answering.

**Resiliency**

As the research base for ECMHC grows, the field is expanding its focus from simply reducing challenging behaviors to increasing the social-emotional resiliency. A 40-year longitudinal study of Hawaiian children with four or more significant risk factors at aged two, found that one third went on to become loving, responsible adults (Masten, Best, & Garmezy, 1991; Werner & Smith, 1982, 1992). Masten and Garemezy termed this phenomenon “resiliency.” Resilient children appear to have certain common characteristics that seem to buffer the stresses of life and yield positive outcomes in adulthood (Masten & Garmezy, 1985). These factors have been labeled as “protective factors” and have been grouped into three categories: initiative, attachment, and self-
control (Garmezy, 1985). Initiative has been described as “a child’s ability to use independent thoughts and actions to meet his or her needs (Koralek, 1999, p. 19).” “Attachment is a mutual, strong, and long-lasting relationship between a child and significant adults (Koralek, 1999, p. 13).” Self-control is defined as the “ability to considers appropriate (Koralek, 1999, p. 15).”

ECMHC programs have shown promise with increasing resiliency and reducing the negative impacts of stress (Brooks, 1994; Rak & Patterson, 1996). The Devereux foundation has created a resiliency-based assessment and intervention system, the Devereux Early Childhood Assessment experience a range of feelings and express them using the words and actions that society (DECA), focused on these factors; it has been embraced by ECMHC practitioners and is one of the predominant tools for the field (LeBuffe & Naglieri, 1999). This tool will be further discussed in later in this chapter in the program data section.

**Incredible Years Program**

While the DECA system focuses on tools to use in the consultation process, Carolyn Webster-Stratton has concentrated her efforts on developing specific curricula that ECMH professionals can use in their work. The result is the highly-awarded Incredible Years program, which embraces a three-prong approach--teacher training, parent education, and social skill development for children. Each one of these includes extensive training and copious materials. The most prominent component is the child social skills program--Dina School—featuring Dina the Dinosaur. The Incredible Years has an established evidence base that the program reduces externalizing behaviors for
children and increases positive guidance techniques for parents and teachers. The program “has been recognized by the U.S. Office of Juvenile Justice and Delinquency Prevention, the Center for Substance Abuse Prevention (CSAP), and the American Psychological Division 12 Task force (Webster-Stratton & Reid, 2004, 96).”

Expanding the ECMHC Field through Program Evaluation

In an effort to identify effective ECMHC tools and practices, such as the DECA system, Georgetown University published “The Evaluation Tool Kit for Early Childhood Mental Health” (Hepburn et al., 2007). The document suggests that, in addition to the practical aspects of responsiveness to stakeholders and funders, ECMHC program evaluation will support the field’s current science-practitioner model and continue the current trend of field-based research. Recommendations are that such evaluations be summative, follow a formalized process and a documented evaluation model, and that the results be published and shared with the field (Hepburn et al., 2007). Duran et al. (2009) echoed these remarks and added some specific gaps in the published literature base that program evaluations could help address: (1) what are specific model steps/processes, (2) what dosage of consultation is needed for results, (3) which populations are best served by specific models, (4) what outcomes are best for ECMHC researchers to attend to, and (5) what tools are available and what needs to be developed in order to measure these outcomes? In order to respond to these recommendations, ECMHC administrators and staff would benefit from a basic understanding of program evaluation literature.
Program Evaluation

Program evaluation is applied research to make or support decisions about a program (Hadley & Mitchell, 1995). Hepburn and colleagues (2007) encourage program evaluators to attempt to understand, not just if a program works, but also how it works. Program evaluation strategies are usually focused on assessing the impact and satisfaction of the specific clientele served by a particular program. However if designed appropriately, program evaluation results may be of value beyond the specific program assessed. Contingent on the type of design, program evaluation results may generalize to other similar programs and address potential cause-and-effect relationships between program features and associated outcomes (Hadley & Mitchell, 1995).

Formative versus Summative Evaluation

Evaluations can be characterized by purpose. Formative evaluation is typically conducted during the development phase or used to make improvements. The typical audience for the results is program staff and administration. Summative evaluation is usually conducted after the completion of the program for an external audience of decision makers, funders, or policy makers (Madaus & Kelleghan, 2000). Sciven (1991) states that the two can be, and are often, intertwined. If a program conducts a summative evaluation, but then continues to exist, the results may also be used in a formative manner to make programmatic changes moving forward. This is the case for this current study. Summative evaluation should have all of the qualities of any well-designed research study. Since the results will be used to make important decisions, it is essential to have
evidence to support them and to give attention to the generalizability of the results (Fitz-Gibbon & Morris, 1987).

**Internal Evaluator versus External Evaluator**

Evaluations can also be characterized by the type of evaluator. Internal evaluation is conducted by program staff/administration whereas external evaluation is conducted by someone who is not part of the program (Madaus & Kelleghan, 2000). Internal evaluators are far more likely to understand all of the nuances of a program than an outsider could learn, but may be so close to the program that they are unable to be objective. On the other hand, external evaluators, may be more objective (unless they have a hidden agenda), but seldom are able to learn as much about a program as an insider (Worthen, Sanders, & Fitzpatrick, 1997). Brody (2009) identified positive aspects related to the use of internal evaluators (1) they understand aspects of a program that an outsider may not, (2) reduced time can be spent designing the program evaluation, and (3) the results can have immediate application because the evaluator is a participant and contributor of the program.

Love (1998) identified the unique strengths of internal evaluators and acknowledged that the use of internal evaluators is growing within organizations, especially in the fields of education and human services. Internal evaluators are better able to identify strategies that fit their specific situations, more effectively promote the findings, increase staff credibility due to a long-term agency commitment, and reduce anxiety associated with evaluation activities. Most importantly, they are better able to assist in crucial strategic and policy decisions. He concludes that internal evaluators are
an important part of contemporary program evaluation practice and suggests that consideration be given to combining internal and external evaluation components in order to maximize the benefits and minimize the deficits of each.

**The Internal Evaluator as a Scientist-Practitioner**

In many ways, the role of an internal evaluator aligns well with the scientist-practitioner model that suggests a person can engage in practice and research simultaneously as a set of integrated activities, and that by doing so enhance both (Stollenberg & Pace, 2007). Sexton (1996) endorsed this model for counseling, proposing that it helps counselors have realistic expectations of research, make appropriate use of research techniques to guide their interventions, remain current on best practices, be more responsive to their clients, effectively communicate research findings to clients, and improve the integrity of treatment by producing specific intervention protocols and assessment strategies to create consistent service delivery. In the current social service landscape emphasizing evidence-based practice (EBP), scientist-practitioners may offer unique opportunities to develop relevant, practical EBPs and assist in the implementation of EBPs (Lowman, 2012; Spoth & Greenberg, 2011). Shapiro (2002) offered some principles for science-practitioners: “(1) Access and integrate scientific findings into healthcare decisions, (2) Frame and test hypotheses and use results to inform healthcare decisions, (3) Build and maintain a network of other healthcare professionals to support the delivery of scientist-practitioner contributions, (4) Conduct research-based training and support to other health professionals to enhance the
delivery of care, and (5) Contribute to practice-based research to improve the quality and effectiveness of healthcare (p. 234).”

**Qualitative Concepts Applicable to Internal Program Evaluation**

The internal perspective that an evaluator may have as a program participant or an organizational employee is not entirely new to research. Qualitative research often incorporates the researcher’s subjective experiences as part of the research process including data collection and analyses. Because of this stance, qualitative researchers have developed strategies to promote the credibility of their findings. Internal evaluators may find these techniques, as well as other qualitative research strategies, applicable to their efforts (Patton 2002). Credibility techniques, reflexivity, emergent design, and document analysis are specific qualitative techniques that may be particularly suitable to program evaluation.

Patton (2002) characterizes credibility techniques as strategies for ensuring the trustworthiness and authenticity of findings that are inclusive of the subjectivity of the researcher, whether he or she is employing qualitative, quantitative, or mixed methods. Among the credibility techniques described by Patton (2002) are: (1) identifying rival conclusions—methodically exploring alternative explanations; (2) exploring negative cases—situations where the program model was not effective, or satisfaction was not good; and (3) triangulation—combining several different types of methods or data sources to test for consistency of results. Gilgun (2011) advises researchers to explore negative case examples during data collection and analysis. She suggests that it is
particularly important to systematically look for data that can add to, undermine, or even refute preliminary data and initial analyses.

Patton (2002) explains that credibility is enhanced when researchers keep a log of their subjective experiences during the research project in a process called reflexivity. Reflexivity is self-awareness on the part of the researcher concerning what he or she brings to the process and includes a critical review of this awareness (Finlay, 2003). Gilgun (2010) adds that researchers, no matter what their methodology or perspective, must be reflexive in their work especially accounting for the personal and professional meaning their topics have for them. Investigators’ credibility is enhanced when they log any personal experiences that may have affected data collection, analysis, and interpretation; and fully disclose this during the process and reporting (Patton 2002).

A qualitative practice that seems particularly appropriate to program evaluation is document analyses. Documents play a central role in the practice of social services and often form an important part of program activities (Nolas, 2011). Depending on the content of program documents, they can be analyzed using quantitative or qualitative methodology. For documents containing qualitative information, Thomas (2006) describes a straightforward, practical process of inductive analysis that program evaluators can employ that allows them to continue to remain open to emergent design. His approach gives evaluators a systematic strategy for condensing extensive qualitative data into brief summary formats that links the research questions with themes in the raw data. Thomas’s approach involves five steps.
Step One: Preparation of the raw data files by formatting them into a uniform text size, margins, etc. This is followed by making print copies as well as back-up electronic copies.

Step Two: The evaluator closely reads each text document in detail until there is a familiarity with the content and themes covered in the text.

Step Three: Once familiar with the content, the evaluator identifies and defines categories or themes—major ideas and concepts shared among the documents reviewed. These should be linked to the evaluation questions. Paper copies can be highlighted to demonstrate how specific sections are coded; or electronic text segments can be copied and pasted into grids. Thomas suggests that in program document analysis, the researcher should be guided by the evaluation questions. As a result, text may be coded into more than one category or may not be coded into any category.

Step Four: Once initial broad and supportive categories are coded, the evaluator continues revising and refining the category system by searching for subtopics, contradictory ideas, and useful quotations.

Step Five: Continue refining and reducing categories until three to eight summary categories that summarize essential themes found in the raw data and link to the evaluation objectives. Thomas views coding that has more than eight major themes is incomplete, and requires the evaluator to review the objectives of the evaluation and make hard decisions about which themes are the most critical to meeting these objectives.

By combining document analyses with the analyses of other types of data, a researcher can accomplish triangulation—mixing multiple data sources, analyses, or
views to assess for consistency of results (Patton, 2002). Triangulation has four different approaches (Denzin, 1978): (1) data—multiple data sources, (2) investigator—multiple investigators, (3) theory—multiple perspectives of interpretation for a single set of data, and (4) methodology—multiple methods. All four of these approaches can be applied to program evaluation (Stufflebeam, 2000a). Evaluators interested in triangulation through methodology may be assisted in their efforts by reviewing the literature from mixed-methods researchers.

**Mixed Methods in Program Evaluation**

Confirming research results through multiple methods within a single study has evolved into a distinct approach called “mixed methods” research (Tashakkori & Teddlie, 1998). This type of inquiry focuses on incorporating quantitative and qualitative research strategies and methods in order to integrate the strengths of both (Creswell, 2009). Numerous configurations have been developed by mixed methods researchers and overlap exists (Creswell & Plano Clark, 2007). Stufflebeam (2000a) described the application of mixed methods strategies to program evaluation to increase the depth, scope, and dependability of findings. He identifies this approach as being appropriate to summative and formative evaluations; comparison of programs; or impact of a single program. He cautions against using mixed methods approaches because it is “popular” or to compensate for lack of rigor in design. Program evaluators are advised to be guided by the methods that will be the best to answer their specific evaluation questions. An evaluator can further fine-tune an approach for answering their evaluation questions through a basic review of evaluation models.
Evaluation Models

Stufflebeam (2000a) provides an overview of twenty-two different program evaluation models. He classified these into four categories: Pseudo-evaluation, Question-Method Evaluation, Improvement-Accountability Evaluation, and Social Agenda/Advocacy Evaluation. He describes pseudo-evaluation as one with an ulterior motive. It often employs spurious methodology and releases incomplete results to accomplish its purposes. Question-Method evaluations generally employ more objective methodology, but usually seek to answer only one specific question or assess only one aspect of a program. The guiding philosophy is that it is better to do a very thorough job with one question/one program component than to over extend. In contrast, Improvement-Accountability evaluations seek to assess all aspects of an entire program, are often summative in nature, and generally employ mixed-methods. Finally, social-agenda/advocacy evaluations are typically concerned with access to an education or social service program for a marginalized population. They often employ the use of stakeholders, are based on many perspectives, and typically make greater use of qualitative techniques.

Garboan (2008) reviewed existing program evaluation models based on their focus and derived six basic categories: results, process, systems, finances, stakeholders, and program theory. He concludes his review by commenting that the current trend, and best recommendation, is for program evaluators to employ more than one model at a time in order to capture the many complex dimensions of a program. He highlighted
Stufflebeam’s CIPP model as the best example of this trend because of its ability to systematically combine all six evaluation foci within one evaluation model.

**The CIPP Model**

Stufflebeam’s (2000b) CIPP approach is a multi-step process consisting of four mini-evaluations: C for Context of the program; I for the Inputs (material and manpower) that make a program work; P for Process or how are program goals accomplished; and P for the Products of the program. He suggests that the CIPP framework, because it has identified goals and methodological choices, can promote objectivity during internal evaluation. Hadley and Mitchell (1995) further endorse this model for the counseling profession and other mental health professions because it is comprehensive and helps ensure that no evaluation questions or program aspects get overlooked. The CIPP model can be used by internal evaluators (program staff and administrators) as well as external evaluators (accreditation officials, funders, evaluation researchers); and is highly versatile in its many applications ranging from education and social service non-profits to government entities and branches of the military. Because of the model’s versatility, numerous quantitative and qualitative methodologies can be incorporated (Stufflebeam, 2000b).

During a summative evaluation, the goal is to sum up the program’s impact and significance. In order to do this, the context evaluation should focus on comparing the program’s initial goals and properties in relation to the originally identified needs, problems, assets, and opportunities. The input evaluation would compare the program’s design and budget with other programs that serve similar constituents. The process
evaluation would compare the originally developed program design and the actual processes implemented. Finally, the product evaluation would compare the outcomes and feasibility to develop an interpretation of the program’s overall impact.

The Context component requires the description of a program’s intended participants, an assessment of their needs, identification of problems and/or barriers to meeting these needs, and evaluate the program’s success in addressing these needs. This component entails asking questions such as: What unmet needs exist? And, what is the community and organizational context in which the program operates (Hadley & Mitchell, 1995; Stufflebeam, 2000b)?

The Input component is used to assess the program’s associated logic model, work plan, and budget. This includes all human resources, as well. It focuses on questions such as: What resources does the program have at its disposal? And what barriers and constraints exist (Hadley & Mitchell, 1995; Stufflebeam, 2000b)?

The Process component entails documenting the program’s process, and requires the evaluator to assess implementation fidelity. The component highlights omissions or poor execution of procedures. During this type of evaluation, it can be helpful to create a flow chart to understand how the program works and to eliminate any redundancies or inefficiencies (Hadley & Mitchell, 1995; Stufflebeam, 2000b).

Finally, the Product component involves measurement, interpretation, and judgment of the program’s achievements. This requires the evaluator to assess how well the program met the needs of its participants (Hadley & Mitchell, 1995; Stufflebeam, 2000b).
Beyond these general descriptions of each component, Stufflebeam and Shinkfield (2007) have identified specific objectives of formative and summative evaluations for each CIPP component. In a formative evaluation, the goal is to assist with future decision making and quality assurance. The context evaluation should identify needs and rank program objectives based on the assessed needs, problems, assets, and opportunities. The input evaluation should focus on developing work plans based on an assessment of alternative strategies and allocation of resources. The process evaluation would lead to the creation of a plan for implementation, including monitoring procedures. Finally, the product evaluation would be concerned with providing data to support decision making related to continuing or terminating the project based on assessed outcomes and side effects.

This section identified some procedural considerations and strategies for conducting program evaluation, as well as describing a comprehensive evaluation model. The next section will describe the program components of Partnerships for Early Childhood Mental Health which is the specific focus of this study.

**Description of the Program**

Partnerships for Early Childhood Mental Health is a program of Tri-County Mental Health and Counseling Services, Inc. (TCMHC). This section describes the geographic and organizational context for program; the program’s history, philosophy, mission and goals, program model; and existing program data used as part of this study.
Organization and Location

Tri-County Mental Health and Counseling Services, Inc. is a “non-profit, licensed community mental health center serving five counties in rural, Appalachian, southeastern Ohio. This region spans over 2000 square miles and includes the Ohio River Valley and the Hocking Hills (www.tcmhcs.org, 2012, “About Us,” para. 1).” Demographically, 30% of the population in the area lives in poverty compared to a state average of 22%, 30% on food stamps compared to the state average of 19%, 60% of children receive Medicaid/CHIP as compared to 10% for the state average, and 40% are on free/reduced lunch compared to a state average of 22% (Children’s Defense Fund, 2011). In this economically stressed environment, TCMHC carries out its mission “to promote the well-being of its constituents and the quality of life in its communities by providing high quality, cost effective behavioral healthcare services (www.tcmhcs.org, “About Us,” para. 2).”

All agency programs are “accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), Certified by the Ohio Department of Mental Health, Certified by the Ohio Department of Alcohol and Drug Addiction Services, and Licensed by the Ohio Board of Pharmacy (www.tcmhcs.org, 2012, “Services,” para 1).” TCMHC offers a full-range of mental health services including:

- Community Psychiatric Supportive Treatment Services (case management for adults and children with a diagnosed mental health condition) Services,
- Outpatient Counseling Services, School-based counseling (mental health counselors stationed at local schools to deliver intervention services), Intensive
Home-Based Treatment (weekly and on-call home-based counseling and case management for those with severe emotional disturbance), Partial Hospitalization (day treatment services for children and adolescents who cannot be safely maintained in a public school setting), Early Childhood Intervention (consultation and treatment for children under the age of five), Trauma-Informed Care (evidenced based treatment models appropriate for those who have experienced trauma), Psychiatry (medication services for adults and children), Primary Care/Behavioral Healthcare Integration (counselors who are stationed at participating physician offices), and Sexual Abuse Prevention Program (preventive psycho-education delivered in schools and community) (www.tcmhc.org, 2012, “Services,” para. 2).

**Program History and Philosophy**

Prior to the ECMHI, TCMHC served no children under 4 years of age. In 2009, 2,650 children in Southeastern Ohio received early screening, assessment, or treatment services as a result of the Initiative’s presence in the Southeastern Ohio region. The current Program Director and researcher has been instrumental in expanding the program. Tri-County’s ECMH services have grown from a single provider to a team of five specialists. For the last two years, the team has focused on developing an ECMH Consultation Program Model to serve local school districts. The result is an innovative ECMH model that blends consultation and professional development for teachers and direct mental health services for children, titled “Partnerships for Early Childhood Mental Health Consultation.” This program has been funded by
a Health Resources and Services Administration (HRSA) Office of Rural Health Policy Outreach grant awarded to Ohio University’s Heritage College of Osteopathic Medicine (OU-HCOM) under the directorship of Dr. Jane Hamel-Lambert, with additional support from biostatistician Dr. Victor Heh, also from OU-HCOM, and Dr. Holly Raffle from the Voinovich School of Leadership and Public Affairs. The program has been expanded to serve additional schools through funds from Project LAUNCH, a Substance Abuse and Mental Health Services Administration grant awarded to the Ohio Department of Health. The model has also been customized for Head Start and Early Head Start with local support from Hocking-Athens-Perry Community Action Head Start and the local mental health board serving Athens, Hocking, and Vinton Counties (Integrating Professionals for Appalachian Children, 2012, “Network Partner,” para. 5).

**Program Mission and Goals**

The Partnerships for Early Childhood Mental Health’s Consultation Program exists to build partnerships between parents, teachers, and early childhood mental health consultants to help promote the social-emotional wellness and school readiness of children in their care. Program objectives include:

1. Increased collaborative ventures between schools/ EC settings/ and ECMH consultants.

2. Increased capacity of participating early childhood professionals and parents for building resiliency and managing challenging behaviors for children in their care.
(3) Increased resiliency of participating children (initiative, attachment, self-control, and reduced behavioral concerns). (Shamblin, 2011, p. 3)

These objectives incorporate six key features that have been identified by the team.

First, it advances the team vision to facilitate partnerships between parents, teachers, and early childhood professionals to promote the social-emotional wellness and school readiness of children in their care. Second, it focuses on problem-solving, capacity-building interventions that are implemented within collaborative relationships between the professional early childhood mental health consultant and other early childhood professionals who provide services to a child and family. Third, it promotes a comprehensive approach: Universal services focused on supporting the healthy social-emotional development of all children in a class, with the consultant helping teachers create a profile of the social-emotional strengths and challenges of the children in their classrooms then identifying strategies to increase protective factors and decrease behavioral concerns; Targeted services focused on behavioral supports for individual children with challenging behaviors, with the consultant helping teachers and parents with strategies to address a specific behavioral challenge or answer a specific mental health question; and Intensive services focused on mental health assessment and treatment for individual children with identified special needs. Fourth, it involves parents in helping reduce the challenging behaviors of targeted and intensive children. Fifth, and finally, it assists school personnel in
understanding and meeting the mental health needs of children from stressed care situations (Shamblin, 2011, p. 7-8).

**Program Theory of Change**

These program objectives have been summarized in the “Partnerships” Theory of Change Model developed as part of the program director’s participation in Robert Wood Johnson’s Retooling Professionals Evaluation Fellowship. Figure 1 is a copy of the “Partnerships” Theory of Change Model (Shamblin, 2012, p.5). The program collects data to review progress on its goals and outcomes annually. The specific data used are described later in this chapter in the “Program Model” and “Existing Program Data” sections.
THEORY OF CHANGE: Partnerships for Early Childhood Mental Health Program

STRATEGIC FOCUS:
We build partnerships between EC Professionals, Parents, and ECMH consultants to increase the social-emotional resiliency of young children in their care

CONTEXT
Assets:
(1) Established relationships with the schools and our agency
(2) ECMH staff that are invested and interested in doing a good job
(3) ECMH Staff trained in relationship-based work
(4) We have data collection

Challenges
(1) Time investment for program evaluation falls on teachers/ECMH staff/ Program Director which takes focus away from delivering program
(2) Subjective nature of relationship-based work/ Difficult to measure
(3) Access to parents
(4) Do Schools/ Parents want to “Partner”?

ASSUMPTIONS
(1) If teachers, parents, and ECMH Consultants build partnerships, then children will have better SE outcomes
(2) IY/ Dina School provides structure opportunity for relationship building/ shared curriculum implementation
(3) DECA profiles lead to shared analysis of children/ shared planning
(4) Joint planning leads to shared goals/ improved partnering
(5) Being on site in schools/homes leads to strengthened partnerships
(6) Teachers/parents/ and ECMH consultants want to partner in
(7) They place great value in improving SE outcomes of children

PROGRAM GOALS
(1) To increase skill and capacity of participating teachers for building resiliency of all children in their classes and specifically for children with challenging behaviors.
(2) To increase resiliency of participating children (initiative, attachment, self-control, and reduced challenging behaviors).
(3) To increase collaborative ventures between schools, other EC settings, and ECMH.

PROGRAM ACTIVITIES
(1) ECMHC’s on site/ in class minimum 3 hours a week
(2) Observation/feedback on teaching activities
(3) Weekly mentoring/ coaching to teachers
(4) Dina School script and make/bring materials
(5) Assist in classroom when appropriate
(6) Consultation meetings with teachers to review new information, answer questions from weekly coaching, and jointly plan upcoming activities
(7) Newsletter to provide updates and ideas for consultants and teachers
(8) Teacher lending library
(9) Administrative Updates

Short-Term Outcomes (6 mos.)
(1) Open communication between teachers/ ECMHC’s
(2) ECMHC’s and teachers will begin to jointly develop new activities for children
(3) Classroom DECA profiles show increase in resiliency skills and reduced behavioral concerns; decreased number of children in a “concern” range
(4) Teachers regularly consult with ECMHC’s about children/ challenges through formal and informal methods
(5) ECMHC’s feel comfortable in classrooms/ feel competent in their roles
(6) School Administrators know staff and program goals
(7) School staff and administration talk positively about the program to staff, parents, and other administrators

Long-Term Outcomes (2-3 years)
(1) ECMH Program Director and School Administrators jointly develop a plan for sustaining services
(2) ECMHC’s are fully integrated team members of the school
(3) Bi-Directional capacity development between school personnel and mental health

Figure 1. “Partnerships” Theory of Change Model (Shamblin, 2012, p.5)

² Unpublished existing program document reprinted with permission from S. Shamblin and Tri-County Mental Health and Counseling Services, Inc.
Program Model

The “Partnerships” Program Model contains core consultation features originally described by Cohen and Kaufman (2000), combines them with components of the DECA system developed by Naglieri and LeBuffe (1999), and has made adaptations to both of these based on feedback from teachers and consultants.

The “Partnerships” Program Model is consistent with Cohen and Kaufman’s definition that ECMHC be focused on “problem-solving and capacity building intervention within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals with other areas of expertise or parenting responsibilities” (Cohen & Kaufman, 2005, p. 4). Additionally, the staff provides intervention at a teacher level—identified as “Programmatic Consultation” by Cohen and Kaufman (2000, 2005)—and at the individual child/family level—identified by Cohen and Kaufman (2000, 2005) as “Child-and-Family-Centered Consultation”.

Further, the primary emphasis of intervention is at the teacher/classroom level, with the underlying philosophy that solving issues at this level will reduce the amount of intervention at the individual child/family level (Cohen & Kaufman, 2000, 2005). As a result, the “Partnerships” model stresses the improvement of overall classroom quality by assisting “in solving a specific issue that affects more than one child in the class (Cohen & Kaufman, 2005, p.5).” When intervention at the teacher level is not enough to manage challenges for specific individual children, then the “Partnerships” staff intervene at a targeted or intensive level with that child. As opposed to conducting therapeutic strategies themselves, the “Partnerships” consultants help teachers and parents develop
plans they can implement containing specific strategies designed to improve the child’s classroom behaviors (Cohen & Kaufman, 2005).

Although Cohen and Kaufman (2000, 2005) provided the “Partnerships” staff a foundation for their consultation work, the lack of detail was confusing for consultants trying to implement the services and confusing for school teachers and parents who received the services. Both groups especially struggled to understand how to work together at the “teacher consultation” level. The program adopted materials from the Devereux Foundation in Pennsylvania, which had created a consultation system focusing on developing resiliency in young children. The Devereux Early Childhood Assessment Program (DECA) is based on the idea that resiliency in early childhood is composed of three primary protective factors: self-control, attachment, and initiative (Naglieri & LeBuffe, 1999, p. 4). By working together, the ECMH consultant and early childhood staff identify strengths and weaknesses in these protective factors then design and implement strategies to strengthen protective factors for children in their care (Naglieri & LeBuffe, 1999). The DECA program has been shown to be effective in “increasing protective factors and decreasing behavioral concerns (LeBuffe & Naglieri, 1999, p. 4).” The DECA system offers a conceptual framework and specific process to assess and intervene at the teacher and individual child level. The “Partnerships” program staff was able to use this to add detail to the basic consultation model of Cohen and Kaufman (2000, 2005).

Although, both the Cohen-Kaufman model (2000, 2005) and the DECA program (Naglieri & LeBuffe, 1999) have informed the services delivered by the “Partnerships” consultants, they have continued to make adaptations based on annual feedback from
teachers and parents. One major issue was that there were situations when individual children, despite the consultation to teachers and parents, were in need of mental health assessment and treatment. Geographic distance to the community mental health center combined with transition to an unfamiliar service provider, created a barrier for these services. The “Partnerships” program staff decided to add a third intervention level to their model to address this need. Arguably, the third intervention moves beyond consultation because it addresses home relationships and internal child well-being. However, since it retains the focus on resiliency and teaming with a child’s caregivers, the “Partnerships” program team decided to include these services into their consultation model, as opposed to conceptualizing them as something separate.

As it currently exists, following three years of feedback from participating school personnel, the “Partnerships” Program Model consists of three layers of service which can be envisioned as a triangle (Figure 2).

![Figure 2. “Partnerships” Program Model Levels of Service (Shamblin, 2011, p. 5)](image)

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3 Adapted from unpublished program document with permission from S. Shamblin and Tri-County Mental Health and Counseling, Inc.
The bottom or first layer of service is universal consultation focused on increasing the capacity of teachers to support healthy social-emotional development for all of the children in their classes. Two primary activities are conducted by ECMH consultants. First, they deliver a social-emotional curriculum called the Incredible Years (IY) Dina School Program every week. Developed by Webster-Stratton and Reid (2004), IY Dina School is based on cognitive-behavioral group strategies for preschoolers. In a randomized, controlled pilot study, children who received this intervention in their classrooms had an increased use of pro-social conflict management with peers and reduced challenging behaviors at school and home (Hutchings, Bywater, Daley, & Lane, 2007). As part of the curriculum implementation, consultants go to classrooms during “Circle Time” and conduct these social skills activities with all children-- focusing on increased identification of feelings, increased anger management, and increased pro-social skills with peers. Consultants make enrichment activities for teachers to use with children, and they coach/model their implementation. The second primary activity in universal consultation is formal consultation with the teacher on individually identified goals based on the teacher’s scores on the Teacher Opinion Scale (a self-rated, Likert scale about a teacher’s confidence to manage challenging behaviors), the Preschool Mental Health Climate Scale (a consultant observation/rating system on classroom strategies and methodology); and the Teacher Interest Survey (mental health topics the teacher would like help with). These tools will be further discussed later in this chapter.

The second program service, or middle layer of the triangle, is targeted consultation. This program component serves individually identified children who need specialized behavioral supports but not mental health treatment. In this layer of service,
the consultant assesses and helps the teacher and parent develop a behavior plan and monitor its implementation.

The final program service, and third tier of the triangle, is intensive consultation which consists of on-site mental health assessment and treatment for individually identified children whose needs are not being met by the targeted services (second tier).

Figure 3 is the complete “Partnerships” Program Model as it appears in the program manual (Shamblin, 2011, p. 8). Additional details are included in the “Partnerships” program manual found in the Supplemental Materials section.
<table>
<thead>
<tr>
<th>Tier</th>
<th>Assessment Stage</th>
<th>Planning Stage</th>
<th>Intervention Stage</th>
<th>Evaluation of Service</th>
</tr>
</thead>
</table>
| **Universal Consultation** | - Teacher completes: Teacher Opinion Survey (TOS), Classroom DECA’s, Interest Survey  
- ECMHC completes Preschool Mental Health Climate Scale (PMHCS), DECA Profile, Consultation Report  
- Process Repeated in early spring | - Consultant and teacher meet to review consultation report and write annual consultation plan  
- Plans made for consultant’s implementation of social skills curriculum  
- Plan reviewed/updated in January  
- Teacher self-identifies consultation requests as needed; plan updated as needed | - Weekly: Consultant conducts social skills curriculum and provides follow-up materials for teacher  
- Monthly: Conduct teacher training/skill building on teacher-selected topics  
- Quarterly: E-Newsletter  
- Ongoing: E-Newsletter | - Fall/Winter/Spring: Change in DECA’s  
- Fall/Spring: TOS, PMHCS, Teacher-Consultant Collaboration Survey  
- Spring: Teacher Satisfaction Survey, Teacher Demographic Questionnaire |
| **Targeted Consultation** | - Child identified by score on classroom DECA, teacher concerns, or parent concerns  
- DECA completed by caregiver  
- Consultant completes classroom behavior assessment | - Parent, teacher, and consultant meet to review classroom behavior assessment and write targeted consultation plan.  
- Plan is reviewed/updated mid-year or as needed based on child’s progress on identified goals | - Social skills training/coaching by consultant  
- Special classroom materials for teacher (i.e. Social Stories, Schedule cards, etc.)  
- Home-School communication system  
- Behavioral supports for parents to use at home to provide consistency of behavioral strategies  
- Monthly progress report for teacher/parent completed by consultant | - Fall/Winter/Spring: Change in parent and teacher DECA’s  
- Spring: Parent Satisfaction Survey  
- Ongoing: Completion of goals on plan |
| **Intensive Services** | - Consultant and parent complete the TCMHC Diagnostic Assessment  
- ASQ (If needed)  
- DECA-C  
- Additional assessments as needed  
- Review other relevant assessments from school and other providers | - Consultant and parent, with teacher input, complete TCMHC Individual Service plan. | - Individual/Family/Group treatment services, as appropriate. These may include Parent-Child Interaction Therapy, Trauma-Focused CBT, parent-child psychotherapy, developmental individual differences-relationship floor time, applied behavior strategies, and Incredible Years | - Completion of goals on treatment plan |

Figure 3: Partnerships for Early Childhood Mental Health Program Model (Shamblin, 2011, p. 8)\(^4\)

\(^4\) Unpublished program document reprinted with permission from S. Shamblin and Tri-County Mental Health and Counseling Services, Inc.
Existing Program Data

As described by the “Partnerships” Program Model, and to assess the goals on the “Partnerships” Theory of Change Model, the program had already collected a great deal of information. The program staff has carefully considered the data they collect so that each component of the “Partnerships” Program Model is covered and that the components of the “Partnerships” Theory of Change Model have been addressed. Because of the grant partnerships the program had developed with faculty from Ohio University (OU), all of the program data was collected under an OU IRB approved protocol and was capable of being used for this current study. Copies of these IRB protocols are included in the Supplemental Materials section. As a result of these activities, the program had rich data sets and existing reports describing its services. These were used for this program evaluation. This section further describes these outcome measures and documents. Table 1 summarizes each piece of data and its link to the “Partnerships” Theory of Change Model.

Specific outcome measures were selected by program administrators because they were recommended by Hepburn et al. (2007). These include: The Devereux Early Childhood Assessment (DECA), the Teacher Opinion Survey (TOS), and the Preschool Mental Health Climate Scales (PMHCS). Reference information for each of these tools is located in the References section and within the next paragraphs.

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5 No instruments were administered for the purposes of this study. The study is solely based on pre-existing data sets owned by the Partnerships for Early Childhood Mental Health Program. Tri-County Mental Health and Counseling has taken all appropriate measures for using instruments listed in this dissertation.
The DECA (LeBuffe & Naglieri, 1999) is a norm-referenced standardized assessment of the resiliency, protective factors of Initiative, Attachment, and Self-Control. The measure is used in all 50 states, and retains 18 study sites for continuous validation of the tool including, three in Ohio and one childcare center in Athens, OH. At the Universal Consultation Level, “Partnerships” participating teachers complete DECA’s for all the children in their classes during the fall, winter, and spring. The DECA contains 37 Likert-type items listing various child behaviors that are rated for the frequency displayed by the child “Never, Rarely, Occasionally, Frequently, and Very Frequently.” The raw scores are translated into standard T-scores (with a mean of 50 and a standard deviation of 10) that can be used to make comparisons across the year for an individual child, between children, and between caregivers. A T-score that is less than or equal to 40 on the Initiative, Attachment, and Self-Control sub-scales would be categorized as a “concern” and should be addressed by individualized interventions. Conversely, a T-score of 60 or above on the Behavioral Concerns subscale would be identified as a “concern” and should be addressed by individualized interventions. The tool is designed to be completed by teachers or parents, and can be completed as frequently as desired. The standardization sample on which scores were normed included 2,000 preschool aged children that were stratified to approximate United States demographics in all respects. Internal reliability was measured using Cronbach’s alpha, and was calculated to be .91 for parent ratings and .94 for teacher ratings. Test-retest correlations were .74 for parent ratings and .94 for teachers. To assess psychometric validity, the DECA was correlated with results from the “Preschool Life Events
Checklist” (Work, Cowen, & Wyman, 1990), the “Sources of Stress Inventory” (Chandler, 1981), and the “Preschool Daily Hassles Checklist” (Kanner, Coyne, Schaefer, & Lazarus, 1981). Children who were identified in the “concern” range by the comparison tools were also identified in that same range on the DECA. More information about the DECA and a copy of the questionnaire can be obtained at (www.centerforresilientchildren.org/preschool/assessments-resources).

At the Targeted and Intensive Consultation Levels, parents/primary caregivers also complete the tool at these three points. As part of existing grant partnerships, DECA outcomes for the “Partnerships” program have undergone statistical analyses for the last three years by staff at Ohio University’s Heritage College of Osteopathic Medicine. These report have been used by the program to assess progress on goal number 2 (“To increase resiliency of participating children and reduce challenging behaviors”) and outcome number 3 (“Classroom DECA profiles show increase in resiliency skills and reduced behavioral concerns; decreased number of children in the ‘concern’ range”) on the “Partnerships” Theory of Change Model. Specific titles of these reports are: “HRSA Outreach Project Evaluation: YR one 2009-2010” (Heh, 2010), a statistical analysis of the DECA scores for targeted services and the Teacher Opinion Scales for teachers; “HRSA Outreach grant: Results of statistical analysis YR 2 2010-2011” (Heh, 2011), a statistical analysis of the DECA scores for universal and targeted consultation services, Teacher Opinion Scales for teachers, and Preschool Mental Health Climate Scales; and “Statistical analysis of the ECMH consultation program at TCMHC 2011-2012 school year” (Nakazawa, 2012), a comparative analysis for the DECA scores for universal
consultation services of three programs representing different phases of implementation. A review of these reports was included in this program evaluation and copies are located in Appendices A-C. This will be further discussed in Chapter 3.

The TOS (Geller & Lynch, 1999) and the PMHCS (Gilliam, 2008) have not been standardized. The TOS is a Likert-type survey of teachers’ self-reported attitudes and beliefs. The twelve items focus on a teacher’s feelings of confidence to manage challenging child behaviors and hopefulness of his/her abilities to impact these behaviors. Scores from each measure have been used to track change through a school year and to compare participating teachers with wait-list teachers who have agreed to complete program tools (Hepburn et al., 2007). More information about the TOS and a copy of the tool can be obtained from Wingspan, LLC (www.wingspanworks.com). Teachers in the “Partnerships” program complete the TOS in the fall and spring as a part of the universal consultation services. The outcomes on the TOS are used to review progress on goal number one and outcome number ten of the “Partnerships” Theory of Change Model.

While TOS outcomes were included in the 2009 and 2010 statistical reports, an analysis of TOS outcomes for 2011-2012 had not been conducted. As a result, this current study included new statistical analyses for this data.

The PMHCS (Gilliam, 2008) is an observation rating system completed by the ECMH Consultant. The instrument is designed to assess the classroom environment and teacher practices including use of transitions, teacher-child interactions, adult-adult interactions, recognition and validation of child feelings, and resolution of child conflicts. The tool is not yet normed but does give average scores for each subsection and a total
score. It has been used by ECMH programs to compare change through the school year and to compare ratings between teachers (Gilliam, 2008). More information and a copy of the PMHCS can be obtained at (www.childstudycenter.yale.edu). As part of the universal level of services, consultants in the “Partnerships” program complete the PMHCS for each classroom in the fall and spring. Staff not only use this to guide their consultation with teachers, but also to assess the program’s progress on goal number one (“To increase the skill and capacity of participating teachers for building resiliency of all children in their classes and specifically for children with challenging behaviors”) and goal number ten (“Bi-directional capacity development between school personnel and mental health consultants”) of the “Partnerships” Theory of Change Model. While PMHCS outcomes were included in the 2009 and 2010 statistical reports, an analysis of PMHCS outcomes for 2011-2012 had not been conducted. As a result, this current study included new statistical analyses for this data.

In addition to these three measures, the program adopted the “Satisfaction with ECMH Consultation” satisfaction survey developed and published in Georgetown University’s “Evaluation Tool Kit” (Hepburn, et al., 2007). The Reference section contains information for accessing this document. This is completed by parents each spring as part of the targeted consultation services. Surveys help staff assess parental satisfaction and review progress on goal number two of the “Partnerships” Theory of Change Model (“To increase resiliency of participating children and reduce challenging behaviors”).
Consultants document their activities on a “consultation log” developed by the program and revised by the staff each summer. A copy of the log is located in Appendix M. Consultation logs contain rich information and are used to help the program monitor implementation of program activities itemized on the “Partnerships” Theory of Change Model, and to determine progress on program outcomes one, two, four, five, nine, and ten.

Besides these process and outcome measures, the “Partnerships” program had previous program reports conducted as part of grant projects and community collaborations. These were used in this current study and included: “Partnerships for Early Childhood Mental Health Early Childhood Mental Health Program – Year Three” (Voinovich, 2012), an evaluation report on school personnel focus groups completed by the Voinovich School; “2009 - 2012 Rural Health Care Services Outreach Grant Program Source Book entry for Building Capacity – Raising Resiliency” (Hamel-Lambert, Shamblin, & Meeks, 2012), a final report of the HRSA Outreach grant project; “An Evaluation of the Collaborative Relationships between Teachers and Consultants in the Partnerships for Early Childhood Mental Health Program: Final Report for Robert Wood Johnson Retooling Professionals Evaluation Fellowship” (Shamblin, 2012), an evaluation report completed by the program director for her Robert Wood Johnson Retooling Professionals Evaluation Fellowship; “Building Capacity-Raising Resiliency: HRSA Outreach Grant Narrative” (Hamel-Lambert, Shamblin, & Meeks, 2008), “Project LAUNCH for Ohio’s Appalachian counties” (Ohio Department of Health, 2009), the “HRSA Performance Improvement Measurement System (PIMS) report”, and HRSA
progress reports. Copies of these documents are located in Appendices D-K. Finally, two local reports containing information about the region were consulted for the “Context” evaluation component: “Project LAUNCH Environmental Scan Report for the Ohio Counties of Athens, Hocking, Meigs, and Vinton March 2010” (Gallway, 2010), a formal needs assessments completed Ohio University for the SAMHSA’s Project LAUNCH grant which can be downloaded at www.ipacohio.org; and “2010-2011 Athens County Community Assessment: A secondary analysis for the Athens county child and family health services consortium” (Voinovich School of Leadership and Public Affairs, 2011), a formal needs assessment conducted as a requirement Ohio University’s Community Health Program’s Ohio Department of Health’s Child and Family Services Program which can be downloaded at www.oucom.ohiou.edu.

Table 1 summarizes the extant quantitative and qualitative data used for this program evaluation and links each data component with the program goals, activities, and/or outcomes that are a part of the theory of change model. Sample size for each data set, specific strategies used to analyze each data component, and the connection to each data point to the CIPP components will be discussed in Chapters Three and Four.
Table 1

*Existing Program Data and linkage to “Partnerships” Theory of Change*

<table>
<thead>
<tr>
<th>Type of Data</th>
<th>Tool/Document</th>
<th>Program Goal #</th>
<th>Program Activity #</th>
<th>Program Outcome #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Data Analyses</td>
<td>DECA* (fall, winter, spring administrations For 2009, 2010, 2011)</td>
<td>2</td>
<td>____</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>TOS** (fall and spring administrations for 2009, 2010, 2011)</td>
<td>1</td>
<td>____</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>PMHCS*** (fall and spring administrations, 2011)</td>
<td>1</td>
<td>____</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Statistic Reports</td>
<td>1, 2</td>
<td>____</td>
<td>3, 10</td>
</tr>
<tr>
<td></td>
<td>ECMHC Logs with frequency and categories of consultation activities</td>
<td>____</td>
<td>1-6</td>
<td>1, 2, 4, 5, 9, 10</td>
</tr>
<tr>
<td></td>
<td>Program Budgets</td>
<td>3</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>HRSA PIMS+ reports</td>
<td>3</td>
<td>9</td>
<td>8, 10</td>
</tr>
<tr>
<td></td>
<td>Parent Satisfaction Surveys</td>
<td>2</td>
<td>1, 6</td>
<td>____</td>
</tr>
<tr>
<td>Document Analyses</td>
<td>Voinovich School Focus</td>
<td>1, 2, 3</td>
<td>1-9</td>
<td>1, 2, 4-10</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td></td>
<td>Group and Interview Reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Health Needs Assessment</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td></td>
<td>Project LAUNCH Scan</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td></td>
<td>HRSA Outreach Grant Narrative and Budget</td>
<td>3</td>
<td>___</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Project LAUNCH Grant</td>
<td>1</td>
<td>7, 8</td>
<td>4, 10</td>
</tr>
<tr>
<td></td>
<td>The HRSA Federal Annual Progress Reports (PIMS)</td>
<td>1, 2, 3</td>
<td>1-9</td>
<td>1, 2, 4, 5, 9, 10</td>
</tr>
<tr>
<td></td>
<td>Teacher Interest Surveys (2011, program created)</td>
<td>1, 2, 3</td>
<td>1-6</td>
<td>1, 2, 4, 5, 9, 10</td>
</tr>
<tr>
<td></td>
<td>ECMHC consultation logs with descriptions of consultation contacts</td>
<td>___</td>
<td>1-6</td>
<td>1, 2, 4, 5, 9, 10</td>
</tr>
<tr>
<td></td>
<td>Robert Wood Johnson Report</td>
<td>1, 2, 3</td>
<td>1-9</td>
<td>1-10</td>
</tr>
</tbody>
</table>

*Devereux Early Childhood Assessment

**Teacher Opinion Scale

***Preschool Mental Health Climate Scale

+Health Services Resource Administration Performance Improvement Measurement System
Summary and Conclusions

Early childhood represents a critical time in social-emotional development. Failing to address the behavioral and mental health issues for young children may have serious implications for their school success and long-term well-being, and possible economic consequences for society. One strategy that has shown promise for reducing mental health problems and increasing resiliency is early childhood mental health consultation. To date, the majority of evidence for ECMHC has grown out of practice-based research. This research base can be expanded through well conducted program evaluation. Stufflebeam’s CIPP (2000b) model represents a well-articulated procedure for conducting this type of evaluation.

Partnerships for Early Childhood Mental Health has been built on the principles outlined in this Literature Review. Chapter Three will discuss how this study used Stufflebeam’s (2000b) CIPP model to conduct a summative evaluation of the program.
Chapter 3: Methodology

The purpose of this study was to conduct a program evaluation of School Partnerships for Early Childhood Mental Health using Stufflebeam’s (2000b) CIPP Program Evaluation Model which considers a program’s context, inputs, processes, and products. To conduct the CIPP evaluation, the researcher used a mixed method process to analyze available existing program data. This consisted of systematic review of narrative reports, methodical synthesis of previous statistical reports, and calculation of descriptive and inferential statistics for remaining program outcome data. The study focused on assessing the program’s success in accomplishing the goals identified on the “Partnerships” Theory of Change Model which are: (1) increasing the competence and confidence of participating teachers to meet the social-emotional needs and reduce the challenging behaviors of the children they teach, and (2) increasing resiliency for children whose teachers participate in the program (Shamblin, 2011).

In order to address this broader inquiry, and to align with the CIPP components, the following specific evaluation questions guided the study:

1) Context: How well did the program address the needs of Athens County preschool children and teachers identified during the program’s development and prior to its implementation? Going forward, how will the program address any unmet needs?

2) Input: What resources were used to implement the program; and what is the program’s cost effectiveness? How does the program’s per unit costs per class, teacher, and child compare to other programs in Ohio? How does the program
compare to any discussed in the literature? Going forward, what changes would enhance efficiency?

(3) Process: How does the program delivered by staff compare to the “Partnerships” Theory of Change and program models? Were all component parts delivered and what percentage of time was spent on each? What critical processes were identified by ECMHC staff and participating school personnel? Going forward, what changes are recommended?

(4) Product: Did the program help teachers feel more confident and become more competent in reducing challenging child behaviors? If so, how? Did the program increase the resiliency of participating children? If so, how? What is the overall impact of this program model?

Table 2 presents an overview of the evaluation strategies the researcher used to answer these questions. The remainder of this chapter describes the detail of this plan including the specific research design and methods for this study and the connection to each of the CIPP components.
### Evaluation Overview

**Table 2**

**Context Component:** Compare the program’s goals and properties to the original identified needs, problems, assets, and opportunities in the context in which it operates

<table>
<thead>
<tr>
<th>Evaluation Question(s)</th>
<th>Data Sources</th>
<th>Methodology</th>
</tr>
</thead>
</table>
| 1. How well did the program address the needs of Athens County preschool children and teachers identified during the program’s development and prior to its implementation? | 1. Community Health Programs Needs Assessment  
2. HRSA* Outreach Grant Proposal  
3. Project LAUNCH Environmental Scan  
4. Project LAUNCH grant narrative  
5. Initial PMHCS **  
6. PIMS ***reports  
7. Voinovich Focus Group Report  
8. Final PMHCS*  
9. Baseline TOS*+  
11. Grant progress reports | 1. Document Review  
2. Create a “Context Evaluation Coding” Checklist from relevant documents  
3. Rate the program’s accomplishments over the last two years using relevant document sources  
4. Same process completed by an independent reviewer to verify researcher ratings |
Table 2 (Continued)

**Input: Compare of the program’s design and budget to other similar programs, and to the targeted needs of participants**

<table>
<thead>
<tr>
<th>Evaluation Question (s)</th>
<th>Data Sources</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What resources were used to implement the program?</td>
<td>1. Program Budget and Fiscal Records</td>
<td>1. Identify all program inputs</td>
</tr>
<tr>
<td>2. What is the program’s cost effectiveness?</td>
<td>2. ODMH**** reports on other ECMHC programs in Ohio</td>
<td>2. Calculate per unit cost for consultant, site, classroom, teacher, and child</td>
</tr>
<tr>
<td>3. How does the program’s per unit costs per class, teacher, and child compare to other programs in Ohio?</td>
<td>3. Relevant national data on other ECMHC programs</td>
<td>3. Obtain ODMH reports containing information for other programs in Ohio and develop average state per unit costs for consultant, site, classroom, teacher, and child</td>
</tr>
<tr>
<td>4. How does the program compare to any discussed in the literature?</td>
<td></td>
<td>4. Investigate relevant national data related to per unit costs</td>
</tr>
<tr>
<td>5. Going forward, what changes would enhance efficiency?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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*ODMH**** indicates different reports containing information on various programs in Ohio.*
Table 2 (Continued)

<table>
<thead>
<tr>
<th>Process: Comparison of the program’s design and the actual implementation of these processes</th>
<th>Evaluation Question (s)</th>
<th>Data Sources</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. How does the program delivered by staff compare to the “Partnerships” Theory of Change and program models?</td>
<td>1. Consultant logs</td>
<td>1. Analyze consultant logs for types of consultation activities conducted, frequency, and percentage of time spent on each type of activity</td>
</tr>
<tr>
<td></td>
<td>2. Were all component parts delivered and what percentage of time was spent on each?</td>
<td>2. Program Model</td>
<td>2. Compare to the Theory of Change and Program Models: Are being delivered and being given the percentage of time envisioned?</td>
</tr>
<tr>
<td></td>
<td>3. What critical processes were identified by ECMHC staff and participating school personnel?</td>
<td>3. Voinovich Evaluation Report</td>
<td>3. To validate findings, analyze items 1-13 on teacher satisfaction surveys (contains frequencies that various consultation activities occurred in classrooms</td>
</tr>
<tr>
<td></td>
<td>4. Going forward, what changes are recommended?</td>
<td>4. Robert Wood Johnson Project Report</td>
<td>4. Analyze the Voinovich Evaluation Report of School focus group and interviews to identify program activities that teachers recognized as significant contributions to program outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. Analyze the Robert Wood Johnson Project Report to identify program activities that consultants and teachers felt made the most contributions to positive and negative outcome</td>
</tr>
<tr>
<td>Evaluation Question</td>
<td>Data Sources</td>
<td>Methodology</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>1. Did the program help teachers feel more confident and become more competent in reducing challenging child behaviors? If so, how?</td>
<td>1. Previous statistical reports</td>
<td>1. Review previous statistical reports to assess causal validity. Synthesize significant findings from reports.</td>
<td></td>
</tr>
<tr>
<td>2. Did the program increase the resiliency of participating children? If so, how?</td>
<td>2. Satisfaction Surveys</td>
<td>2. Conduct new statistical procedures of unanalyzed program data for the 2011-2012 program year. Complete a paired sample t-test for the TOS*+ and PMHCS** outcomes</td>
<td></td>
</tr>
<tr>
<td>3. What is the overall impact of this program model?</td>
<td>3. Voinovich Evaluation Report</td>
<td>3. Calculate descriptive statistics for the program satisfaction surveys from the 2011-2012 program years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Fall and Spring TOS*+</td>
<td>4. Review the existing Focus Group Reports for qualitative information regarding the program’s impact</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Fall and Spring PMHCS**</td>
<td>5. Review the Robert Wood Johnson Project Report for information regarding the program’s impact</td>
<td></td>
</tr>
</tbody>
</table>
*Human Resources and Services Administration

**Preschool Mental Health Climate Scale

*** Performance Indicators System Report for Office of Rural Health Policy Federal Grant Report

****Ohio Department of Mental Health

*+Teacher Opinion Scale
**Research Design**

This study employed Stufflebeam’s (2000b) CIPP framework to conduct an evaluation of Partnerships for Early Childhood Mental Health. A mixed-methods approach (Tashakkori & Teddlie, 1998, 2003) was used to analyze extant program documents and statistical data. These data were collected by the program over the last two program years through protocols approved by Ohio University’s full IRB process. Although summative in focus, given the iterative nature of program evaluation discussed by Scriven (1991), the researcher also included formative recommendations for the program to consider as it moves forward in future years. In order to stay responsive to the ever-changing nature of evaluation context as described by Smith (1998) emergent design principles were applied within the structure of the CIPP framework. The researcher, who is also the program director, utilized internal evaluation components and applied qualitative research techniques.

The researcher is an experienced early childhood mental health professional. She has more than ten years of experience as an ECMH consultant and has conducted state level trainings on the topic for the Ohio Department of Mental Health for over five years. As such, she was further able to add connoisseurship elements to the program evaluation. “Connoisseur evaluation places the evaluator’s perceptions and expertise at the center of the evaluation process” (Patton, 2002, p. 172). In her role as an internal evaluator, the researcher was able to use both her expertise in early childhood mental health consultation and her thorough knowledge of the “Partnerships” program to employ this
qualitative approach to form practical and educated appraisals of the program processes and outcomes (Eisner, 1985).

**Role as Program Director and Internal Evaluator**

As the program director, the researcher was instrumental in the existing design of the program. She supervises the program staff and oversees their implementation of the program services. In order to manage the dual roles of program director and internal evaluator, the researcher invoked three recognized stances—internal evaluator, a connoisseurship perspective, and “scientist-practitioner.” All three are variations on a common theme—a person can engage in research while simultaneously using his/her own expertise and subjective experiences to contribute to the research. In order to add transparency to the process, the researcher keeps a paper trail of activities and makes process and reflexive entries in a research log.

For this study, the researcher formed a paper trail by focusing the study on previous program data and documents—all are located in the appendices section. By concentrating the study in this way, the researcher hoped to reduce the possibility of tension with existing staff or disruption to current program implementation. The children and families who were part of these services are no longer involved with the program. The work evaluated in this study had already been completed, the grant that funded these activities had ended and was closed out, and what had been documented couldn’t be changed. This study of documented past program services conducted by the researcher in her role as internal evaluator was done apart from her role as the supervisor of current program services. The extant data and existing program documents were collected under
an active, approved IRB protocol through Ohio University as part of previous and current grant partnerships with this university. These protocols are contained in the Supplemental Materials section. The specific data and documents used were itemized and detailed in Chapter Two. Further aspects will be provided later in this chapter.

By limiting the study to analysis of extant program documents and data, and taking a connoisseurship perspective with prescribed qualitative techniques, the researcher tried to create a transparent investigation. Future external evaluators would be able to review the same information to assess the veracity of this study’s process and associated findings. To further enhance the credibility of the study, an independent external reviewer was employed to verify matrix-coding results for the “Context” evaluation component.

**Analysis of Existing Program Data**

As discussed in the previous section, this study combined a systematic review of extant program documents and statistical analyses of remaining program outcomes. Chapter Two described the relevant documents and data collected by the program. Table 3 lists each piece of program data including documents and remaining outcomes, then summarizes how it was included in the context, input, process, and product evaluations. Details on analytic processes are provided following the table.
### Table 3

*Documents Analyzed and Alignment with the Evaluation Component*

<table>
<thead>
<tr>
<th>Type of Analysis</th>
<th>Document/Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic Document</td>
<td>• 2010-2011 Athens County Community Assessment: A secondary analysis for the Athens county child and family health services consortium (Voinovich, 2011)</td>
</tr>
<tr>
<td>Systematic Document</td>
<td>• Project LAUNCH Environmental Scan Report for the Ohio Counties of Athens, Hocking, Meigs, and Vinton March 2010 (Gallway, 2010)</td>
</tr>
<tr>
<td>Systematic Document</td>
<td>• Project LAUNCH for Ohio Grant Proposal (Ohio Department of Health, 2009)</td>
</tr>
<tr>
<td>Systematic Document</td>
<td>• Partnerships for Early Childhood Mental Health Program—Year Three (Voinovich, 2011)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inclusion of document in the CIPP framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
</tr>
<tr>
<td>---------</td>
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<tr>
<td>X</td>
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<tr>
<td>X</td>
</tr>
<tr>
<td>X</td>
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<tr>
<td>X</td>
</tr>
<tr>
<td>Synthesis:</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
</tbody>
</table>
Table 3 (Continued)

<table>
<thead>
<tr>
<th>New Descriptive and Inferential Statistical Analyses of Existing Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consultation Logs (9 months of log entries for 3 consultants)</td>
</tr>
<tr>
<td>• Teacher Opinion Scales (Fall and Spring) (11 teachers)</td>
</tr>
<tr>
<td>• Preschool Mental Health Climate Scales (Fall and Spring) (11 classrooms)</td>
</tr>
</tbody>
</table>
Document Analysis

Two general types of documents were analyzed: previous statistical reports and narratives reports. In 2009, 2010, and 2011 the program’s DECA outcomes for participating children were statistically analyzed as part of grant evaluation activities resulting in the following three reports: “HRSA Outreach Project Evaluation: YR one 2009-2010” (Heh, 2010), a statistical analysis of the DECA scores for targeted services and the Teacher Opinion Scales for teachers; “HRSA Outreach grant: Results of statistical analysis YR 2 2010-2011” (Heh, 2011), a statistical analysis of the DECA scores for universal and targeted consultation services, Teacher Opinion Scales for teachers, and Preschool Mental Health Climate Scales; “Statistical analysis of the ECMH consultation program at TCMHC 2011-2012 school year” (Nakazawa, 2012), a comparative analysis for the DECA scores for universal consultation services of three programs representing different phases of implementation. Copies of the reports are in Appendices A-C. These reports were assessed for causal validity and synthesized to consolidate findings relevant to this program evaluation. These reports had never been combined in this way, or linked to other program reports and outcomes to form a full picture of the program’s impact.

Narrative reports were analyzed using the inductive evaluation strategy outlined by Thomas (2006) and described in Chapter Two. Documents were converted to a uniform format, thoroughly read and understood, and then coded into apriori categories that align with the evaluation questions relevant to the corresponding CIPP component. Documents used for this process were as follows: “Partnerships for Early Childhood

The next section will describe the application of the CIPP model to this extant document analysis including the specific evaluation questions for each component and the accompanying strategies used to answer those questions. To guide the researcher and the reader through the CIPP evaluation process, a program logic model was developed. Figure 4 is a copy of the logic model developed by Partnerships for Early Childhood Mental Health as it appears the program manual (Shamblin, 2011).
Figure 4. Logic Model for Partnerships for Early Childhood Mental Health (Shamblin, 2011)\textsuperscript{6}

\textsuperscript{6} Adapted from program materials with permission from S. Shamblin and Tri-County Mental Health and Counseling Services, Inc.
Context

Description

Stufflebeam (2000b) describes the objective of a summative context evaluation as a comparison of the program’s design with the environmental context in which it operates including the identified needs, problems, assets, and opportunities. With that objective in mind, this facet of the program evaluation attended to the following questions and employed the following strategies.

Context Component Evaluation Questions

1. How well did the program address the needs of Athens County preschool children and teachers identified during the program’s development and prior to its implementation?

2. Going forward, how will the program address any unmet needs?

Strategies Used to Complete the Context Evaluation Component

To answer these “context” questions, the researcher developed a Context Evaluation Coding Scheme that was applied to relevant extant program documents. Existing documents were sorted into two categories: (1) those describing the service landscape in which the “Partners” program exists, and (2) those describing the program’s services. Documents in Group One included: “2010-2011 Athens County Community Assessment: A Secondary Analysis for the Athens County Child and Family Health Services Consortium” (Voinovich, 2011), “Project LAUNCH Environmental Scan Report for the Ohio Counties of Athens, Hocking, Meigs, and Vinton March 2010” (Gallway, 2010), “Human Resources Services Administration Outreach Grant Proposal Narrative”
(Hamel-Lambert, Shamblin, & Meeks, 2008), “SAMHSA Project LAUNCH Grant Narrative” (Ohio Department of Health, 2009), initial scores of the Teacher Opinion Scales (TOS) and the Preschool Mental Health Climate Scales (PMHCS). Documents in Group Two included: “Partnerships for Early Childhood Mental Health Program—Year Three” (Voinovich, 2011), Teacher Opinion Scales, Preschool Mental Health Climate Scales, the “Partnerships” program manual, grant progress reports, the “HRSA Sourcebook Entry” (Hamel-Lambert, Shamblin, & Meeks, 2012), the Performance Improvement Systems Report (PIMS), and final scores on the TOS and PMHCS.

The researcher reviewed the Group One documents and used them to create a checklist of unmet needs of preschool children and their families that were described in the documents. She then reviewed the initial results of the Preschool Mental Health Climate Scales, the Teacher Opinion Scales, and Teacher Demographic Surveys. She identified relative weaknesses and areas of teacher growth and added these to the list of unmet needs.

Next, the researcher reviewed the documents in Group Two. This information was used to rate the program’s accomplishments over the last two years on unmet needs listed on the checklist. Each item on the checklist was ranked on a score from 0 - 2; with “0” indicating that documents reviewed made no mention of this need being addressed by the program, “1” indicating that documents mentioned actions by the program that addressed the item, and “2” indicating that documents contained outcomes associated with this item.
This coding process was also completed by an independent reviewer for this component. This reviewer was previously employed as an ECMHC consultant for the “Partnerships” program. She parted amicably, and now works as a counselor at a local school and conducts her own qualitative research. She is familiar with the “Partnerships” program model, the local service landscape, and document coding techniques. The independent reviewer was given a packet containing Group One documents, a packet containing Group Two documents, a sheet of written directions, and a blank worksheet. The directions and coding worksheet are included in Appendix L. She returned the completed coding sheets to the researcher via an e-mail as a scanned pdf document which is also located in Appendix L.

Input

Description

Stufflebeam (2000) describes the goal of a summative input evaluation to be a comparison of the program’s budget to those of other similar programs and the efficiency of meeting the needs of program constituents. With that objective in mind, this aspect of the program evaluation focused on the following questions and applied the following strategies.

Input Component Evaluation Question

1. What resources were used to implement the program?
2. What is the program’s cost effectiveness?
3. How does the program’s per unit costs per class, teacher, and child compare to other programs in Ohio?
4. How does the program compare to any discussed in the literature?

5. Going forward, what changes would enhance efficiency?

**Strategies Used to Complete the Input Evaluation Component**

By reviewing previous grant budget narratives and invoices, the researcher identified all program inputs and costs associated with each (i.e., staff, training, materials). Inputs and costs were used to calculate per consultant, per site, per classroom, per teacher, and per child unit costs for the program. Next, the researcher obtained from the Ohio Department of Mental Health’s website (http://mentalhealth.ohio.gov), copies of annual reports for their early childhood mental health initiative. These reports contain aggregate data of all early childhood consultation programs in the state of Ohio. Reports were available for 2006, 2007, 2009, and 2010. Information from these reports was used to calculate state averages for per consultant, site, classroom, teacher, and child unit costs. Finally the researcher reviewed available national literature on other consultation programs and calculated a national average for each type of unit cost, which were then compared with the “Partnerships” program.

**Process**

**Description**

Stufflebeam (2000) describes the aim of a summative process evaluation to be a comparison of the program’s design and with its actual implementation. With that aim in mind, this portion of the program evaluation concentrated on the following questions and exercised the following strategies.
**Process Component Evaluation Question**

1. How does the program delivered by staff compare to the “Partnerships” Theory of Change and program models?

2. Were all component parts delivered and what percentage of time was spent on each?

3. What critical processes were identified by ECMHC staff and participating school personnel? Going forward, what changes are recommended?

**Strategies Used to Complete the Process Evaluation Component**

The researcher analyzed 304 consultant log entries for types of consultation activities conducted, frequency, and percentage of time spent on each type of activity. This information was compared to the “Partnerships” Program Model and the “Partnerships” Theory of Change Model described in Chapter Two. A comparison was conducted to determine if all components of the model were delivered and were given the percentage of program time envisioned. Next, the researcher used descriptive statistics to analyze responses on items 1-13 of the teacher satisfaction surveys. These items ask teachers to rate the frequency that various consultation activities occurred in their classrooms. This was compared to the analysis of the consultant logs to see if results were consistent.

Finally, the researcher reviewed “Partnerships for Early Childhood Mental Health Program—Year Three” (Voinovich, 2011) and “An Evaluation of the Collaborative Relationships Between Teachers and Consultants in the Partnerships for Early Childhood Mental Health Program: A Final Report for Robert Wood Johnson Retooling
Professionals Evaluation Fellowship” (Shamblin, 2011) to identify program components recognized by school personnel and consultants as critical.

Product

Description

Stufflebeam (2000) describes the purpose of a summative product evaluation to be assess the program’s outcomes and overall impact. This final phase of the evaluation was guided by the following questions and was conducted using the following strategies.

Product Component Evaluation Question

1. Did the program help teachers feel more confident and become more competent in reducing challenging child behaviors? If so, how?
2. Did the program increase the resiliency of participating children? If so, how?
3. What is the overall impact of this program model?

Strategies Used to Complete the Product Evaluation Component

The researcher used a combination of document review, report synthesis, and new statistical analyses to address the product evaluation component. First, the researcher reviewed three existing statistical reports completed by independent biostatisticians from Ohio University as part of the HRSA Outreach and SAMHSA Project LAUNCH grant funded services. She assessed the threats to causal validity for each report and synthesized significant program impacts relevant to evaluation questions. Second, the researcher completed new statistical measures for unanalyzed data sets from the 2011-2012 program-year. She completed a paired sample t-test for the fall and spring administrations for the Teacher Opinion Scales and the Preschool Mental Health Climate
Scales. While a pre-post analysis of these tools in the absence of a control group leaves open threats to internal-causal validity, this analysis was only one part of this larger program evaluation and still contributed to the researcher’s ability to answer the “Product” questions. This issue will be further discussed in Chapter Four. Teacher Satisfaction Surveys collected in the spring of 2012, were analyzed with descriptive statistics. Finally, two qualitative reports were systematically analyzed with the approach described by Thomas (2006) using emergent themes to identify program impacts recognized by school personnel and consultants. The reports reviewed were “Partnerships for Early Childhood Mental Health Program—Year Three” (Voinovich, 2011) and “An Evaluation of the Collaborative Relationships Between Teachers and Consultants in the Partnerships for Early Childhood Mental Health Program: A Final Report for Robert Wood Johnson Retooling Professionals Evaluation Fellowship” (Shamblin, 2011) to identify program impacts recognized by school personnel and consultants.

**Summary**

This section outlined the specific evaluation questions and strategies the researcher used to conduct the program evaluation with Stufflebeam’s (2000b) CIPP model. The research design primarily focused on summative evaluation elements using the context, input, process, and product components. Relevant narrative documents were systematically reviewed, previous statistical reports were synthesized, and remaining outcomes underwent new analyses using descriptive and inferential statistics. By using a comprehensive evaluation model (CIPP) and employing qualitative and quantitative
strategies, the researcher was able to gain an in-depth picture of the “Partnerships” program. Results obtained from these activities are discussed in the next chapter, Chapter Four.
Chapter 4: Results

This study was a program evaluation of Partnerships for Early Childhood Mental Health using Stufflebeam’s (2002) CIPP Program Evaluation Model that considers a program’s context, inputs, processes, and products. The study focused on assessing the program’s success in accomplishing the goals identified on the “Partnerships” Theory of Change Model which are: (1) increasing the competence and confidence of participating teachers to meet the social-emotional needs and reduce the challenging behaviors of the children they teach, and (2) increasing resiliency for children whose teachers participate in the program (Shamblin, 2011).

In order to address this broader inquiry, and to align with the CIPP components, the following specific evaluation questions guided the study:

(1) Context: How well did the program address the needs of Athens County preschool children and teachers identified during the program’s development and prior to its implementation? Going forward, how will the program address any unmet needs?

(2) Input: What resources were used to implement the program; and what is the program’s cost effectiveness? How does the program’s per unit costs per class, teacher, and child compare to other programs in Ohio? How does the program compare to any discussed in the literature? Going forward, what changes would enhance efficiency?

(3) Process: How does the program delivered by staff compare to the “Partnerships” Theory of Change and Program Models? Were all component parts delivered
and what percentage of time was spent on each? What critical processes were identified by ECMHC staff and participating school personnel? Going forward, what changes are recommended?

(4) Product: Did the program help teachers feel more confident and become more competent in reducing challenging child behaviors? If so, how? Did the program increase the resiliency of participating children? If so, how? What is the overall impact of this program model?

This chapter presents the results of these components and is organized into five sections: (a) Context, (b) Input, (c) Process, (d) Product, and (f) Summary.

**Context**

Partnerships for Early Childhood Mental Health developed its current model through a Health and Human Services Association (HRSA) Office of Rural Health Policy Outreach Grant and a Substance Abuse and Mental Health Services Administration (SAMHSA) Project LAUNCH Grant. It was designed to address unmet mental health needs of preschool children identified by community stakeholders in preparation for these grants which were documented in “2010-2011 Athens County Community Assessment: A Secondary Analysis for the Athens County Child and Family Health Services Consortium” (Voinovich, 2011), and “Project LAUNCH Environmental Scan Report for the Ohio Counties of Athens, Hocking, Meigs, and Vinton March 2010” (Gallway, 2010). The “Partnerships” program model continued to evolve in response to on-going evaluation activities conducted for these grants.
To answer the “context” component questions, the researcher developed a context evaluation coding system that was applied to relevant extant program documents. Existing program documents were sorted into two categories: (1) those describing the service landscape in which the “Partners” program was created, and (2) those describing the existing program’s services. Documents in Group One included: “2010-2011 Athens County Community Assessment: A Secondary Analysis for the Athens County Child and Family Health Services Consortium” (Voinovich, 2011), “Project LAUNCH Environmental Scan Report for the Ohio Counties of Athens, Hocking, Meigs, and Vinton March 2010” (Gallway, 2010), “Human Resources Services Administration Outreach Grant Proposal Narrative” (Hamel-Lambert, Shamblin, & Meeks, 2008), “SAMHSA Project LAUNCH Grant Narrative” (Ohio Department of Health, 2009), initial scores of the Teacher Opinion Scales (TOS) and the Preschool Mental Health Climate Scales (PMHCS). Documents in Group Two included: “Partnerships for Early Childhood Mental Health Program—Year Three” (Voinovich, 2011), Teacher Opinion Scales, Preschool Mental Health Climate Scales, the “Partnerships” program manual, grant progress reports, the “HRSA Sourcebook Entry” (Hamel-Lambert, Shamblin, & Meeks, 2012), the Performance Improvement Systems Report (PIMS), and final scores on the TOS and PMHCS.

The researcher reviewed the Group One documents and used them to create a check list of unmet needs of preschool children and their families which were described in the documents. She then reviewed the initial results of the Preschool Mental Health Climate Scales, the Teacher Opinion Scales, and Teacher Demographic Surveys.
identified relative weaknesses and areas of teacher growth and added these to the list of unmet needs.

Next, the researcher reviewed the documents in Group Two. This information was used to rate the program’s accomplishments over the last two years on unmet needs listed on the coding checklist. Each item on the checklist was ranked on a score from 0 - 2; with “0” indicating that documents reviewed made no mention of this need being addressed by the program, “1” indicating that documents mentioned actions by the program that addressed the item, and “2” indicating that documents contained outcomes associated with this item. This coding process was also completed by an independent reviewer. Results are summarized in Table 4.

The researcher and the independent reviewer agreed on their rankings for 15 of the 21 items on the checklist (71%). Both raters ranked the program a “2” for 53% of the items on the checklist. Areas not addressed by the program were primarily related to health conditions, which do not relate to program objectives identified on the “Partnerships” Theory of Change Model. In other words, they are items that the “Partnerships” program is not attempting to address. If the checklist items are reduced to those identified on the “Partnerships” Theory of Change model (marked with a “+” sign on the Table 4), there are a total of 16 items. There was agreement between the two raters on 10 of these items (63%), and both rated the program with a “2” on nine of the items (56%). From a statistical standpoint, this agreement rate may seem low. However, the researcher was more interested in identifying the checklist items endorsed as a “2” by both reviewers. She defined these items as areas where the program appears
to be fully addressing the needs of its stakeholders. Checklist items that had disagreement in ratings, or a rating of “1” by both reviewers (where activities were identified, but no outcomes) the researcher defined as possible future improvement areas. These include: lack of coordination across systems, redundancy of paperwork, mental health of parents or other adult primary caregivers, and attending to Appalachian culture. Checklist items which received a ranking of “0” by both reviewers constitute areas not being addressed by the program at all. These were: lack of access to a primary care physician, reducing child obesity, immunization, lead poisoning, infant mortality. Going forward, the program will have to determine how these items relate to its scope. These results will be further discussed in Chapter Five.
Table 4

*Context Coding System with Associated Rankings*

<table>
<thead>
<tr>
<th>Item and documents containing information relevant to this item. *See table notes for document abbreviations</th>
<th>Ranking by Researcher <strong>See table notes</strong></th>
<th>Explanation of ranking and documents containing information relevant to the ranking. “----” denotes absence of information. *See table notes for key to document abbreviations</th>
<th>Ranking by Independent Consultant <strong>See table notes</strong></th>
<th>Explanation of ranking and documents containing information relevant to the ranking. “----” denotes absence of information. *See table notes for key to document abbreviations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy Access to services for young children + (PLES, ON, CFHS, PLN)</td>
<td>2</td>
<td>Documents describe services delivered at schools and in children’s homes (OGFCR, SBCRR, PRN, ECMHYY3)</td>
<td>2</td>
<td>Documents describe numerous methods of service delivery—School, home, clinic, public setting (OGFCR, SBCRR, PRN, ECMHYY3)</td>
</tr>
<tr>
<td>Parents</td>
<td>2</td>
<td>Documents describe services delivered at schools and in-homes; teachers facilitate first meetings between parents and ECMH professionals (SBCCR, ECMHY3)</td>
<td>2</td>
<td>Documents describe how program staff help to bridge communication between home and school; working with families to address school issues (SBCRR, ECMHY3)</td>
</tr>
<tr>
<td>------------------</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>overwhelmed with identifying and accessing services + (PLES, ON)</td>
<td>1</td>
<td>Documents describe consultants working with school personnel but few references to other community professionals, particularly medicine (OGFRCR, SBCRR)</td>
<td>2</td>
<td>Documents describe staff linking families to other services outside of ECMH program (OGFRCR, SBCRR)</td>
</tr>
<tr>
<td>Redundancy and amount of paperwork parents have to complete + (PLES)</td>
<td>1</td>
<td>No paperwork for parents for universal services, but individual child services have same amount of paperwork as traditional clinic-based services (PRN)</td>
<td>0</td>
<td>----</td>
</tr>
<tr>
<td>More professionals available with more tools to provide care for children + (PLES, ON, PLN)</td>
<td>1</td>
<td>Documents contain teacher self-reports on increased abilities; ECMH specialists working on-site with early childhood teachers (OGFCR, SBCRR, PRN, ECMHYY3)</td>
<td>2</td>
<td>Documents describe use of numerous assessments, level of expertise, coordination between school special services and community services (OGFCR, SBCRR, PRN, ECMHYY3)</td>
</tr>
<tr>
<td>Lack of screening + (PLES, PLN)</td>
<td>Documents describe screenings using the DECA by consultants, teachers, and parents (SBCRR)</td>
<td>2</td>
<td>Documents describe Mental Health Assessment/Screening with DECA (SBCRR)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>-------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Lack of family transportation + (PLES, ON)</td>
<td>Documents describe services offered at school or in family homes (OGFCR)</td>
<td>2</td>
<td>Documents describe programming addressing geographic/travel issues; services on site at schools and in-homes (OGFCR)</td>
<td></td>
</tr>
<tr>
<td>Mental Health challenges of adult caregivers + (PLES, CFHS, PLN)</td>
<td>1</td>
<td>Documents describe consultants referring parents for services but no information about the results of these referrals (OGFCR, SBCRR, PRN, ECMHY3)</td>
<td>0</td>
<td>----</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----</td>
<td>---------------------------------------------------------------</td>
<td>---</td>
<td>-----</td>
</tr>
<tr>
<td>Programs/ Professionals that are sensitive to Appalachian culture+ (PLES, ON, PLN)</td>
<td>1</td>
<td>Documents describe rural strategies to recruit providers from the region, but no measures/outcomes related to cultural sensitivity (OGFCR, SBCRR)</td>
<td>1</td>
<td>Documents describe attention paid to the challenge of being located in rural Appalachian Ohio (OGFCR, SBCRR)</td>
</tr>
<tr>
<td>Topic</td>
<td>Documents</td>
<td>Notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More mental health services for younger children + (PLES, ON, CFHS, PLN)</td>
<td>2</td>
<td>Documents describe an increase of ECMH staff from 1 to 5, multiple levels of service (OGFCR, SBCRR, PRN, ECMHYY3)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affordable services that all children can participate in + (PLES)</td>
<td>2</td>
<td>Document describes that universal and targeted consultation services are free; intensive services funded Medicaid and Insurance reimbursement, but free for children who don’t have these payee sources (OGFCR)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Documents describe many choices for mental health services ranging from universal, targeted, intensive consultation (OGFCR, SBCRR, PRN, ECMHYY3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Documents identify that universal and targeted consultation free, but 3rd party reimbursement for intensive may be a problem for some children (OGFCR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic</td>
<td>Documents</td>
<td>Notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health services offered in a “neutral” location like school, home, etc. + (PLES, ON)</td>
<td>2</td>
<td>Documents describe that all program services are delivered in schools and in homes (OGFCR, SBCRR, PRN, ECMHCYY3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of access to medical home (PLES)</td>
<td>0</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma-related services + (CFHS, ON, PLN)</td>
<td>2</td>
<td>Documents report that all providers have completed certificates in evidenced-based trauma models--Parent-Child Interaction Therapy and Cognitive Behavior Therapy (SBCRR)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Documents describe training in trauma-focused therapies for ECMH staff (SBCRR)

Documents describe that consultants deliver schools or home-based services (OGFCR, SBCRR, PRN, ECMHCYY3)
<table>
<thead>
<tr>
<th>Area</th>
<th>Country 1</th>
<th>Country 2</th>
<th>Country 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased capacity for ECE for mental health issues of young children + (ON)</td>
<td>Documents contain teacher self-reports of increased skill/knowledge and increase in available ECMH staff (OGFCR, SBCRR, PRN, TOS)</td>
<td>Documents have outcomes associated with increased skill of teachers (OGFCR, SBCRR, PRN, TOS)</td>
<td></td>
</tr>
<tr>
<td>Decrease challenging behaviors in preschool classrooms + (ON, PMHCS)</td>
<td>Documents contain teacher and consultant reports of decreased challenging behaviors (PMHCS, OGFCR, SBCRR)</td>
<td>Documents contain teacher reports of reduced challenges (OGFCR, SBCRR)</td>
<td></td>
</tr>
<tr>
<td>Teachers increase feelings and problem solving + (PMHCS)</td>
<td>Teachers scores increased and self-reported increased competence (PMHCS)</td>
<td>Documents contain reports by teachers that feel supported personally and professionally by consultant (ECMHCY3)</td>
<td></td>
</tr>
<tr>
<td>Reduce child obesity (CFHS)</td>
<td>----</td>
<td>0</td>
<td>----</td>
</tr>
</tbody>
</table>
Table 4 (continued)

<table>
<thead>
<tr>
<th>Increase immunization rate (CFHS)</th>
<th>0</th>
<th>----</th>
<th>0</th>
<th>----</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce childhood lead poisoning (CFHS)</td>
<td>0</td>
<td>----</td>
<td>0</td>
<td>----</td>
</tr>
<tr>
<td>Reduce rate of infant mortality (CFHS)</td>
<td>0</td>
<td>----</td>
<td>0</td>
<td>----</td>
</tr>
</tbody>
</table>

* Document Abbreviations: CFHS Final Report (CFHS); Preschool Mental Health Climate Scales (PMHCS); Project LAUNCH Environmental Scan (PLES), Outreach Narrative (ON), Teacher Opinion Scales (TOS), Project LAUNCH narrative (PLN), Outreach Grant Final Closeout Report (OGFCR), Sourcebook Entry for Building Capacity-Raising Resiliency (SBCRR), Progress report narrative (PRN), Early Childhood Mental Health Year 3 Final Report (ECMHy3)

** Ranking: “0” = no evidence that this item was addressed by the program; “1” = the item was mentioned in association with program services; and “2”= documents mention program outcomes associated with this item.

+ Item associated with program Theory of Change Model
Input

As part of the input component, the researcher identified all of the resources, personnel, and other costs associated with implementing the program year (Table 5).

Table 5

2011-2012 Program Budget

<table>
<thead>
<tr>
<th>Resource</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>$184,406.00</td>
</tr>
<tr>
<td>Mileage</td>
<td>$1,433.44</td>
</tr>
<tr>
<td>Supplies</td>
<td>$2,226.00</td>
</tr>
<tr>
<td>Training</td>
<td>$1,065.00</td>
</tr>
<tr>
<td>Total</td>
<td>$189,130.44</td>
</tr>
</tbody>
</table>

Next, this total budget was used to calculate per unit costs at the consultant, program, classroom, teacher, and child levels. These are listed in Table 6.

Table 6

Calculation of Program Per Unit Costs

<table>
<thead>
<tr>
<th>2011-2012 Number Served</th>
<th>2011-2012 Number Served</th>
<th>Per Unit Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Consultants</td>
<td>3</td>
<td>$63,043.48</td>
</tr>
<tr>
<td>Number of schools/sites</td>
<td>5</td>
<td>$37,826.09</td>
</tr>
<tr>
<td>Number of classrooms</td>
<td>11</td>
<td>$17,193.68</td>
</tr>
<tr>
<td>Number of school staff (teachers/aides)</td>
<td>22</td>
<td>$8,596.84</td>
</tr>
<tr>
<td>Number of children access to consultation</td>
<td>217</td>
<td>$871.57</td>
</tr>
</tbody>
</table>
Next, a similar series of per-unit costs were calculated for Ohio using available annual reports for the Ohio Department of Mental Health Early Childhood Initiative Office. Reports were available for 2006, 2007, 2009, and 2010. Table 7 lists the results obtained.

Table 7
Review of Ohio Department of Mental Health Consultation Reports

<table>
<thead>
<tr>
<th>FY</th>
<th>Total Budget</th>
<th>Sites/Programs</th>
<th>Classes</th>
<th>ECE Staff</th>
<th>Children</th>
<th>Per Unit Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>$4,100,000.00</td>
<td>988</td>
<td>(No data)</td>
<td>1186</td>
<td>11,206</td>
<td>$4,149.80</td>
</tr>
<tr>
<td>2007</td>
<td>$3,900,000.00</td>
<td>166</td>
<td>1,029</td>
<td>1,425</td>
<td>3,469</td>
<td>$23,493.98</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16,021</td>
<td>$3,790.09</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2,736.84</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,124.24</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$243.43</td>
</tr>
<tr>
<td>2008</td>
<td>No Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>$5,300,000.00</td>
<td>167</td>
<td>805</td>
<td>1,471</td>
<td>2,931</td>
<td>$31,736.53</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15,196</td>
<td>$6,583.85</td>
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<td>$3,602.99</td>
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<td></td>
<td></td>
<td>$1,808.26</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$348.78</td>
</tr>
<tr>
<td>2010</td>
<td>$4,150,000.00</td>
<td>155</td>
<td>652</td>
<td>1582</td>
<td>3348</td>
<td>$26,774.19</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>24281</td>
<td>$6,365.03</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>$2,623.26</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td>$1,239.55</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$170.92</td>
</tr>
<tr>
<td></td>
<td>Ohio Average</td>
<td>Consultant</td>
<td>Program/</td>
<td>Site/</td>
<td>ECE Staff</td>
<td>Children</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Program/</td>
<td>Site/</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Per Unit Cost

<table>
<thead>
<tr>
<th>FY</th>
<th>Consultant</th>
<th>Program/</th>
<th>Site/</th>
<th>ECE Staff</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>$27,071.69</td>
<td>$5,222.19</td>
<td>$2,987.70</td>
<td>$1,907.26</td>
<td>$282.25</td>
</tr>
</tbody>
</table>
Next national average per unit cost was calculated from nationally recognized exemplar programs reviewed in “What Works? A Study of Effective Early Childhood Mental Health Consultation Programs (Duran, Hepburn, Irvine, Kaufman, Anthony, Horen, & Perry, 2009)”. The results are listed in Table 8.

Table 8

*National Samples (Duran, Hepburn, Irvine, Kaufman, Anthony, Horen, Perry, 2009)*

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Budget</th>
<th>Number of Consultants</th>
<th>Sites/Programs</th>
<th>Classes</th>
<th>ECE Staff</th>
<th>Children</th>
<th>Per Unit Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan (2008)</td>
<td>$1,852,999.00</td>
<td>16 full/14 part</td>
<td>430</td>
<td>X</td>
<td>X</td>
<td>6884</td>
<td>$61,766.63</td>
</tr>
<tr>
<td>Michigan (2008)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecticut (2009)</td>
<td>$2,100,000.00</td>
<td>20</td>
<td>244</td>
<td>X</td>
<td>X</td>
<td>1,869</td>
<td>$105,000</td>
</tr>
<tr>
<td>Connecticut (2009)</td>
<td></td>
<td></td>
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<tr>
<td>Central Massachusetts (2009)</td>
<td>$1,100,000.00</td>
<td>13 full/part</td>
<td>85</td>
<td>180</td>
<td>400</td>
<td>4000</td>
<td>$84,615.38</td>
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<td>Central Massachusetts (2009)</td>
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<td>$12,941.18</td>
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<td>$2,750.00</td>
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<td></td>
<td></td>
<td>$275</td>
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<tr>
<td>Location</td>
<td>Year</td>
<td>Total Budget</td>
<td>Number of Consultants</td>
<td>Site Cost</td>
<td>Class Cost</td>
<td>Teacher Cost</td>
<td>Child Cost</td>
</tr>
<tr>
<td>-------------------</td>
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<td>-----------</td>
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</tr>
<tr>
<td>Boulder, CO</td>
<td>2009</td>
<td>$431,346</td>
<td>3 full/1 part</td>
<td>$107,836.5</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Sites: 7</td>
<td>$61,620.86</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Classes: X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Teachers: X</td>
<td>X</td>
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<td></td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td>Children: 321</td>
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<tr>
<td>Baltimore, MD</td>
<td>2008</td>
<td>$150,000</td>
<td>2</td>
<td>$75,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sites: 25</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Classes: X</td>
<td>X</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Teachers: X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Children: 50</td>
<td></td>
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<tr>
<td>San Francisco</td>
<td>2009</td>
<td>$556,000</td>
<td>9</td>
<td>$61,777.78</td>
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</tr>
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<td></td>
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<td>Sites: 15</td>
<td>$37,066.67</td>
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<td></td>
<td></td>
<td></td>
<td>Classes: 31</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Teachers: X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Average</td>
<td></td>
<td></td>
<td>Consultant:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Unit Cost</td>
<td></td>
<td></td>
<td>Site:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Class:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>EC Staff:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Child:</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Finally, these Ohio and National average per unit costs were compared to those calculated for the “Partnerships” program. This information is summarized in Table 9.

Table 9

*Comparisons of Per Unit Costs*

<table>
<thead>
<tr>
<th></th>
<th>Per Consultant</th>
<th>Per Site</th>
<th>Per Classroom</th>
<th>Per Teacher</th>
<th>Per Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnerships</td>
<td>$63,043.48</td>
<td>$37,826.09</td>
<td>$17,193.68</td>
<td>$8,596.84</td>
<td>$871.57</td>
</tr>
<tr>
<td>Ohio</td>
<td>$27,071.69</td>
<td>$5,222.19</td>
<td>$2,987.70</td>
<td>$1,907.26</td>
<td>$282.25</td>
</tr>
<tr>
<td>National Average</td>
<td>$99,199.26</td>
<td>$26,108.91</td>
<td>$12,023.30</td>
<td>$1,936.80</td>
<td>$1,310.39</td>
</tr>
</tbody>
</table>

When compared to average per unit costs in Ohio, the “Partnerships” program was more expensive on every measure. In national comparisons, interestingly, the program per unit costs were less per consultant and per child; but were more expensive per site, per classroom, and per teacher costs. Consultation models implemented, geographic distance between sites/classroom, and regional economics are all factors that would impact per unit costs. In moving forward, the program will need to assess outcomes in relation to state and national outcomes to determine if the added costs are creating added value for participating children. This will be further discussed in Chapter Five.
Process

To assess the staff’s implementation of the model to fidelity, three strategies were used: (1) Consultant logs for the 2010-2011 and the 2011-2012 program years were analyzed for types of consultation activities and time spent on each. Each year’s analysis consisted of nine months of logs for three consultants (304 log entries). The results were compared to the program model and theory of change model; (2) Items 1-13 of the teacher satisfaction survey were analyzed. These items list consultation activities and teachers report the rate each activity occurred in their classrooms. Eight out of eleven participating teachers returned surveys; and (3) Two documents were reviewed to identify critical program components and processes recognized by school personnel and “Partnerships” staff: “Partnerships for Early Childhood Mental Health Program—Year Three” (Voinovich, 2011) and “An Evaluation of the Collaborative Relationships Between Teachers and Consultants in the Partnerships for Early Childhood Mental Health Program: A Final Report for Robert Wood Johnson Retooling Professionals Evaluation Fellowship” (Shamblin, 2011).

Review of Consultant Logs

The program model consists of a pyramid, with the universal consultation time on the bottom. Theoretically, the majority of a consultant’s time should be spent conducting universal consultation activities, with lesser time spent on individual targeted and intensive consultation. A time-study for the 2010-2011 program year was completed by calculating the total minutes spent on each consultation activity as recorded on the consultation logs, and then compared this with the total amount of consultation time.
Logs are divided into sections for each type of consultation activity and consultants record the date for each classroom visit and the time spent in each type of activity. A copy of the log is found in the Appendix M.

The analysis of 304 log entries revealed that the average amount of time spent on universal consultation per classroom was 64% and the average amount of time spent on targeted/intensive consultation activities was 36%. However, there was great variability in findings. In some classrooms where no children received targeted or intensive services, 100% of the consultant’s time was spent on universal consultation activities. In other classes, 70-80% of the consultant’s time was spent on targeted consultation because there were children receiving targeted/intensive consultation. There was no separate data kept to distinguish time spent on targeted versus intensive consultation activities. A table containing the 2010-2011 time-study is located in Appendix O.

For the 2011-2012 school year, the “Partnerships” staff redesigned their documentation process to include specific types of activities conducted as part of their universal consultation services. The categories they used were activities listed on the “Partnerships” Theory of Change Model. A time study was completed on these log entries that revealed 26% of time was spent on individual targeted and intensive consultation and 74% was spent on targeted consultation. This is a close approximation of the 30%-70% division planned by the program. Additionally, the consultant activities listed on the “Partnerships” Theory of Change Model were all represented in the logs, and were rather evenly distributed (ranging from 16% to 20% of the consultant’s time).
The percentage of time spent on each universal consultation activity is listed in Table 10. A table of the entire 2011-2012 time-study information is located in Appendix P.

Table 10

2011-2012 Consultation Break-Down ($n = 304$ log entries)

<table>
<thead>
<tr>
<th>Universal Consultation Activities listed on the Theory of Change</th>
<th>Consultation Category from consultation logs</th>
<th>Percentage of Consultation Time Spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ECMHC’s provide observation/feedback on teaching activities</td>
<td>Conduct Observations</td>
<td>20%</td>
</tr>
<tr>
<td>• ECMHC’s provide weekly mentoring/coaching to teachers</td>
<td>Model classroom behavior management techniques</td>
<td>18%</td>
</tr>
<tr>
<td>• ECMHC’s assist in classroom when appropriate</td>
<td>Other types of consultation activities with teacher</td>
<td>16%</td>
</tr>
<tr>
<td>• ECMHC’s implement IY Dina School and make/bring materials</td>
<td>Conduct Dina/Incredible Years activities</td>
<td>20%</td>
</tr>
<tr>
<td>• Individual Targeted/Intensive consultation activities</td>
<td>Consultation with teacher on individual child questions (19%), consultation with other school personnel (1%), and consultation with child’s parent (6%)</td>
<td>26%</td>
</tr>
</tbody>
</table>
Teacher Satisfaction Surveys

In addition to the consultant logs, the “process” component contained an analysis of items 1-13 on the Teacher Satisfaction Surveys. These survey items ask teachers to rate the frequency specific consultation activities occur in their classrooms. Eight of the eleven participating teachers completed the survey. A copy of the survey can be found in “Early Childhood Mental Health Consultation: An Evaluation Toolkit” (Hepburn, Kaufman, Perry, Allen, Brennan, & Green, 2007, p. 73-74).

Results revealed variability among teacher responses. In terms of average responses, the most frequent activity conducted by consultants is the provision of “teachers support for their own well-being” which was the only item rated as occurring on a weekly basis. Even this item had a wide range of responses. This information is summarized in Table 11.
Table 11

2011 Teacher Satisfaction Surveys Items 1-13 ECMHC Activities

<table>
<thead>
<tr>
<th>Item</th>
<th>Avg</th>
<th>Range</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Classroom screenings and observations</td>
<td>3.2</td>
<td>2-5</td>
<td>1.2</td>
</tr>
<tr>
<td>2. Individual child screenings</td>
<td>2.5</td>
<td>1-5</td>
<td>1.3</td>
</tr>
<tr>
<td>3. In-depth assessments of individual children</td>
<td>1.9</td>
<td>1-4</td>
<td>1.1</td>
</tr>
<tr>
<td>4. Developed service plans for children with special needs</td>
<td>1.9</td>
<td>1-4</td>
<td>1.5</td>
</tr>
<tr>
<td>5. Made referrals to community services</td>
<td>2.0</td>
<td>1-4</td>
<td>1.3</td>
</tr>
<tr>
<td>6. Attended management team meetings</td>
<td>2.9</td>
<td>1-5</td>
<td>1.7</td>
</tr>
<tr>
<td>7. Met with staff to discuss specific children</td>
<td>3.8</td>
<td>2-5</td>
<td>1.3</td>
</tr>
<tr>
<td>8. Provided direct therapeutic/counseling to children/families</td>
<td>2.1</td>
<td>1-5</td>
<td>1.7</td>
</tr>
<tr>
<td>9. Conducted formal teacher trainings</td>
<td>1.5</td>
<td>1-4</td>
<td>1.3</td>
</tr>
<tr>
<td>10. Talked with parents</td>
<td>2.9</td>
<td>1-5</td>
<td>1.6</td>
</tr>
<tr>
<td>11. Provided support to staff for their own well-being</td>
<td>4.4</td>
<td>1-5</td>
<td>1.1</td>
</tr>
<tr>
<td>12. Provided informal training and assistance to teachers/staff</td>
<td>2.8</td>
<td>1-5</td>
<td>1.3</td>
</tr>
<tr>
<td>13. Met with staff to talk about general classroom issues</td>
<td>3.8</td>
<td>1-5</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Note:  n=8

Response Categories: 1 = “Rarely/Never”; 2 = “1-2 Times”; 3 = “Every Month”; 4 = “Monthly; and 5 = “Weekly or More”

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7 A copy of the survey can be found in “Early Childhood Mental Health Consultation: An Evaluation Toolkit” (Hepburn, Kaufman, Perry, Allen, Brennan, & Green, 2007, p. 73-74).
Relevant Findings from Document Reviews

The final piece of the “process” evaluation component was a review of two documents, “Partnerships for Early Childhood Mental Health Program—Year Three” (Voinovich, 2011) and “An Evaluation of the Collaborative Relationships Between Teachers and Consultants in the Partnerships for Early Childhood Mental Health Program: A Final Report for Robert Wood Johnson Retooling Professionals Evaluation Fellowship” (Shamblin, 2011). Full copies of both reports are contained in Appendices D and E. Pertinent process-related comments are highlighted in the remainder of this section.

Teachers were able to accurately describe the three types of services (universal, targeted, and intensive) and identified each layer as necessary. They reported that it was critical that the program remain flexible to the specific needs of each teacher/classroom. Teacher consultation services identified included classroom observation, assistance with classroom planning, feedback on overall classroom environment and child behaviors, and personal support for themselves (Voinovich, 2011). The following quote summarizes these concepts:

Teachers, principals, and superintendents highlighted several classroom support services, such as the Incredible Years Program (viz., Dina School) and writing center activities, as being both effective and well-received by the children. The ECMH consultant came to each classroom once a week to deliver classroom support services and provide follow-up activities for teachers to continue throughout the week at their discretion. According to informants, teachers frequently implemented these activities during the rest of each week because it helped to build classroom routine and
consistency. Continued implementation also increased the rapport between children and the ECMH consultant.

Due to the strong presence of classroom support services, informants noted that many children viewed the ECMH consultant as a “friend” and felt comfortable talking to her at will. Informants suggested that classroom support services were highly effective in teaching children to: identify their feelings, develop emotional competence, build social skills, reduce aggressive behaviors, make friends, overcome shyness, and participate in class. Finally, under the guidance of the ECMH consultant, the entire classroom identified and worked on achieving classroom goals, which also contributed to a cohesive and cooperative classroom environment. (Voinovich, 2011, p. 4).

For individual children, teachers identified the following targeted and intensive components as critical.

Common problem areas addressed by targeted services were communication, classroom participation, shyness, anger, and the transition to preschool. Informants indicated that available targeted services represented a range of ECMH consultant involvement, the need for which was largely determined at her discretion. During school hours, the consultant could provide individual counseling inside the classroom or pull a child from class to provide individual services. In some cases, the ECMH consultant worked with families during the summer before preschool in order to build the trust necessary to effectively promote participation. Outside of school, the ECMH consultant was able to provide individual and family counseling, make home visits,
and refer cases to Tri-County Mental Health and Counseling Services, as necessary (Voinovich, 2011, pp. 5-6).

Many of these same themes were identified in “An Evaluation of the Collaborative Relationships Between Teachers and Consultants in the Partnerships for Early Childhood Mental Health Program: A Final Report for Robert Wood Johnson Retooling Professionals Evaluation Fellowship” (Shamblin, 2011). Important program components and key processes identified by teachers and consultant sources were listed on pages 8 and 9 of this report.

- **Presence of a fully integrated consultant.** In previous years, the program model utilized a consultation-by-request approach-- a consultant served multiple sites, had less time at each site, and was less involved in the school community. Although contact was consistent, consultants primarily focused on classrooms where there were many children receiving individual services. The consultant-teacher ratio of 1 consultant per 5 teachers. During this current program year, 2011-2012, the program switched to a service model incorporating an embedded consultant who was integrated into the school community. A consultant was assigned to a classroom for a minimum of one day a week reducing the ratio to 1 consultant for 3.5 teachers. This change led to a dramatic increase in average hours of consultation that each teacher received (217 average hours of consultation per teacher versus 53 average hours of consultation per teacher in the previous year). Because consultants weren’t traveling so much, they were also able to spend more time doing direct service: the average amount of consultation time per consultant increased from 268 hours to 796 hours for the school year.
All teachers and consultants, across all data sources identified this as a major improvement over previous delivery models. One consultant respondent identified the ability to spend at least one full day a week in a class as particularly helpful to the program implementation. (Shamblin, 2011, p. 8)

- **Consultation for individual children with challenges.** All teachers and consultants cited the value of targeted consultation for individual challenging children. They reported that this was helpful, not only to these children, but was also beneficial for all children in the group because of an enhanced classroom environment. This was supported by teacher focus group responses, consultant interviews, and in satisfaction surveys where all teachers “strongly agreed” that the program had helped them feel less stressed, helped with the children, and improved the quality of their classroom. Specific examples identified by teachers participating in the focus group included, “children speaking up and participating in class, making friends, and fighting less.” (Voinovich, 2012, p.12).

- **Classroom consultation activities:** All consultants participating in the interviews were able to accurately articulate all of the program components. They identified the critical nature of providing teachers with specific, concrete strategies to use in their classrooms. Teacher survey responses reinforced this view, reflecting that the greatest amount of consultation time was spent on discussing strategies for managing their own well-being and for handling challenging children. An analysis of consultant logs further revealed specific consultation activities that were important. Eighty percent of classroom consultation involved four major
activities: 20% observing classroom children/processes; 19% consulting with a teacher on an individually requested teacher topics, 18% modeling classroom behavior strategies, and 20% conducting Dina classroom activities. (Shamblin, 2011, p. 9)

- Incredible Years Dina Classroom Curriculum. Although consultants only spent 20% of their time conducting this program, it was prominently cited by teachers in the focus group, consultant interviewees, and in open-ended survey questions. Teachers felt this program assisted consultants in “fitting into” their classrooms and consultants viewed the program was as “door-opener” for them with participating teachers. Consultants specifically felt that the program led to increased teacher engagement in the program and improved child outcomes. (Shamblin, 2011, p. 9)

All resources analyzed for the “process” component suggests suggest that consultants are delivering the program services in a way that is consistent with the program model and the “Partnerships” Theory of Change Model. Key features identified are implementation of the IY Dina School program, the professional and personal support given to teachers, and the ability of consultants to work with individual children in classrooms and provide intensive services (mental health treatment) at schools and in homes. There appears to be variability in frequency of activities listed on the satisfaction surveys. However, this demonstrated flexibility of consultants and adaptability of the model were identified by school personal as critical to their satisfaction and to the success of the program.
Product

The final phase of this program evaluation, the “product” component, consisted of several analyses. First, the researcher reviewed existing program statistic reports, identified threats to validity, and synthesized findings relevant to program impacts. Second, the researcher assessed by doing new statistical analyses of remaining extant quantitative outcomes collected during the 2011-2012 program year. These included the Teacher Opinion Scales, the Preschool Mental Health Climate Scales, and the remaining items on the Teacher Satisfaction Surveys. Paired sample t-tests were calculated for the Teacher Opinion Scales and the Preschool Mental Health Climate Scales to assess if there were significant changes between the fall and spring administrations of either instrument. Descriptive statistics were calculated for the items on the satisfaction surveys. Finally, two documents were reviewed to identify any program impacts recognized by school personnel and consultants. These were “Partnerships for Early Childhood Mental Health Program—Year Three” (Voinovich, 2011) and “An Evaluation of the Collaborative Relationships Between Teachers and Consultants in the Partnerships for Early Childhood Mental Health Program: A Final Report for Robert Wood Johnson Retooling Professionals Evaluation Fellowship” (Shamblin, 2011).

Findings from Previous Statistical Reports

Three statistical reports have been completed for the “Partnerships” program: “HRSA Outreach Project Evaluation: YR One 2009-2010” (Heh, 2010) containing a statistical analysis of the DECA scores for targeted services and the Teacher Opinion Scales for teachers; “HRSA Outreach Grant: Results of Statistical Analysis YR 2 2010-
2011” (Heh, 2011) that included analyses of the DECA scores for universal and targeted consultation services, Teacher Opinion Scales (TOS), and the Preschool Mental Health Climate Scales (PMHCS); “Statistical Analysis of the ECMH Consultation Program at TCMHC 2011-2012 School Year” (Nakazawa, 2012) that involved a comparative analysis for the DECA scores for universal consultation services. The full reports are contained in the Appendices A-C. Findings are summarized in Table 12.
## Table 12

### Relevant Findings from Existing Statistic Reports

<table>
<thead>
<tr>
<th>Report</th>
<th>Relevant Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partnerships Program: HRSA Outreach Project Evaluation:</strong> YR one 2009-2010 (Heh, 2010)</td>
<td><strong>Teacher Opinion Scales (TOS)</strong></td>
</tr>
<tr>
<td></td>
<td>• Data for (7) participants</td>
</tr>
<tr>
<td></td>
<td>• Mean score in the spring ($M=49.77$, $SD=3.11$) was significantly greater than the mean score in the fall ($M=46.75$, $SD=2.96$), $t (7) = 2.38$, $p&lt;.05$)</td>
</tr>
<tr>
<td></td>
<td>• Standardized effect size, Cohen’s $d$, was 0.84</td>
</tr>
<tr>
<td><strong>Devereux Early Childhood Assessments (DECA) for Targeted Services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Data for (10) participants</td>
</tr>
<tr>
<td></td>
<td>• Teacher ratings showed that attachment and total protective scores significantly improved over time, however initiative and self-control did not</td>
</tr>
<tr>
<td></td>
<td>• Parent ratings reflected that children’s self-control, attachment, and behavioral concerns changed significantly between fall and spring</td>
</tr>
</tbody>
</table>

| HRSA Outreach grant: Results of statistical analysis YR 2 2010-2011 (Heh, 2011) | **Teacher Opinion Scales**  |
|  | • Data for (9) participants and (2) wait-list control  |
|  | • Pre-to-post differences were not statistically significant: fall ($M=48.7$, $SD=3.31$); the spring ($M=49.8$, $SD=4.79$), $t (9) =-.56$, $p=.6$)  |
|  | • The shift in teacher opinion across the year reflected a medium effect ($d=0.27$)  |
| **Devereux Early Childhood Assessments for Universal Consultation** |  |
|  | • Data for (133) children, (11) classes  |
|  | • Comparison of wait-list and participating children whose initial scores were in the “typical” or “concern”
The data was statistically “fit” to the best growth model using multilevel growth modeling (at the child, class, and school levels) to determine the rate of seasonal growth in for each subscale.

• On the Self-Control Subscale, program children had an average growth rate of 8 points. Children in the control classrooms, on average, only made a gain of 1.6 points.

• On the Initiative Subscale, program children made an average growth of 10 points. Children in the control classroom, on average, only made gains of 5 points.

Table 12 (continued)

<table>
<thead>
<tr>
<th>Statistical analysis of the ECMH consultation program at TCMHC 2011-2012 school year (Nakazawa, 2012),</th>
<th>Devereux Early Childhood Assessment for Universal Consultation Services Across 3 Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Data for (550) Head Start children, (81) Project-Launch funded children, (65) Outreach funded children</td>
<td>• No significant differences on scores in the Fall among the 3 programs</td>
</tr>
<tr>
<td>• Spring: The mean score for Outreach was significantly greater than the other two programs (p &lt; 0.001) for all variables, controlling for these covariates: Classroom Size, % Girls, and % English Ineptitude were significant</td>
<td>• Classroom-level random effects may impact changes in scores than school-level and individual child level effects</td>
</tr>
<tr>
<td>• While different classrooms/teachers had different rates of improvement (i.e., significant standard deviations of classroom random slopes), within a particular classroom children improved at a similar rate</td>
<td></td>
</tr>
</tbody>
</table>
Before synthesizing the findings of the three reports, the design and causal validity of each was reviewed. The Year One 2009-2010 report was completed by Victor Heh, biostatistician at the Heritage College of Osteopathic Medicine. The report contains an analysis of the pre-post DECA outcome data for individual children receiving targeted services (n = 10) and the pre-post teacher opinion surveys for participating teachers (n = 7). The small sample sizes limit the usefulness of the t-test statistic used in this report. Another major limitation of this report in determining program impact is the reliance on a pre-post design without a comparison group. This type of design is vulnerable to several internal validity threats. Four are particularly relevant to the Year One analysis: developmental maturation, familiarity with the materials/tools, other influences on the measured outcomes, and regression to the mean (Creswell, 2009). Through the natural process of development, typical preschool children, even with no intervention, may make gains in self-control, initiative, and attachment. Because consultation activities do not occur in isolation—they are happening within classroom environments where there are many other learning activities—gains in DECA scores may be influenced by the education strategies employed by teachers other than those provided by the ECMH consultant. Teachers and parents may have rated children higher on spring DECA’s, and teachers may have scored themselves higher on spring TOS’s, simply because they were more familiar with the items or may have felt that specific items should have improved because they were involved in interventions designed to address them. Without a comparison group who had not received consultation, there is no way to know from this single report if the outcomes were due to the consultation provided. Finally, “regression
to the mean’ is a statistical phenomenon where the extremes do not tend to repeat themselves. In other words, children who had extremely high or low scores on the fall administration are unlikely to have these same extreme scores in the spring. As a result, spring scores are likely to demonstrate improvement, even without intervention. However, this report constitutes only one small piece of information for the “product” evaluation of the “Partnerships” program.

The Year Two 2010-2011 report was also completed by Mr. Heh. It contained an analysis of the fall-spring TOS administrations (n = 11), and fall-winter-spring administrations for the DECA (n = 133). Before the implementation of Year Two, the program had made several adaptations. First, the program included fall, winter, and spring DECA administrations for all children in participating classrooms to assess the impact of universal consultation. Second, they recruited two wait-list control classes whose teachers completed all program tools. Teachers who were slated to begin receiving services during the 2011-2012 school year were asked if they would be willing to become wait-list control classes. It was explained that this would include completing all of the program tools without receiving the services until the next school year. Of four possible teachers, two volunteered. This formed a convenience comparison group.

These design changes, addressed some of the internal validity threats found in the Year One report, but did not eliminate all causal validity concerns. In this report, the major limitation is from threats to external validity (Creswell, 2009). The comparison group was composed of volunteers. It is unclear if the non-participating teachers/classrooms were similar to the participating ones. Any differences in DECA
outcomes between the two groups may have been impacted by multiple differences in teacher characteristics (such as teaching skill or personality) or classroom composition (differences in the numbers of children from stressed home environments, who have developmental delays, etc.). As volunteers, it is also possible that the two comparison group teachers differed in personal characteristics (such as initiative or self-confidence) from the two teachers that did not volunteer. Results may have been different if all four teachers participated in a comparison group. To offset some of these concerns, baseline DECA scores were statistically compared. No differences were found in the starting DECA scores for the participating and control groups. While there may have been important differences in unobserved variables between the two groups, the children and teachers were all from the same preschool programs under the administration of the Athens-Meigs Educational Service Center. Teachers had the same educational levels, had to use the same curriculum materials, and adhere to the same administrative expectations. Students came from the same geographic area with the same demographic profile. Although imperfect, the comparison group used in this design represents a practical and feasible attempt on the part of the “Partnerships” program to compare changes in DECA and TOS scores, in the presence and in the absence of their consultation services.

The Year Three 2011-2012 report was funded by the SAMHSA Project LAUNCH grant, and was completed by Dr. Masato Nakawanza and focused on the universal consultation services. It assessed changes in fall, winter, and spring scores for the whole-classroom DECA administration. The program was unable to recruit wait-list
control classrooms for this program year. In an effort to strengthen the analysis, the DECA results for schools using the “Partnerships” model were compared with the DECA results for the services delivered to Head Start using the ODMH consultation model. In the ODMH funded model, the consultant only visited a Head Start site when staff requested assistance with a specific classroom problem or challenge. The consultant did not routinely visit sites to work with teachers or children. In this regard, the Head Start group represented a non-equivalent comparison group. Head Start and Public Preschool programs have different curricula, teachers have differing levels of education, and administrative expectations are not the same. However, both programs serve the same children in the same age bracket, from the same demographic-geographic area. This report faces many of the validity threats as the Year One and Year Two reports. Despite these limitations, the design represents another practical attempt by the “Partnerships” program staff to evaluate differences in the two types of service-delivery.

In reviewing the three existing statistic reports, there are causal validity threats for each one. As single pieces of information, they are limited in providing information about program impacts for participating children and teachers. However, a synthesis of these three reports still offers an important contribution to the “product” component of the CIPP evaluation. As a collection of documents, they represent a continuum of quasi-experimental designs often used by social service researchers and evaluators in assessing program impacts (Creswell, 2009). In that vein, and with corroboration from the additional CIPP evaluation components, they provide useful information regarding the impact of the “Partnerships” program. Significant findings from these reports point to
potential benefit for participating teachers and teachers. In addition to these reports, there is qualitative data that supports these findings. This will be discussed further in Chapter Five.

The program potentially contributes to increased teacher capacity. For the Year One (2010) and Year Two (2011) reports, a paired sample t-test was used to evaluate differences in teacher scores between the fall and spring administrations. The TOS scores were not analyzed for the Year Three (2012) report. In the Year One report, the mean TOS score in the spring \((M = 49.77, SD = 3.11)\) was significantly greater than the mean score in the fall \((M = 46.75, SD = 2.96)\), \(t (7) = 2.38, p < .05\). The standardized effect size, \(Cohen’s d\), was 0.84 indicating a large effect size (Heh, 2010). From a practical application perspective, this would still be considered a large effect size and implies that the program is having an impact on the competence and confidence of participating teachers. The Year Two report is less conclusive. For participating teachers, the pre-to-post differences were not statistically significant and they were not significantly different from the comparison teachers: fall \((M = 48.7, SD = 3.31)\); the spring \((M = 49.8, SD = 4.79), t (9) = -.56, p = .6\). However, the shift in teacher opinion across the year reflected a medium effect size \((d = 0.27)\) (Heh, 2011). Although not statistically significant, a medium effect size may still support potential positive impact for teachers when combined with other evaluation data such as the teacher satisfaction surveys and document reviews.

For children receiving targeted consultation services, there is potential impact on some resiliency measures. Year One (2010) report contains the only analysis for targeted
consultation services. For children receiving this service, teachers and parents completed DECA’s in the fall and spring. Both teacher and parent ratings were analyzed using two different procedures: mixed model analysis of repeated measures and individual growth curve analysis. The two procedures gave similar results. Controlling for the amount of consultation time received, the teacher’s TOS scores, and the teacher’s satisfaction survey scores, the teacher-DECA ratings showed that attachment and total protective scores significantly improved over time. Initiative and self-control scores did not. For parent ratings, scores for self-control, attachment, and behavioral concerns changed significantly over time, controlling for parent satisfaction survey results (Heh, 2010). A full explanation of these results and the associated procedures are found in the copy of this report found in Appendix A.

Promising results were identified for children participating in the universal consultation services. DECA results for children receiving universal consultation services were analyzed in the Year Two (2011) and the Year Three (2012) reports, but different methods were used.

In the Year Two (2012) report, multilevel growth modeling with a three level analysis (individual child, classroom, and school) was used to determine the rate of growth across the year for children in participating classes and in wait-list control classes. DECA scores collected in the fall, winter, and spring were used. Comparative analysis indicated wait-list classes had an over-representation of children whose initial scores were in the “strength” range (T score > 60). In order to control for these differences, a sub-group analysis was conducted which included only wait-list and participating
classroom children whose initial scores were in the “typical” or “concern” range (T score < 60). Fixed slope, random intercept fit the data, so multilevel growth modeling was conducted to determine the rate of seasonal growth for each subscale. On the Self-Control Subscale, program children had an average growth rate of 8 points. Again, this rate of growth would move the average child scoring in the “Concern Range” into the “Typical Range.” Children in the control classrooms, on average, only made a gain of 1.6 points. On the Initiative Subscale, program children made an average growth of 10 points. Children in the control classroom, on average, only made gains of 5 points. There were no significant differences in rate of growth for the attachment scale (Heh, 2011). A full description of these statistical procedures and results are contained in the Year Two (2011) report located in Appendix B.

The Year Three (2012) report also supported potential impact to children who participated in the universal consultation services. This report analyzed DECA results using linear multi-level regression analysis for three levels (individual child, classroom, and site) to construct growth models for children participating in the “Partnerships” program services funded by the HRSA Outreach grant (65 children in four classes at two schools), the “Partnerships” program services funded by the SAMHSA Project LAUNCH grant (81 children in six classrooms within three schools), and the state-funded Head Start services using the ODMH service model (550 children in 29 within seven schools). The HRSA Outreach funded services had been in place for three years, with the same teachers and consultant implementing the “Partnerships” model for all three years. The Project LAUNCH funded services had only been in place for one year, so the teachers
and consultants were new to implementing the “Partnerships” model. The state funded services at Head Start are delivered by an experienced consultant with a three year relationship with participating teachers. However, the “Partnerships” model is not used. These programs received services based on the ODMH consultation model. Scores for the three programs did not differ significantly from each other at the Fall baseline (p > 0.10) for any of the DECA subscales, but by spring, the mean score for Outreach was significantly greater than the other two programs (p < 0.001) on all DECA sub-scales (initiative, attachment, self-control, and behavior concerns), controlling for class size and composition (gender and age of students). In terms of random effects, adding intercepts or slopes at the classroom level significantly improved the models on all variables, but this did not occur at the individual child or the school levels. This suggests that: (1) classroom-level environments may be more important than school-level ones, and (2) while different classrooms had different rates of growth overall, within a particular classroom, children improved at a similar rate (Nakawaza, 2012). A full description of these analyses and the results tables are located in the Year Three report located in Appendix C.

Statistical Analyses Remaining Extant Quantitative Data for 2011-2012 Program Year

In addition to synthesizing past statistical reports, the researcher conducted her own statistical analyses on the program’s remaining, unanalyzed extant quantitative outcomes collected during the 2011-2012 program year. These analyses included calculating paired sample t-tests for the Teacher Opinion Scales (TOS) and for the
Preschool Mental Health Climate Scales (PMHCS). Teacher Satisfaction Surveys were analyzed with descriptive statistics.

**Teacher Opinion Scale.** The mean scores differed significantly at $p < .05$; $t(11) = -2.5$, $p = .030$, two-tailed. The mean score for spring ($M = 42.00$, $SD = 3.16$) was two points higher than the mean score for fall ($M = 39.6$, $SD = 2.94$). The 95% confidence intervals (CI) for the difference between sample means had a lower bound of 4.45 and an upper bound of .276.

**Preschool Mental Health Climate Scales.** The PMHCS has two scores. The first score is for “positive attributes” and contains teaching strategies that encourage positive child behaviors and support social-emotional development. The second score is for negative attributes--teaching behaviors that may actually increase challenging child behaviors—and includes items such as lack of clear classroom rules.

For the positive attributes scale, the spring mean score ($M = 4.28$, $SD = .38$) did not differ significantly from the fall scores ($M = 4.29$, $SD = .58$); $t(10) = .116$, $p = .910$, two-tailed. The 95% confidence intervals (CI) for the difference between means had a lower bound of -.258 and an upper bound of .286.

For the negative attributes scale, the mean spring score ($M = 1.38; SD = .287$) demonstrated statistically significant reduction from the mean fall score ($M = 1.15; SD = .196$) at $p < .05$; $t(11) = -3.707$, $p = .004$. The 95% confidence intervals (CI) for the difference between the means had a lower bound of -.367 and an upper bound of -.091.

All the data sets and results of the specific analyses for these items are contained in Appendices Q and R.
Teacher Satisfaction Survey. While there was slight variability in teacher responses, on average, teachers positively endorsed 13 of the 17 survey items. Specifically, teachers reported they were satisfied with the program; felt it needed no changes, and the program was beneficial. These responses, when connected with the statistical analyses of the TOS scores, suggest that the “Partnerships” program is having positive impact for participating teachers. Specific survey results are summarized in Tables 13 and 14. A copy of the survey can be found in “Early Childhood Mental Health Consultation: An Evaluation Toolkit” (Hepburn, Kaufman, Perry, Allen, Brennan, & Green, 2007, p. 73-74).
Table 13

**Satisfaction Results Items 14-30 Consultant Relationship**

<table>
<thead>
<tr>
<th>Item</th>
<th>Avg</th>
<th>Range</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. I have a good relationship with my consultant</td>
<td>1.0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>15. Consultant works as a partner with me</td>
<td>1.0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>16. Consultant seems like a member of the staff/ Not an outsider</td>
<td>1.1</td>
<td>1-2</td>
<td>.35</td>
</tr>
<tr>
<td>17. Consultant has good relationship with parents</td>
<td>1.5</td>
<td>1-3</td>
<td>.76</td>
</tr>
<tr>
<td>18. Consultant works closely with parents</td>
<td>2.0</td>
<td>1-4</td>
<td>1.1</td>
</tr>
<tr>
<td>19. I regularly go to my consultant for help with children</td>
<td>1.5</td>
<td>1-2</td>
<td>.53</td>
</tr>
<tr>
<td>20. Consultant is able to work with non-English speakers</td>
<td>.75</td>
<td>0-2</td>
<td>1.0</td>
</tr>
<tr>
<td>21. Consultant respect’s my knowledge and perspectives on children’s issues</td>
<td>1.0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>22. The consultant is “part of the team”</td>
<td>1.1</td>
<td>1-2</td>
<td>.35</td>
</tr>
<tr>
<td>23. Parents trust the consultant</td>
<td>1.4</td>
<td>1-3</td>
<td>.74</td>
</tr>
<tr>
<td>24. The consultant is available when I need him/her</td>
<td>1.5</td>
<td>1-3</td>
<td>.76</td>
</tr>
<tr>
<td>25. The consultant demonstrates an awareness of individual cultural factors</td>
<td>1.4</td>
<td>1-2</td>
<td>.52</td>
</tr>
<tr>
<td>26. Our program’s mental health consultation services have improved the quality of our classroom environment</td>
<td>1.4</td>
<td>1-2</td>
<td>.52</td>
</tr>
<tr>
<td>27. Our mental health consultation services help children with challenging behaviors</td>
<td>1.5</td>
<td>1-2</td>
<td>.47</td>
</tr>
<tr>
<td>28. Our mental health consultation services help families know how to cope with children’s challenging behaviors</td>
<td>1.5</td>
<td>1-2</td>
<td>.54</td>
</tr>
<tr>
<td>29. Our mental health services help staff feel less stressed</td>
<td>2.0</td>
<td>1-2</td>
<td>.52</td>
</tr>
<tr>
<td>30. Our mental health services and approach are in need of improvement</td>
<td>2.75</td>
<td>1-4</td>
<td>1.2</td>
</tr>
</tbody>
</table>

*Note:

N = 8

Response Categories: 1 = “Strongly Agree”; 2 = “Agree”; 3 = “Somewhat Agree”; 4 = “Somewhat Disagree”; and 5 = “Strongly Disagree

---

8 A copy of the survey can be found in “Early Childhood Mental Health Consultation: An Evaluation Toolkit” (Hepburn, Kaufman, Perry, Allen, Brennan, & Green, 2007, p. 73-74).
Table 14

2012 Teacher Survey Responses to Open-Ended Questions

<table>
<thead>
<tr>
<th>What does Consultant do that is most helpful</th>
<th>Comments on Open-Ended Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Her personality and caring was helpful to build relationships with children. All children in the room enjoyed her presence. She offered me good advice. Parents she was able to contact reported back with positive comments</td>
<td></td>
</tr>
<tr>
<td>• She is very helpful with ALL children in the classroom! She is very caring to ALL of the children! I enjoyed having her in my classroom very much</td>
<td></td>
</tr>
<tr>
<td>• Works within classroom with certain children at center time; DINA program; targeted children and 1 on 1 with families</td>
<td></td>
</tr>
<tr>
<td>• She does Dina school and introduces a lot of feelings awareness for kids. This has created a relationship with each student and the students look to her for guidance and support as much as the regular teachers</td>
<td></td>
</tr>
<tr>
<td>• Easy access to mental health services for children and family support--families as they work through challenges raising young children</td>
<td></td>
</tr>
<tr>
<td>• She is wonderful member of our classroom. She does so much that its impossible to pick just one</td>
<td></td>
</tr>
</tbody>
</table>

---

9 A copy of the survey can be found in “Early Childhood Mental Health Consultation: An Evaluation Toolkit” (Hepburn, Kaufman, Perry, Allen, Brennan, & Green, 2007, p. 73-74).
<table>
<thead>
<tr>
<th>Suggestions for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Work more with our parents</td>
</tr>
<tr>
<td>• Start DINA program sooner in the school year</td>
</tr>
<tr>
<td>• I hope we get her back next year</td>
</tr>
<tr>
<td>• Figure out how to start right when the school year starts</td>
</tr>
<tr>
<td>• More conversations about what parents are being taught</td>
</tr>
<tr>
<td>• She came to our school with lots of experience with counseling and working in schools. She was a great match. The program is strong when there is an experienced consultant. The program is as good as the consultant. IF the consultant is not experienced or not comfortable working with low SES families the program is at risk of failure</td>
</tr>
<tr>
<td>• This is a wonderful program this year. Many changes were made last year that made the program a success today.</td>
</tr>
</tbody>
</table>
Document Review

The final step of the “product” evaluation component was a review of two documents: “Partnerships for Early Childhood Mental Health Program—Year Three” (Voinovich, 2011) and “An Evaluation of the Collaborative Relationships Between Teachers and Consultants in the Partnerships for Early Childhood Mental Health Program: A Final report for Robert Wood Johnson Retooling Professionals Evaluation Fellowship” (Shamblin, 2011). Copies of these reports are in Appendices D and E.

The two reports were systematically analyzed with the approach described by Thomas (2006). Through this process, the following themes emerged. School personnel reported satisfaction with the program staff. They described staff as being very knowledgeable in early childhood and mental health with a clear understanding of school processes and procedures, and who were supportive, approachable, and genuine. Teachers thought they had increased their knowledge and skills, especially in regards to addressing mental health issues in the classroom. They reported learning new classroom management skills and strategies to address individual behavior issues and felt less stressed. In addition, teachers reported classroom benefits of increased social skills and calmer environments with decreased conflict and more use of friendship skills (Shamblin, 2011; Voinovich, 2011).

Specific comments that support these themes can be found in “Partnerships for Early Childhood Mental Health Program: A Final Report for Robert Wood Johnson Retooling Professionals Evaluation Fellowship” (Shamblin, 2011).

- All teachers and consultants expressed feeling positive about the
program and working with each other. 100% of teachers responded on the satisfaction survey that they “strongly disagreed” that the program needed improvement. Specific survey comments made by teachers attesting to this high satisfaction include, “We work really well together…she has great ideas and is always prepared to help in any way:” and “My consultant has been great. I don’t feel like there are any weaknesses in our team approach.” These sentiments were also echoed in the teacher focus group report, where it was noted that, “Teachers, principals, and administrators consistently expressed great satisfaction with the ECMH Program Director and ECMH consultant. Both individuals were seen as knowledgeable in early childhood and mental health, with a functional understanding of how schools operate. (Shamblin, 2011, p.8)

- Teachers and consultants reported benefits for children, their organization, and themselves as a result of the program. This was supported by the teacher focus group report, consultant interviews, and both surveys. 100% consultants and teachers “agreed” or “strongly agreed” that the program was personally beneficial; 100% teachers and 90% consultants felt that it was also beneficial to their organizations. Teachers made numerous comments in both the focus group and on open-ended survey questions indicating that they felt less stressed, that children had improved behaviors, and that classrooms were calmer.
Likewise, consultant interviewees pointed to reduced challenging behaviors for individual children and increased development in skills for their teachers and themselves. These views were exemplified by such teacher comments as, “Her personality and caring was helpful to build relationships with children. All children in the room enjoyed her presence. She offered me good advice. Parents who she contacted reported back positive comments.” and “She is very helpful with ALL children in the classroom! She is very caring to ALL of the children! I enjoyed having her in my classroom very much.” Both teachers and consultants felt that the program contributed to their own professional successes; and that they couldn’t have accomplished these professional successes on their own (90% teachers, 75% consultants). (Shamblin, 2011, p.8)

- Teachers and consultants share commitment to the program’s success.
  This was reflected by comments in the teacher focus group, consultant interviews, and on the collaboration survey where 80% teachers and 75% consultants agreed that there was shared commitment.
  (Shamblin, 2011, p.8)

A recap of the findings of the “Product” evaluation component suggests that the program is having some positive impact for participating teachers and children. Teachers and school personnel have a high satisfaction with the program and report that it is beneficial to their schools, their classes, themselves, and the children they serve. The
emergent process of the documents review revealed that the consultants working for the program also have high satisfaction and identify positive program impacts for the teachers and children with whom they work. An additional theme emerged—the value school personnel placed on the individual consultants, not just the program services. The document review findings and satisfaction results provided additional support for the positive TOS outcomes, and mental health climate scales. The document review also helped substantiate findings from the syntheses of the previous statistical report. Both suggest the program is having positive impact for participating children in terms of DECA outcomes related to overall resiliency (total protective factors scores) and ability to form positive relationships (attachment scores). In moving forward, the program may want to consider building on these provisional results by pursuing more tightly controlled comparisons for its DECA outcome measures and continuing to determine if the Teacher Opinion Scale and PSMHC are the best tools for identifying impact for teachers.

Summary

A synthesis of the Context, Input, Process, and Product components of this evaluation provide an overall positive picture of the School Partnerships for Mental Health Program. The program appears to be addressing many of the needs of preschool children in the region for which it was designed. Program staff seems to be directing their efforts to meet the context components identified on the “Partnerships” Theory of Change Model. While more expensive than the predominant model delivered within Ohio, the program’s per child cost is less than exemplars identified in the literature. The higher costs may be offset by the program’s strengths and benefits. A strength is the
clear articulation of the “Partnerships” Theory of Change Model and the “Partnerships” Program Model. Staff appears to be implementing these models to fidelity but with enough flexibility that services meet the specific needs of individual teachers, classes, and children. Participating school personnel value the program staff and are satisfied with services. They report having positive benefits—increased skill and reduced stress. Teacher outcome data are consistent with these self-reported benefits. The impact for participating children is also positive. These results seem to indicate that children demonstrate increased total protective factors and attachment scores for both teacher and parent report at the targeted level and by teacher scores at the universal level. There is some suggestion that when the program model is fully implemented to fidelity at the teacher and consultant level, that children have significant increases in attachment and self-control, as well as decreases in challenging behaviors. Preliminary results demonstrate that the gains made by children using this program model have statistically significant improvements in these scales over children receiving consultation modeled after the Ohio model. Finally, results appear to reflect that the program achieves its impact through the expertise of its staff, relationships made with school personnel, and the implementation of the Dina School Incredible Years program (Webster-Stratton & Reid, 2004).
Chapter 5: Discussion of the Results

Partnerships for Early Childhood Mental Health, an early childhood mental health consultation program serving three counties of Southeastern Ohio, was created to address the social-emotional needs of preschool children in the region. Originally based on the consultation format described by Georgetown University and implemented throughout Ohio, the program slowly evolved its own unique model through a variety of federal grant opportunities. As part of these grants projects, the program has participated in simple evaluations for some of its component parts. However, there had never been an attempt to unify all of these evaluation components or to conduct an extensive evaluation of the whole program.

In this study, a summative evaluation of the context, input, process, and product was conducted to form a thorough understanding of the program. Each of these four components is part of Stufflebeam’s (2000) CIPP program evaluation model. These four components comprised four mini-evaluations guided by their own specific questions.

1) Context: How well did the program address the needs of Athens County preschool children and teachers identified during the program’s development and prior to its implementation? Going forward, how will the program address any unmet needs?

2) Input: What resources were used to implement the program; and what is the program’s cost effectiveness? How does the program’s per unit costs per class, teacher, and child compare to other programs in Ohio? How does the program
compare to any discussed in the literature? Going forward, what changes would enhance efficiency?

(3) Process: How does the program delivered by staff compare to the “Partnerships” Theory of Change and Program Models? Were all component parts delivered and what percentage of time was spent on each? What critical processes were identified by ECMHC staff and participating school personnel? Going forward, what changes are recommended?

(4) Product: Did the program help teachers feel more confident and become more competent in reducing challenging child behaviors? If so, how? Did the program increase the resiliency of participating children? If so, how? What is the overall impact of this program model?

This study produced a number of findings to answer these questions. Results indicate that the program addressed many of the identified mental health needs of the preschool population it was designed to serve. However, there is opportunity for the program to be more responsive to its context. The program has done little to address identified health needs for this population or the mental health needs of participating parents. Moving forward, the program staff will need to decide if they wish to tackle these, and if they can do so without sacrificing other program components. The “Partnerships” program is more expensive than the predominant model delivered throughout Ohio, but the program’s per child cost is less than exemplars identified in the literature. The program staff will need to decide if these higher costs are offset by the program’s strengths and benefits.
A strength is the clearly articulated Theory of Change and Program Models. Program consultants appear to be reliably implementing both models, but with enough flexibility that they are meeting the specific needs of individual teachers, classes, and children. The services, as they are being delivered, have been well received by participating school personnel and program staff. Participating teachers report the positive benefits of increased skill and reduced stress. Teacher outcome data supporting these self-reports is limited but promising. Teachers and staff report reduced challenging behaviors and increased pro-social behaviors for participating children. Again, outcome data to support this is limited, but positive for increased resiliency (attachment, initiative, and self-control) and for decreased behavior concerns.

This chapter will provide further discussion of the study results, implications for the program, and recommendations for the program staff to consider. Subsequently, significance of these results for the field of early childhood mental health will be highlighted.

**Discussion of Results**

Overall, the Context, Input, Process, and Product components of this evaluation provide a positive picture of the Partnerships for Mental Health Program. The study results reflected program strengths and future considerations.

**Context**

The context component revealed that the program had documented outcomes associated with 53% of needs identified by available local needs assessments conducted before the program was established, and 56% of the items on their Theory of Change
Model. According to the coding responses of both the researcher and the independent reviewer, the program appears to be addressing many of the identified mental health needs of the preschool children and teachers that it was designed to serve. Previous needs assessments also reflected significant adult-caregiver mental health needs and unaddressed health needs for preschool children. The “Partnerships” program has done little to address these, but based on the “Partnerships” Theory of Change Model, it was never designed to address these issues. The mental health needs of adult caregivers and primary healthcare may be outside the program’s scope. While the program staff could consider increasing the program scope, it should regard this carefully. Increasing scope would likely have major implications for quality if manpower resources are stretched too thin. One cannot be “all things to all people.” Program participants may be better served by staff developing linkages to other community programs that do address these identified needs. Consultants may already be providing this service, but if they are, there is no mechanism for documenting their efforts or tracking results. Tracking of this type of information would be feasible, but the time involved would need to be balanced with delivery of consultation services and the program benefits of tracking the information.

The accuracy of the context component results are contingent on the documents reviewed and the process used. The needs assessments used to develop the checklist were conducted by external evaluators trained in standard procedures for conducting community needs assessments, and involved broad representatives of community stakeholders. The coding method used to review the program’s response to these contextual needs has limitations. The use of a coding worksheet, an independent
reviewer, and reliance on documented evidence added objectivity to the process. Additionally, all documents used for the context evaluation are included in the Appendices section so that others may complete the same process and assess the accuracy of the findings.

However, this process did not allow the researcher to quantify the degree to which the program had identified addressed issues. For example, one identified need was “more mental health services for younger children.” The “Partnerships” program addresses this need—it has increased the number of mental health specialists working with young children from 1 to 5. However, this study did not assess the level at which this increased manpower addresses this need. Questions remain unanswered such as “what percentage of preschool children had increased access to the mental health services?”; “What percentage of preschool children in the area actually accessed these services.” Moving forward, the “Partnerships” staff may consider not only how they will use the results of this context evaluation to make decisions about program scope, but also how they can become more sophisticated in their approach to assessing their responsiveness to their constituents. However, taken in conjunction with the other components of this evaluation, the results of the context component suggest that the program has focused its services in a way that is reflective of needs expressed by community stakeholders.

**Input**

The “input” component of the evaluation reflected that the program is more expensive than the predominant model delivered within Ohio on every measure, but the per child cost is less expensive than exemplars identified in Chapter Four. One impact to
these results is the variation of consultation models. The “Partnerships” Program Model integrates consultants into early childhood and school settings—consultants are placed at schools and visit the same five classrooms every week and conduct an intense array of services. This “integrated” model has resulted in teacher satisfaction and consultant satisfaction. The Ohio Department of Mental Health model differs significantly from the “Partners” program model. In the ODHM model, consultants only go to centers when they are called for a specific problem and can serve many more programs. The focus is on connecting with centers to solve a specific classroom problem and then moving on to another center. Children identified as needing individual consultation or treatment are referred out. This type of approach increases the number of children, teachers, and sites that a consultant can serve and reduces the per unit costs. National comparisons include programs that operate on models more similar to Partnerships for Early Childhood Mental Health. Interestingly, the program per unit cost was significantly less per consultant and per child; but was more expensive at the unit cost for site, classroom, and teacher. Again, consultation models vary widely and could be impacting this comparison. Another impact to this comparison may be geographic distance, number of classrooms per site, and number of children in each class. The “Partnerships” program may be able to serve fewer sites/classrooms/and teachers than the national models reviewed because of its rural setting. Consultants are assigned to a school for a full day for each class to reduce mileage costs. Schools may have fewer classes per site than suburban or urban settings. However, the “Partnerships” program seems to be serving more children per site for the same costs as the national models. Moving forward, the
staff program will need to assess its program outcomes in relation to state and national outcomes to determine if the higher costs are creating added value for participating teachers and children.

**Process**

The higher program’s costs may be offset by the program’s strengths and benefits. The process component of the evaluation revealed that a strength of the program is that it has a clearly articulated Program Model and Theory of Change Model. Additionally, it appears that the activities and processes outlined in these models are being implemented to fidelity by staff, but with enough flexibility to meet the specific needs of individual teachers, classes, and children. The program also appears to have adequate measures to track its implementation and to obtain related feedback. The log developed by the consultants was an important addition for determining the consultation tasks being implemented and time spent on each. Data from consultant logs and the teacher surveys were complimentary. Moving forward, this will allow the program staff to continue streamlining its processes and discontinue any not identified as critical. For example, consultants and teachers identified several critical components. One of these was the Incredible Years Dina School program. Teacher preference for the Dina School program, over the parent training and teacher training components, is consistent with the Incredible Years own research (Webster-Stratton & Reid, 2004). Other program components identified as critical were the professional and personal support given to teachers and the ability of consultants to work with individual children in classrooms and provide intensive services (mental health treatment) at schools and in homes. No one mentioned
access to resources in the “Teacher Lending Library” or the “E-newsletter”, both activities listed on the Theory of Change model. These activities may be of less value to participants. The staff can assess if manpower and material resources could be diverted from these activities with little impact to the program satisfaction and outcomes.

**Product**

The “Partnerships” program has good satisfaction from participating school personnel and consultants. Teachers self-reported the positive benefits of increased skill and reduced stress. However, there is limited outcome data supporting teacher self-reported benefits. The Teacher Opinion Scales (TOS) and the Preschool Mental Health Climate Scales (PMHCS) being used by the program is susceptible to all of the same biases and subjectivity associated with other self-report tools based on Likert-type scales. Yet, these tools are the most current ones being used by ECMH consultants and recommended to practitioners (Hepburn et al., 2007). To the degree these tools measure teacher confidence and competence to address challenging child behaviors, the “Partnerships” program has demonstrated a mixed impact. There were significant changes on TOS scores, and on the negative attributes scale of the PMHCS. However, these findings should be viewed cautiously because of the causal validity threats associated with the pre-post design and lack of matched comparison groups. Despite these concerns, the qualitative reports for program impacts are strong.

Teachers and consultants both report positive benefit for participating children. There is also limited, but positive outcome data to support these identified positive impacts. The Devereux Early Childhood Assessment (DECA) is a standardized tool with
stronger validity in comparison to the TOS and the PMHCS. The use of this tool to assess child outcomes is program strength, as is the statistical analyses of these data. Although past reports suggest positive impacts for participating children, each report contained causal validity concerns. Yet, these DECA outcome reports, taken in conjunction with other evaluation reports from teachers’ focus groups and consultant interviews, yield promise that the program is positively impacting the attainment of resiliency and the reduction of challenging behaviors. As it moves forward, the program staff may consider making adaptations to its evaluation design to reduce causal validity threats. There are examples described in the ECMHC literature that will be further discussed later in this chapter.

**Implications and Recommendations for the “Partnerships” Program**

Stufflebeam’s (2000b) CIPP evaluation process has provided the Partnerships staff with a unified understanding of the program’s current impact and relative strengths as future considerations. These can be organized around four factors: (a) responsiveness to context, (b) program finances, (c) program quality, and (d) continuity of impact evaluation.

**Responsiveness to Context**

Several documents were used for the context portion of this evaluation. They were valuable, insofar as they describe the identified needs of the region and the population the “Partnerships” program was created to serve. However, these documents are now over three years old. No other local documents, containing the same level of direct application, were identified. Additionally, the grant initiatives that produced these
documents (i.e. the HRSA Outreach Grant, the SAMHSA Project LAUNCH grant, and the CHS Community Health Programs grant) have ended or will end this year. However, it can be anticipated that the local landscape will be changing—possibly rapidly—based on federal and state level changes in the healthcare industry, education system, Medicaid reimbursement, and community mental health practice. At this stage, it is impossible to predict the local impact to the consumers of the “Partnerships” program—teachers, parents, and children. This presents the program with the challenge of remaining responsive to its context and consumers. How will the program continue to collect information about the needs of the region and population it serves so that it can maintain its ability to adapt and remain relevant? One possible strategy is to develop an advisory group of local stakeholders (community partners, school personnel, staff, and parents) that would meet annually or semi-annually to give feedback in a style reflective of the accountability bridge discussed by Astromovich and Coker (2007). The accountability bridge model is based on the philosophy that being responsive to program participants is not only important for being accountable to external funders, but is also important for being responsive and accountable to program participants—an inherent value of the counseling profession. The model has two cycles: evaluation of the counseling context through feedback of clients and stakeholders with strategic planning and program modification, followed by a program implementation loop (Astromovich & Coker, 2007). Green and Allen (2012) also speak to ECMHC program managers about the importance of remaining accountable to stakeholders and describe a similar feedback loop for continuous quality improvement. An advisory group for the “Partnerships” program has
the potential not only to assist the program with identifying the changing needs of its context, but can also assist with prioritizing which needs to address so that the program is able to stay focused and not over extend its resources.

**Program Finances**

The input evaluation revealed that the Partnerships program is more expensive than other consultation programs in Ohio, although it arguably offers a more comprehensive program. Nationally, the per child costs are more competitive, however, the programs described in this report were primarily located in urban areas with a greater financial base than the Appalachian region where the program is located. Previously the program was able to build its services on federal and state level grant funds that may be unreliable in the long term. A review of the program budget shows limited ability to cut costs; 98% of expenditures are personnel related-- staff salaries and fringe benefits-- which produces a future sustainability challenge for the program. One strategy is to leverage the program’s satisfaction data to encourage investment at the local level. The program director has already been successful in doing this with the local Head Start program and the local mental health board. School systems are an obvious choice; however local schools are facing budget challenges. Initial attempts to obtain school support have been mixed, with some schools pledging significant support and some giving none. Interestingly, the schools with the fewest resources have given the most financial support. These superintendents have communicated their belief that the program contributes value for their staff and students, and saves them money in the long run. Identifying specific cost savings for schools would be valuable to the program’s
efforts to advocate for funding from other school partners. Given the current focus on early childhood by the federal government (www.whitehouse.gov, 2013), it is possible that there will additional funding opportunities for the “Partnerships” program and its school partners. However, in the absence of outside grant support, the program may need to develop a system to prioritize services to schools based on a minimum level of school investment. The per unit costs found in the “input” component would help the director set rates if there is interest in pursuing a fee-for-service approach.

While the “Partnerships” program staff could consider returning to a less comprehensive model, similar to the model delivered in the rest of Ohio, this seems ill-advised. The program had this type of model in the past and changed to a more comprehensive model based on strong feedback from school partners. The new comprehensive model has garnered strong satisfaction from participating teachers and principals. This was clearly identified in the teacher focus group and the survey, through comments like, “This is a wonderful program this year. Many changes were made last year that made the program a success today.”

**Program Quality**

The process evaluation results suggest that the program has clear components and procedures that appear implemented as they are described. The consultation logs adopted by the program in 2012 were instrumental in identifying how program components were being delivered. The program should consider continuing to use them and revising them each year so that it can maintain the ability to adapt to each individual classroom situation within a standard framework that has some consistency across sites and between
individual consultants. Annual evaluation of these logs can also ensure that the most
critical components are implemented and non-critical ones terminated—forming another
mechanism for the program to remain responsive to its context and clientele.

The process evaluation also identified that the individual characteristics of
consultants and their relationship abilities are critical to teacher satisfaction. Teachers
valued the expert knowledge of program consultants and their abilities to form
relationships with teachers, parents, and students. This was framed perfectly by one
teacher’s survey response,

“She came to our school with lots of experience with counseling and working in
schools. She was a great match. The program is strong when there is an
experienced consultant. The program is as good as the consultant. IF the
consultant is not experienced or not comfortable working with low SES families
the program is at risk of failure.” (Response on Teacher Survey; Table 14 in
Chapter 4 of this document).

The reliance on quality staff to deliver a quality program has implications for the
program in terms of staff retention and recruitment. In the Robert Wood Johnson report
(Shamblin, 2011), current staff expressed a high level of satisfaction with their jobs, a
condition that is critical to maintain. Staff has the dubious honor of working in a
profession that combines early childhood and mental health—both considered high burn-
out professions with high staff turnover (Maslach & Jackson, 1987; Onyett, Pillinger, &
Muijen, 1997; Lloyd, King, & Chenoweth, 2002; Rosenberg & Pace, 2006). At the
administration level, it will be important in moving forward to develop staff appreciation
and self-care opportunities. When new consultants need to be hired, the administration should consider prioritize hiring staff that have experience with school settings, who have demonstrated abilities to translate behavior/mental health principles to early childhood professionals, and who are flexible, team-players (Shamblin, 2012). The program administration may consider including a mechanism for shared decision-making with school partners when adding new staffing, such as representation during the interview process, may be a strategy for continuing to build school investment in the program, with an eye on sustainability. Strategies for training new staff have been developed. These are outlined in the “Partnerships” Program Manual located in the Supplemental Materials section. However, these should continually be refined with specific strategies for mentoring new staff.

**Continuity of Impact Evaluation**

The product evaluation identified some promising outcomes for participating teachers and children. Given that the sustainability of the program may be intimately intertwined with the ability to demonstrate measureable impact for children and teachers, the program staff may be well advised to continue building on the foundation it has laid. The satisfaction survey and annual teacher focus groups provide a good strategy for determining satisfaction and qualitative information about impact. The program has used the Teacher Opinion Survey and the Preschool Mental Health Climate Scale for a few years with mixed results. As the field of ECMH grows, new tools for assessing teacher outcomes may be developed. Until that time, the “Partnerships” program may want to consider using participating teachers and consultants to develop other strategies for
assessing teacher benefits. One practical strategy could be as simple as tightening teacher-consultant goals developed in the fall so they are more observable and measureable, then assessing the attainment of the goals in the spring. Teachers and consultants tend to stay in their jobs for long periods of time in the southern Ohio region. As a result, the attainment of goals could be tracked and monitored from year to year.

The program has made strides to demonstrate its positive impact on participating children. The DECA tool seems to be a good match to the program’s strength-based focus and appropriate for assessing the program’s outcomes for children. Over the last few years, the statistical reports reflect a range of quasi-experimental designs. These have laid a good foundation. The program can use the lessons learned to be more consistent in its approach each year and to tighten its design. Also, there is little movement of families in the region. Children tend to go to school in the kindergarten where they attended preschool. The program may want to consider following children into kindergarten to see if children who participated in preschool ECMH consultation have differences in their DECA resiliency measures in comparison to those children who did not.

This study had relevance and implications for the “Partnerships” program in terms of its responsiveness to context, program finances, program quality, and continuity impact evaluation. To what degree are the results of this study relevant and significant to the field of early childhood mental health consultation?
Significance for the ECMH Field

This study makes several contributions to the field of early childhood mental health consultation. First, the study results reinforce literature describing common characteristics found in ECMH programs. Second, the results of the “product” component are consistent with existing literature supporting ECMHC. Third, the study contains a thorough description of the “Partnerships” program. Nationally, ECMH programs vary widely in their component parts and in the outcomes they are able to deliver. Leaders from the field have encouraged ECMHC programs to contribute to the research base by articulating their program models, conducting sound program evaluation, and communicating the results (Duran et al., 2009). Because it has well-articulated processes, the “Partnerships” program, may serve as an exemplar for programs in similar contexts, particularly those located in rural Appalachian settings. Fourth, the “input” results provide specific financial information, not only for the “Partnerships” program, but also for the ODMH funded model, and national averages. Finally, this study also demonstrates one method that other ECMH programs can use to conduct substantive evaluations of their own programs and publish findings. Stufflebeam’s (2000b) CIPP model is a well-established method, with clear but adaptable procedures applicable to other early childhood mental health consultation programs. This study contains copies of all materials used so that other ECMHC program directors can apply the same strategies to their programs, if they wish.
Common Characteristics of ECMHC

The earliest document reviewing ECMH programs across the United States in an effort to identify best practices was “Promising Practices in Early Childhood Mental Health” by Simpson, Jivanjee, Koroloff, Doerfler, and Garcia (2001) and published by SAMHSA. This document identified ten common criteria of the five promising practices/programs that were reviewed. Promising programs were: family-centered and attended to the strengths, needs, and cultures of participating children; individualized and tailored to the unique needs and strengths of participants; comprehensive and included a variety of intervention levels; coordinated and encompassed multiple child serving systems; they were built on a high level of participation by caregivers recognizing that direct caregivers are uniquely able to encourage the development of children; focused on developmental needs acknowledging that for young children all developmental domains are entwined and must be addressed in a unified way; and built on strengths and resiliency enhancing positive skill development as opposed to problems and deficits.

A second document used by the ECMH field to measure effectiveness of consultation models is Georgetown University’s “What Works? A Study of Effective Early Childhood Mental Health Programs” (Duran et al., 2009). This document consisted of a national scan of 35 states and 29 ECMHC programs. Through this process, researchers identified ten core components of the programs they categorized as successful. Programs recognized as successful and with positive outcomes had these qualities in common: presence of leadership, a well-defined model, a process for hiring and training, quality supervision/support for consultants, strategic partnerships,
community engagement, clear communication, strategies to evaluate services, and secure funding.

The common qualities of promising programs identified in the literature can be reviewed in light of the findings from the program evaluation of the “Partnerships” program. Tables 15 and 16 offer a snapshot of how the “Partnerships” program compares to these qualities.
Table 15


<table>
<thead>
<tr>
<th>Criteria</th>
<th>Partnerships for Early Childhood Mental Health Program</th>
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<tbody>
<tr>
<td>Comprehensive</td>
<td>Program model offers 3 tiers of service so that children’s needs within their classroom setting are met. Universal (prevention) for typical children in a class, targeted (promotion) for children who have specific classroom behavior challenges but do not need mental health services, and intensive (assessment and intervention) for children who have developmental and mental health delays/disorders.</td>
</tr>
<tr>
<td>Community-Based</td>
<td>Services occur within schools and family homes, not at the mental health clinic.</td>
</tr>
<tr>
<td>Uniquely configured for the community</td>
<td>The program model was developed over time with input from school partners and staff at all levels.</td>
</tr>
<tr>
<td>Coordinated with other services</td>
<td>ECMH consultants are part of the school environment and coordinate with teachers, school social workers, school psychologist, speech/language and physical therapists, and teachers.</td>
</tr>
<tr>
<td>Culturally competent</td>
<td>Program model, services, and staff are well-suited for rural Appalachian schools and families.</td>
</tr>
<tr>
<td>Builds on strengths/resilience</td>
<td>Universal services are based on identifying teacher strengths and interests then building on them. Targeted and Intensive services are centered on the Devereux Early Childhood Assessment system which is well-rounded in the resiliency research and literature.</td>
</tr>
<tr>
<td>Focused on development</td>
<td>Particular attention has been paid in developing services and using tools, such as the DECA and Incredible Years programs, which are specifically designed for the preschool population.</td>
</tr>
<tr>
<td>Family participates</td>
<td>Families are invited to participate in parenting programs through the summer and the school year; parents and caregivers are involved with designing targeted and intensive strategies.</td>
</tr>
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Table 16

“What Works? A Study of Effective Early Childhood Mental Health Programs” (Duran et. al., 2009).

<table>
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<tr>
<th>Core Component</th>
<th>Partnerships for Early Childhood Mental Health Program</th>
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<tr>
<td>Strong leadership</td>
<td>ECMH program director has been local and state leader in the development of the ECMH field.</td>
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<tr>
<td>Clear model design</td>
<td>Model has well-articulated levels with targeted goals, service delivery activities, and evaluation components.</td>
</tr>
<tr>
<td>Process for hiring and training staff</td>
<td>ECMH Consultant core competencies aligned with the model are developed, which employs cognitive apprenticeship methodology for the first year of employment.</td>
</tr>
<tr>
<td>Supervision and support mechanisms for consultants</td>
<td>The ECMH consultant’s attainment of the core competencies is aligned with accompanying supervision activities throughout the cognitive apprenticeship year. Following this year, a peer mentorship program has been developed.</td>
</tr>
<tr>
<td>Strategic Partnerships</td>
<td>The program has strong partnerships with schools and early childhood professionals; the parent network, Integrating Professionals for Appalachian Children (IPAC); the local mental health community; and state departments of mental health (ODMH) and health (ODH) through SAMHSA’s Project LAUNCH.</td>
</tr>
<tr>
<td>Community engagement</td>
<td>School partners (even those not directly receiving the services) have been engaged partners in developing the model and in supporting program activities. IPAC sponsors information on their website and e-newsletter.</td>
</tr>
<tr>
<td>Clear communication</td>
<td>Recent qualitative data and surveys report good communication between consultants and school personnel.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Employs mixed methodology to evaluate each tier of service, as well as overall impact.</td>
</tr>
<tr>
<td>Financing</td>
<td>Has been well supported by the home agency (Tri-County Mental Health) and the local mental health board</td>
</tr>
</tbody>
</table>
The “Partnerships” program compares favorably to the criteria of the promising programs outlined in both of these documents. In view of this, dissemination of this study and its results offers a contribution to the expanding literature describing components of ECMH consultation programs. This further supports the universality of the program components identified by both documents and assists researchers in creating common language and metrics to advance the field’s research agenda.

**Consistency with ECMHC Research**

The primary goal of ECMHC is to “strengthen the capacity of teachers to promote positive social and emotional development as well as prevent, identify, and reduce the impact of mental health problems among young children” (Kaufman, Perry, Irvine, Duran, Hepburn, & Anthony, 2012, p.2). The “Partnerships” program goals are consistent with this aim. The results of this study are also consistent with many of the current ECMHC research findings.

The first randomized controlled study of ECMHC found that participating children had reduced externalized behaviors which appeared to be accomplished through an increase in social skills (Alkon, Ramler, & MacLennan, 2003). These initial findings have continued to be supported in follow-up studies, even when the teacher is the only recipient of the consultative services (Han, Catron, Weiss, & Marcie, 2005; Morrison, & Bratton, 2010; Perry, Dunne, McFadden, & Campbell, 2008; Upsher, Wenz-Gross, & Reed, 2009; Williford & Shelton, 2008). Current ECMHC research has also found that participating teachers demonstrate increased confidence and competence (Brennan,

In this evaluation of the “Partnerships” program, participating children demonstrated growth in their overall resiliency and in their attachment—both are prosocial skills. DECA outcomes were mixed for reduction in challenging behaviors. Teacher Opinion Scales (TOS) were positive for increased confidence and competence for teachers. Although there were threats to causal validity identified in the DECA outcome analyses, and in the pre-post design for the TOS, qualitative reports by teachers and program staff supports that the program is having positive impact in addressing decreasing challenging child behaviors, increasing positive child behaviors, and increasing teacher confidence and competence. In the future, if interested, the “Partnerships” staff could look to previous studies for design changes that may strengthen the ability draw causal conclusions about their program.

The Alkon et al. (2003) study was a large statewide, randomized-controlled trial. As such, it is likely not the best model. However, there are several published program studies that are of similar scope and size to the “Partnerships” program. Han et al. (2005) employed a randomly assigned treatment/control group design to study the RECAP program (Reaching Educators, Children, and Parents). This study had a total of 149 child participants, three participating classes, and three control classes. The program is similar to the “Partnerships” program. Consultants provide semi-structured, in-class consultation augmented by classroom-wide behavior management using a cognitive-behavioral skills training curriculum similar to the “Incredible Years” program implemented by the
“Partnerships” consultants. Children who received the RECAP program increased in social skills and decreased in challenging behaviors over the control group children. More recently, Upsher et al. (2009) conducted a study for “Together for Kids.” This consultation program delivers mental health consultation to Head Starts. The study focused on Head Start services. The agency delivered the “Together for Kids” program to four classes (47 children) and remaining Head Start classes served as control classrooms (89) children. Children in the control classes still had access to the agency’s traditional mental health treatment services which had been delivered to the Head Start program in the past. Children receiving the “TFK” program demonstrated a significant reduction of aggression, reduction in expulsion rates, and growth in adaptive behaviors.

**Documentation of Process and Costs**

Perhaps, the value of this study is less about contributing outcome evidence to support the efficacy of consultation. Its greater value may lie in more practical contributions, such as the documentation of process, use of tools to assess these processes, and associated costs. Duran et al. (2009) specifically identified a need for published literature that included specific consultation models, underlying Theories of Change Models, and exact consultation steps and processes. In this regard, this study makes a strong contribution. The “Partnerships” program has a well-articulated model. Its manual contains a complete description of all the program’s consultation steps, processes, and use of tools. All are contained in this study, making it useful for those interested in understanding the mechanics of a specific consultation program, particularly as it is delivered in a rural Appalachian setting. Not only does the study articulate
ECMHC in a specific geographic region, but it also yields strategies for managing an ECMHC program in a community mental health center—a system that is more typically focused only on treatment of “adults with serious and persistent mental illness (SPMI) and children with serious emotional disturbance (SED) (Ohio Department of Mental Health, 2012, p.1)”. The results may have special relevance for the 72% of ECMHC programs housed in community mental health centers (Duran et al., 2009). The “input” component of this study, which focused on developing per-unit consultation rates, may be particularly useful for those administering programs in community-mental health centers whose funding structures are typically based on third-party reimbursement for individual therapy. Documentation on consultation costs is not readily available. This study contained calculations of consultation costs, not just for the “Partnerships” program, but also for the Ohio Department of Mental Health funded model and national examples. Although costs will vary widely based on setting and geographic region, the results of this study offers a strategy that program directors can use to develop their own consultation rates and offers some comparison rates.

**Application of CIPP Methodology for ECMH Program Evaluation**

In addition to practical information about consultation processes and costs, this study also provides an example of Stufflebeam’s (2000b) program evaluation model in an ECMHC program. ECMHC researchers have made specific requests for published program evaluations. The need for program evaluation in ECMHC is further underscored by the scarcity of evaluation being conducted by state governments, despite the significant financial investments being made in ECMHC. Only 17 of 29 states with
ECMHC state-funded programs had any type of evaluation measures in place (Duran et al., 2009)—an irresponsible stewardship of taxpayer dollars. This lack of attention to evaluation by government funders, places more burden on ECMHC program directors to evaluate their services to ensure they are worthy of investment. ECMHC researchers recommend that evaluations be summative; follow a formalized process and a documented evaluation model; and help answer gaps in the research related to specific steps/processes that occur in ECMHC (Duran et al., 2009, Hepburn et al, 2007).

This study based, on Stufflebeam’s CIPP (2000b) model, corresponds with each of these recommendations. This evaluation model has been widely used, is highly adaptable, can be used by external or internal evaluators, and is adjustable to the smallest/largest evaluation budget (Stufflebeam, 2001). While there is literature that describes its use in evaluating education and other intervention programs designed for young children, there does not appear to be documented use in early childhood mental health consultation (Carpinello, Newman, & Jatulis, 1992; Lee & Walsh, 2004; Motlagh, Kelishadi, Ardalan, Gheiratmand, Majdzadeh, & Heidarzadeh, 2009; Schultz, Schmidt, & Stichter, 2011). The study presents an effective application of this evaluation model for ECMH program directors. It describes practical strategies implemented for the evaluation, use of existing program data, and the strengths and precautions of internal evaluation. The modest budget of the program also effectively demonstrates that the CIPP model can be employed with few resources and can be incorporated into the program services.
Summary

Tri-County Mental Health and Counseling and the Partnerships for Early Childhood Mental Health Program have developed an ECMH consultation model based on the limited available literature for this burgeoning field and ongoing feedback from its participants and staff. The program has incorporated a variety of strategies to assess its services but had not conducted a comprehensive evaluation.

In response to the call from ECMH leaders and researchers for existing programs to document their programs, the “Partnerships” program engaged in this study. Stufflebeam’s CIPP model (2000b) was selected because of its adaptability and comprehensiveness. As a result the program staff has been able to form a more cohesive understanding of its service landscape, critical components, sustainability issues, and impact for its participants. The program appears to be addressing many of the needs of its intended population in the region that it serves, yet there is opportunity for growth. While more expensive than the predominant model delivered within Ohio, the program’s per child cost is less than exemplars identified in the literature. The higher costs may be offset by the program’s strengths and benefits. There is a well-defined “Partnerships” Theory of Change Model and “Partnerships” Program Model that appear to be implemented to fidelity but with enough flexibility that it can meet the specific needs of individual teachers, classes, and children. The program has high satisfaction for participating school personnel, and self-reported positive benefits of increased skill and reduced stress. There is limited, but positive, outcome data supporting these self-reported benefits of teachers. Teacher and staff report increased social skill and reduced
challenging behavior for participating children. Limited, but positive outcome data supports an increase in overall resiliency and attachment scores for participating children. Program components are being delivered in a manner consistent with the “Partnerships” Theory of Change Model and the “Partnerships” Program Model. Staff and teachers have identified critical program components: having consultants who are an integrated part of the school setting with a high level of expertise, the three levels of service, support given to school staff, and the implementation of the Dina School Incredible Years program.

Moving forward the program will need to continue remaining responsive to its context, evaluating program finances in relation to its outcomes, engaging participants in program quality, and evaluating its services and impact.

In addition to benefits for the “Partnerships” program, this study has also contributed to the larger ECMHC field. Dissemination of this study and its findings serve as a documented example of the way ECMH consultation is conducted in rural Appalachia Ohio. The description of the program will allow readers to decide for themselves how the findings relate to their circumstances. Use of the CIPP evaluation model demonstrates a flexible, practical, comprehensive process that other ECMH directors can use to gain a unified picture of their programs and assess their services.
References


Himmiger, M. (2010). *SFY 2010 Early childhood mental health consultation program report (July 1, 2009-June 30, 2010)*. Ohio Department of Mental Health. Columbus, OH.


doi:10.1080/09638230020023642


Ohio Department of Mental Health. (2009). *Ohio’s core competencies for early childhood mental health professionals.* Columbus, OH: Ohio Department of Mental Health.


Appendix A: HRSA Outreach Project Evaluation (YR One 2009-2010)

Submitted by Victor Heh

Reliability analysis of mean scale scores, using Cronbach’s alpha, showed that teacher ratings were quite reliable for all subscales and total protective factor except for behavioral concerns (see table1). For mothers, rating for initiative was not reliable for all time points and reliability was low for attraction and total protective factor (TPF) in fall. It would be difficult to delete items as part of total scores since different items function poorly on different measurement occasions. Analyses for behavioral concerns may be much more trustworthy on mothers’ ratings than teachers’ ratings and for other measures teachers’ ratings may be more trustworthy (see table1). Generally, reliability of mothers’ assessments on the DECA scale improved with time. Except for the behavioral concerns scale, mothers showed some level of satisfying rather than optimizing in their responses. For example, if you compare teachers’ (M=21.4, SD=5.7) and mothers’ (M=24.9, SD=2.69) score on fall TPF, you realize mothers had higher mean score but far less standard deviation which may be responsible for the deplorable reliability. The smaller standard deviation and higher average score showed mothers were more likely to rate their children higher on all TPF items than teachers. However, for behavioral concerns, mothers were much more careful in their responses. Just for your information.

Table 1: Descriptive statistics for students (10) who entered the study in fall

<table>
<thead>
<tr>
<th>Measure</th>
<th>Teacher Ratings</th>
<th>Parent Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std Deviation</td>
</tr>
<tr>
<td>Initiative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>23.20</td>
<td>8.22</td>
</tr>
<tr>
<td>Winter</td>
<td>24.80</td>
<td>7.07</td>
</tr>
<tr>
<td>Spring</td>
<td>25.00</td>
<td>9.27</td>
</tr>
<tr>
<td>Self-Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>16.90</td>
<td>5.65</td>
</tr>
<tr>
<td>Winter</td>
<td>19.10</td>
<td>5.34</td>
</tr>
<tr>
<td>Spring</td>
<td>18.60</td>
<td>6.42</td>
</tr>
</tbody>
</table>

---

10 This is an unpublished program report belonging to the “Partnerships for Early Childhood Mental Health Program” It is reprinted for the purposes of this study with permission from Tri-County Mental Health and Counseling Services, Inc.
Teacher Opinion Survey

A paired sample $t$ test was used to evaluate the differences in teacher opinion between the fall and spring quarters. The results indicated that the mean opinion in the spring ($M=49.38, SD=3.11$) was significantly greater than the mean opinion in the fall ($M=46.75, SD=2.96$), $t (7) = 2.38, p<.05$). The standardized effect size, Cohen’s $d$ was 0.84 indicating a large effect size.

Teacher and Parenting Ratings on the DECA Scale

Teacher and parent ratings on the DECA scale were analyzed in two steps using mixed model analysis of repeated measures. Firstly, the covariance structure for within subject DECA scores was determined to be first order auto regressive structure, AR(1), using restricted maximum likelihood estimation procedure. The appropriate covariance structure, among alternative covariance structures, was determined using the Bayesian Information Criterion. Secondly, using the selected covariance structure, the fixed component of the model was estimated with the maximum likelihood estimation procedure. The covariates in the model include time, teacher satisfaction, change in teacher opinion between fall and spring, and parent satisfaction survey.

The result as presented in table 2 shows that teacher attachment ratings significantly increased between the fall and spring seasons. Most of the changes occurred between the fall and winter with the least change occurring between winter and spring. Also, teacher opinion change score, between the fall and spring quarters, was significantly related to teacher attachment ratings. It is worth to note that none of the other subscales (Initiative, Self-control, and Behavioral Concerns) and the $TPF$ was significantly related to the
covariates and neither did they differ significantly over time using the mixed effect analytic approach.

Table 2: Mixed effect analysis of teacher attachment rating over three time points

<table>
<thead>
<tr>
<th>Attachment Variable</th>
<th>Estimates</th>
<th>Std Error</th>
<th>Df</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covariates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in teacher Opinion</td>
<td>1.51</td>
<td>0.64</td>
<td>15.95</td>
<td>0.031</td>
</tr>
<tr>
<td>Teacher satisfaction scores</td>
<td>0.33</td>
<td>0.16</td>
<td>14.41</td>
<td>0.053</td>
</tr>
<tr>
<td><strong>Changes in DECA over time</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>21.09</td>
<td>1.29</td>
<td>32.23</td>
<td>-</td>
</tr>
<tr>
<td>Winter</td>
<td>22.77</td>
<td>1.13</td>
<td>22.48</td>
<td>-</td>
</tr>
<tr>
<td>Spring</td>
<td>23.73</td>
<td>1.15</td>
<td>23.44</td>
<td>-</td>
</tr>
<tr>
<td>Fall to Winter</td>
<td>1.68</td>
<td>1.03</td>
<td>26.31</td>
<td>0.114</td>
</tr>
<tr>
<td>Fall to Spring</td>
<td>2.64</td>
<td>1.26</td>
<td>30.93</td>
<td>0.044</td>
</tr>
<tr>
<td>Winter to Spring</td>
<td>0.96</td>
<td>0.83</td>
<td>24.094</td>
<td>0.263</td>
</tr>
</tbody>
</table>

Teacher opinion was evaluated at 2.58
Teacher satisfaction was evaluated at 45.51
Multiple comparisons using least significant difference (LSD)

The same analysis, as above, was carried out on parental rating with parent satisfaction survey as the only covariate in the model. The result showed that TFP and initiative did not change significantly over time. Parent satisfaction also had no significant relationship with all DECA scales. The results, as can be seen in table3 (a, b & c), showed that self-control, attachment, and behavioral concerns as rated by parents, change significantly over time. Whereas self-control and behavioral concerns showed an improvement over time, attachment shows deterioration over time (note: attachment score in fall cannot be trusted). It is worth to note that as teachers rated children to improve on the attachment scale, parent did otherwise. However, one needs to interpret this result with caution since mothers’ assessment of their children on the attachment scale in fall was not reliable at all.

Table 3a: Mixed effect analysis of parent self-control rating over three time points

<table>
<thead>
<tr>
<th>Self Control</th>
<th>Estimates</th>
<th>Std Error</th>
<th>df</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covariates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent satisfaction scores</td>
<td>0.15</td>
<td>0.22</td>
<td>17.33</td>
<td>0.518</td>
</tr>
<tr>
<td><strong>Changes in DECA over time</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>15.32</td>
<td>1.23</td>
<td>28.18</td>
<td></td>
</tr>
<tr>
<td>Winter</td>
<td>16.88</td>
<td>1.13</td>
<td>22.13</td>
<td></td>
</tr>
<tr>
<td>Spring</td>
<td>18.10</td>
<td>1.12</td>
<td>21.49</td>
<td></td>
</tr>
<tr>
<td>Fall to Winter</td>
<td>1.65</td>
<td>0.88</td>
<td>26.13</td>
<td>0.072</td>
</tr>
<tr>
<td>Fall to Spring</td>
<td>2.87</td>
<td>1.09</td>
<td>29.93</td>
<td>0.014</td>
</tr>
<tr>
<td>Winter to Spring</td>
<td>1.22</td>
<td>0.73</td>
<td>25.08</td>
<td>0.110</td>
</tr>
</tbody>
</table>
Table 3b:

<table>
<thead>
<tr>
<th>Attachment</th>
<th>Estimates</th>
<th>Std Error</th>
<th>df</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Covariates</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent satisfaction scores</td>
<td>0.28</td>
<td>0.19</td>
<td>18.42</td>
<td>0.153</td>
</tr>
</tbody>
</table>

Changes in DECA over time

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
<td>24.96</td>
<td>1.01</td>
<td>32.1</td>
<td></td>
</tr>
<tr>
<td>Winter</td>
<td>23.02</td>
<td>0.98</td>
<td>25.15</td>
<td></td>
</tr>
<tr>
<td>Spring</td>
<td>23.50</td>
<td>0.966</td>
<td>24.324</td>
<td></td>
</tr>
<tr>
<td>Fall to Winter</td>
<td>1.94</td>
<td>0.88</td>
<td>27.04</td>
<td>0.037</td>
</tr>
<tr>
<td>Fall to Spring</td>
<td>1.46</td>
<td>1.08</td>
<td>32.06</td>
<td>0.19</td>
</tr>
<tr>
<td>Winter to Spring</td>
<td>0.476</td>
<td>0.734</td>
<td>25.67</td>
<td>0.522</td>
</tr>
</tbody>
</table>

Table 3c

<table>
<thead>
<tr>
<th>Behavioral Concerns</th>
<th>Estimates</th>
<th>Std Error</th>
<th>df</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Covariates</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent satisfaction scores</td>
<td>-0.16</td>
<td>0.19</td>
<td>20.93</td>
<td>0.405</td>
</tr>
</tbody>
</table>

Changes in DECA over time

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
<td>18.95</td>
<td>1.146</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winter</td>
<td>18.81</td>
<td>1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spring</td>
<td>15.08</td>
<td>1.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall to Winter</td>
<td>0.15</td>
<td>1.67</td>
<td>28.05</td>
<td>0.93</td>
</tr>
<tr>
<td>Fall to Spring</td>
<td>3.87</td>
<td>1.82</td>
<td>39.53</td>
<td>0.040</td>
</tr>
<tr>
<td>Winter to Spring</td>
<td>3.73</td>
<td>1.43</td>
<td>24.93</td>
<td>0.015</td>
</tr>
</tbody>
</table>

Individual growth curve analysis

Teacher and parent ratings on the DECA scale were analyzed using individual growth curve analysis in the latent variable framework. Firstly, two growth factors, final status and rate of change were estimated using the three DECA measurements. Then covariates were added to the model to explain the systematic variation in final status and rate of change if applicable. Given that sample size was small and measurements were taken at only three time points, model identification was insured by fixing some parameters. Fit indices for the structural equation analytic technique were used to determine model fit. The maximum likelihood estimation procedure was used to estimate fix and random
effects. Linear or non-linear models were fit depending on which functional form fit the data best. Missing Data assumption was missing at random (MAR).

Analysis of the teacher ratings showed that the initiative, self-control, and behavioral concerns scales did not differ significantly over time and neither did they relate significantly to changes in teacher opinion scale and teacher satisfaction scale. However, their ratings of the child on the attachment and TPF scales change significantly over time (see tables 4a & b). Random intercepts and fixed slopes provided the best fit to the data. The result also showed that the systematic variation in the final status of the attachment score (but not TFP score) was significantly accounted for by both changes in teacher opinion between fall and spring and teacher satisfaction survey conducted in spring; the higher the attachment score in the spring season, the higher the change in teacher opinion and satisfaction.

Table 4a: Individual growth curve analysis of teacher rating of attachment

<table>
<thead>
<tr>
<th>Attachment Variable</th>
<th>Estimates</th>
<th>Std Error</th>
<th>P value</th>
<th>CFI</th>
<th>TLI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Only growth factors estimated</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>23.74</td>
<td>1.23</td>
<td>&gt;0.001</td>
<td>1</td>
<td>1.014</td>
<td>0</td>
</tr>
<tr>
<td>Variance</td>
<td>22.63</td>
<td>8.43</td>
<td>0.007</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.245*</td>
<td>0.38</td>
<td>0.001</td>
<td>1</td>
<td>1.103</td>
<td>0</td>
</tr>
<tr>
<td>Variance</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Covariates in the model</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in teacher Opinion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final status</td>
<td>1.54</td>
<td>0.63</td>
<td>0.015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher satisfaction scores</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final status</td>
<td>0.368</td>
<td>0.159</td>
<td>0.020</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
*rate of change per season

Chi-square test of model fit for growth model only, p=0.464
Chi-square test of model fit for growth model and covariates, p=0.74

Table 4b

<table>
<thead>
<tr>
<th>Total Protective Factor</th>
<th>Estimates</th>
<th>Std Error</th>
<th>P value</th>
<th>CFI</th>
<th>TLI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Only growth factors estimated</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>67.41</td>
<td>4.18</td>
<td>&gt;0.001</td>
<td>1.00</td>
<td>1.094</td>
<td>0</td>
</tr>
<tr>
<td>Variance</td>
<td>215.75</td>
<td>81.15</td>
<td>0.008</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>6.06*</td>
<td>3.07</td>
<td>0.048</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variance</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Covariates in the model</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in teacher Opinion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final status</td>
<td>2.08</td>
<td>2.21</td>
<td>0.346</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher satisfaction scores</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final status</td>
<td>0.73</td>
<td>0.55</td>
<td>0.181</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
*Total gain in TPF
Chi-square test of model fit for growth model only, p=0.944
Chi-square test of model fit for growth model and covariates, p=0.961

Parental ratings (not presented in tables) for behavioral concern changed significantly per unit time, M=-2.80, p<.001. Overall, attachment reduced over time, M=-1.14, P<.01.
TPF, initiative, and self-control measures did not change significantly over time. Parental satisfaction was not related to any of the DECA measures.

In conclusion, please note that this time analysis was conducted on raw scale scores not TSCORES. TSCORES may be good to show clinical significance at the individual levels. I will be doing this analysis next.

Two different analytical procedures were used with largely similar results. The growth curve analysis showed that, for teachers, attachment and TPF significantly changed over time. Mixed effect model only shows this for attachment. The relationships between attachment and teacher surveys were much more significance in terms of p-values.

For parents, both types of analysis came to the same conclusion that attachment and self-control changed significantly over time.
Appendix B: HRSA Outreach Grant Results of Statistical Analysis (YR 2 2010-2011)

Submitted by Victor Heh

Universal Consultation:

The data consisted of 133 students in 11 classrooms. The minimum class size was 7 and the maximum was 25, and average cluster size of 14.8. Intraclass correlation for fall, winter, and spring was 0.08, 0.17, and 0.27 respectively. This is a measure of how homogenous children are within classrooms. In general, they are quite heterogeneous in the fall but tend to become similar over time. All raw scores were converted to T-SCORES and multilevel growth modeling (three level analyses) was conducted to determine the rate of seasonal growth in self-control among participants. Growth was estimated for students nested in classrooms over the three school seasons of fall, winter, and spring.

Self-Control Subscale:

Fixed slope but random intercept fit the data relatively well. Average linear growth rate of 1.5, $p<.05$, and initial status of 55.9 were estimated for participants resulting in overall average of 3 points gained over the period. For WLC classrooms, initial status was 60.12 and growth rate was 0.041, $p=.233$. The difference in initial status was 4.213, $p = 0.233$ and the difference in growth rate was 1.461, $p = 0.019$. For this result, the WLC started too high and cannot stand as a legitimate comparison group in its current form.

To make the WLC group equivalent to the participating classrooms, a sub group analysis (involving 100 students with starting values less than 60) was conducted. The result for this analysis showed that the initial status difference between the participating and control classrooms reduced to 1.855, $p=0.425$. However, the growth rate difference increased to 3.415 per season, $p=0.025$, after controlling for total consultation time. Consultation time itself was not statistically significant. In summary, the participating classrooms and the WLC classrooms both started with average self-control values of 52.3 and 54.2 and increased at the rate of 4.213, $p<.05$ and 0.798, $p>.05$ respectively per school season.

Note that a TSCORE of 60 and above represent above average and may not have the potential of increasing any further. T-SCORES values below 60 represent average or below average TSCORES and have the potential to increase.

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The result is presented in Table 1, which also include the analysis for other measures.

Table 1: Comparison between Participating classrooms and WLC, Teacher DECA data

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Self-Control</th>
<th>Attachment</th>
<th>Total Protective Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B P-value</td>
<td>B P-value</td>
<td>B P-value</td>
</tr>
<tr>
<td>All Data, N</td>
<td>166</td>
<td>166</td>
<td>166</td>
</tr>
<tr>
<td>Intercept</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>54.218 &lt;.001</td>
<td>63.105 &lt;.001</td>
<td>57.032 &lt;.001</td>
</tr>
<tr>
<td>WLC</td>
<td>54.155 &lt;.001</td>
<td>60.096 &lt;.001</td>
<td>55.422 &lt;.001</td>
</tr>
<tr>
<td>Difference</td>
<td>0.063 0.984</td>
<td>3.009 0.522</td>
<td>1.610 0.694</td>
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<tr>
<td>Slope</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>3.260</td>
<td>2.122</td>
<td>3.122</td>
</tr>
<tr>
<td>WLC</td>
<td>1.584 0.018</td>
<td>0.051 0.328</td>
<td>1.334 0.125</td>
</tr>
<tr>
<td>Difference</td>
<td>1.676 0.160</td>
<td>2.071 0.021</td>
<td>1.788 0.368</td>
</tr>
<tr>
<td>&lt; 60 in fall, N</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>51.868 &lt;.001</td>
<td>56.055 &lt;.001</td>
<td>50.902 &lt;.001</td>
</tr>
<tr>
<td>WLC</td>
<td>50.038 &lt;.001</td>
<td>54.200 &lt;.001</td>
<td>50.134 &lt;.001</td>
</tr>
<tr>
<td>Difference</td>
<td>1.830 0.294</td>
<td>1.855 0.425</td>
<td>0.768 0.706</td>
</tr>
<tr>
<td>Slope</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>5.122</td>
<td>4.213</td>
<td>4.923</td>
</tr>
<tr>
<td>WLC</td>
<td>2.331 0.139</td>
<td>0.798 &lt;.001</td>
<td>3.926 0.021</td>
</tr>
<tr>
<td>Difference</td>
<td>2.791 0.005</td>
<td>3.415 0.025</td>
<td>0.997 0.706</td>
</tr>
</tbody>
</table>

Total consultation time was included in the model and not significant.

Note that the difference between slopes is the relevant analysis here. One may also look at group slopes to determine how each group performed. The slope is linear, meaning that overall change may be determined by multiplying the linear slope by 2. For example, for people starting below initiative TSOCRE of 60 in fall, their overall change is (5.122 x2) = 10.244, attaining practical significance. The difference of 2.791 between the participating classrooms and WLC is statistically significant. Note that the intercept difference not being significant is ok.

Additional Subscales and Total Protective Factors:

Total protective factor
Estimated start value (initial status) =54.159  
Estimated growth rate = 2.434, p<.001  
Intraclass correlation for fall, winter, and spring is 0.095, 0.214, 0.353 respectively
Initiative
Estimated start value (initial status) = 53.655
Estimated growth rate = 2.681, p<.001
Overall growth = 5.362
Intraclass correlation for fall, winter, and spring is 0.070, 0.201, 0.318 respectively

Attachment
Estimated start value (initial status) = 53.00
Estimated growth rate = 2.413, p<.05
Overall growth = 4.83
Intraclass correlation for fall, winter, and spring is 0.190, 0.368, 0.403 respectively

Behavioral concerns
Estimated start value (initial status) = 50.566
Estimated growth rate = -0.888, p=0.321
Overall growth = -1.776
Intraclass correlation for fall, winter, and spring is 0.067, 0.089, 0.239 respectively

Relationship to Pre-School Mental Health Climate Scales:

The relationship between final status and a series of pre-school mental health climate variables measured in spring was determine and presented in table 1.

Table 1: Bivariate Linear Regression between Self Control and Pre-school Mental Health Climate

<table>
<thead>
<tr>
<th>Pre-school Mental Health Climate</th>
<th>β</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitions</td>
<td>1.2</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Directions and Rules</td>
<td>4.80</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Staff Awareness</td>
<td>4.83</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Staff-Child Interaction</td>
<td>4.86</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Feelings and Problem Solving</td>
<td>0.95</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Child interaction</td>
<td>4.83</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Significant differences among participants in classrooms were positively related to certain pre-school mental health climate variables as shown in table 1. Mental health climate variables similarly relate to Total Protective Factors, as well as the Initiative and Attachment Sub-Scales.

Teacher Opinion Scales:

There is not a strong case for using WLC Teacher Opinion Survey in the report. There are only two WLC results, with one having a low value and the other having a high value. Both WLC teachers moved in different direction between pre-to-post.
For Participants, the pre-to-post difference is not significant. However, the shift in opinion as a medium small effect (d=0.27), which is not bad at all. Note that d is Cohen’s effect size.

Paired Samples Statistics

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FALL</td>
<td>48.6667</td>
<td>9</td>
<td>3.31662</td>
<td>1.10554</td>
</tr>
<tr>
<td>SPRING</td>
<td>49.7778</td>
<td>9</td>
<td>4.79004</td>
<td>1.59668</td>
</tr>
</tbody>
</table>

Paired Samples Correlations

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Correlation</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td></td>
<td>-0.068</td>
<td>.862</td>
</tr>
<tr>
<td>TOTOSF_mean &amp; TOTOSS_mean</td>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Paired Samples Test

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval of Difference</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOSOSF mean - TOSOSS mean</td>
<td>-1.11111</td>
<td>6.00925</td>
<td>2.00308</td>
<td>-5.73 - 3.51</td>
<td>-5.55</td>
<td>8</td>
<td>.594</td>
</tr>
</tbody>
</table>

Targeted Consultation:

Sub-group analysis of Children scoring in the “Concern Range” during fall administration:

Self-Control:
Subgroup analysis involving 11 students in 4 classrooms was conducted for those students who scored below average in fall. For the subgroup analysis, initial value of 34.58 and a growth rate of 9.44 (between fall and winter) were estimated.

Total Protective Factors:
9 kids in 4 classrooms; min =1, max =4, average =2.25, average start value=34.69, average growth rate=3.194, p<.001. Overall growth=6.388

Initiative:
14 kids in 7 classrooms; min =1, max =4, average =2, average start value=35.607, average growth rate=5.273, p<.001. Overall growth=10.546
**Attachment:**
8 kids in 4 classrooms; min =1, max =4, average =2, average start value=34.682, average growth rate=4.943, p<.001. Overall growth=9.886

**Behavioral Concerns:**
25 kids in 9 classrooms; min =1, max =6, average =2.78, average start value=64.488, average growth rate=-2.24, p<.05. Overall growth=-4.48

*Relationship between initial status and consultation time for children in the “Concern Range”:*

Table 2: Linear regression of initial status and growth rate on total consultation time

<table>
<thead>
<tr>
<th></th>
<th>Initiative</th>
<th></th>
<th>Self-Control</th>
<th></th>
<th>Total Protective Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>P-value</td>
<td>B</td>
<td>P-value</td>
<td>β</td>
</tr>
<tr>
<td><strong>Within</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>-10.658</td>
<td>&lt; 0.001</td>
<td>-6.332</td>
<td>&lt; 0.001</td>
<td>-10.509</td>
</tr>
<tr>
<td>Slope</td>
<td>2.453</td>
<td>0.001</td>
<td>1.012</td>
<td>0.014</td>
<td>1.505</td>
</tr>
<tr>
<td><strong>Between</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>-0.024</td>
<td>0.522</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Slope</td>
<td>-0.011</td>
<td>0.587</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Interpretation:
Individual starting values negatively relate to total consultation time (May mean that children with lower starting values had significantly more consultation time?)
The higher the consultation time the higher the growth rate for initiative, self-control, and total protective factors. Attachment relates negatively to total consultation time (not presented here)

Note: **within** means individual level results corrected for non-independence . **Between** means aggregated result over classrooms. Modeling was done in one run, meaning a hierarchical modeling was done.
Appendix C: Statistical Analysis of the ECMH Consultation Program at TCMHC

2011-2012 School Year

Submitted by Mosato Nakazawa, Ph.D.
Interim Bio-statistician for the Heritage College of Osteopathic Medicine
Submitted 8-29-12

Analysis of the Initiative T-Score at the Individual Level

Five-hundred fifty children participated in the Head Start program within 29 classrooms within 7 schools. The numbers of children participated in other programs are much smaller: 81 in Launch within 6 classrooms within 3 schools; and 65 in Outreach within 4 classrooms within 2 schools.

The programs did not differ significantly from each other at the Fall baseline (ps > 0.10, Table 1), but by Spring the mean score for Outreach was significantly greater than the other 2 programs (ps < 0.001). Likewise, Outreach had the greatest gain over time (i.e., Spring - Fall; ps < 0.001).

Table 1. Means (SDs) of the Initiative T-Score by Program and Time

<table>
<thead>
<tr>
<th></th>
<th>Fall</th>
<th>Winter</th>
<th>Spring</th>
<th>Spring - Fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head Start</td>
<td>51.9 (7.9)</td>
<td>NA</td>
<td>54.7 (7.4)</td>
<td>2.9</td>
</tr>
<tr>
<td>Launch</td>
<td>52.5 (12.1)</td>
<td>51.1 (9.3)</td>
<td>54.9 (11.1)</td>
<td>2.4</td>
</tr>
<tr>
<td>Outreach</td>
<td>52.2 (7.3)</td>
<td>59.9 (9.5)</td>
<td>63.3 (8.0)</td>
<td>11.4</td>
</tr>
</tbody>
</table>

The data are displayed below at both individual and program levels (Figure 1). Gray thin lines indicate linear slopes for individual children and red thick lines indicate the mean slopes for the three programs. The intercepts are indicated by the value at the Fall baseline (i.e., Time F). The Outreach program had a steeper slope than the other 2, indicating a greater improvement in this program.

Figure 1. Linear Slopes Fit to the Initiative T-Score at Child (Grey Lines) and Program (Red Lines) levels.

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12 This is an unpublished program report belonging to the “Partnerships for Early Childhood Mental Health Program” It is reprinted for the purposes of this study with permission from Tri-County Mental Health and Counseling Services, Inc.
Problem with the Individual-Level Analysis
While the Outreach program seems to have a greater improvement than the other 2 programs, the above analysis ignores any higher-level structures. That is, because the children belong to clusters (e.g., school and classrooms), potential effects that were unique to these clusters may have confounded the program effect. In fact, the figures below indicate substantial variability’s in the patterns of changes over time across schools and classrooms. For example, in the Outreach program we see a huge improvement in one school (Figure 2) and one classroom (Figure 3). This particular school and classroom may have caused the significant program effects described above. Then, one may ask whether the effect of the programs would be still significant after taking such school- and classroom- level variability’s into consideration. That is what the multi-level analysis does.

Figure 2. Linear Slopes Fit to the Initiative T-Score at the School Level
Linear Multi-Level Regression Analysis

To analyze our multi-level data, a series of linear mixed-effects regression (LMER) models were constructed. The Time factor (Fall, Winter, and Spring) was used to compute slopes to assess the rate of “growth” in the Initiative T-Score. Time was also centered so that the intercept indicated the baseline value at the Fall. Individual scores across time (Level 1) were nested within children (Level 2) who were in turn nested within classroom (Level 3), which also were nested within schools (Level 4). The best fitting model was chosen based on log-likelihood tests and the Akaike’s Information Criteria (AIC).

Log-likelihood tests indicate that the best-fitting model be achieved by allowing classrooms to have their own (i.e., random) intercepts and slopes, but allowing schools and children to have their own intercepts only. Heterogeneity of variance across programs and times were also allowed.

The LMER results based on the best fitting model are displayed in Table 2; Outreach was used as the reference group. Two results are noteworthy. First, after incorporating the variability attributed to schools and classrooms, all programs still had similar baseline Initiative T-Score between 50.0-53.0, and these values were not significantly different from each other (Table 2, ps > 0.2). Second, Outreach had a significantly greater slope than the other two programs (ps < 0.01, Table 2), indicating the better improvement among the children participating in this program.
### Table 2. Linear Multi-level Regression Results

<table>
<thead>
<tr>
<th></th>
<th>Estimated Value</th>
<th>Std. Error</th>
<th>t-Value</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intercept</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>52.98</td>
<td>3.56</td>
<td>14.89</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Launch</td>
<td>50.03</td>
<td>2.89</td>
<td>17.30</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Head Start</td>
<td>51.86</td>
<td>1.69</td>
<td>30.65</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Launch vs. Outreach</td>
<td>-2.95</td>
<td>4.59</td>
<td>-0.64</td>
<td>0.53</td>
</tr>
<tr>
<td>Head Start vs. Outreach</td>
<td>-1.11</td>
<td>3.94</td>
<td>-0.28</td>
<td>0.78</td>
</tr>
<tr>
<td><strong>Slope</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>4.39</td>
<td>0.90</td>
<td>4.89</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Launch</td>
<td>1.32</td>
<td>0.73</td>
<td>1.80</td>
<td>0.07</td>
</tr>
<tr>
<td>Head Start</td>
<td>1.35</td>
<td>0.32</td>
<td>4.18</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Launch vs. Outreach</td>
<td>-3.08</td>
<td>1.16</td>
<td>-2.64</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Head Start vs. Outreach</td>
<td>-3.05</td>
<td>0.96</td>
<td>-3.17</td>
<td>&lt; 0.01</td>
</tr>
</tbody>
</table>

**Adding Level-3 Covariate**

The children participating in the Outreach programs showed greater improvement in the Initiative T-Score over time than the other program. Nevertheless, this program effect may have been attributed to other differences in unknown school characteristics (e.g., gender, age, or classroom size). Because no demographic variables were available at the level of individual children, available demographic variables were included in the model as level-3 (i.e., classroom-level) covariates.

The following covariates were created:

- **Classroom Size** (based on the ECMH Demographic Survey Q1). Mean = 15.11.
- **Percentage Girls** (based on Q3). This variable indicates the percentage of girls in a particular classroom. Mean = 46.99%.
- **Mean Age** (based on Q4, A5, and Q6). This variable indicates the mean age of the children in a particular classroom at the beginning of the project. Mean = 3.775
- **Percentage English Ineptitude** (based on Q7). This variable indicates the percentage of children in a particular classroom with limited English proficiency. Mean = 1.46%.

These covariates were centered so that the reference value (i.e., intercept) would indicate the value at the mean of the covariates, instead of 0. Other covariates were excluded from the analysis because including them did not result in a model convergence, perhaps due to excessive missing values in them.

The new results indicate that the program effects on baseline scores and slopes were very similar even after controlling for these covariate (e.g., similar baseline values among the three programs, greater slope in Outreach). Of the four covariate examined, Classroom
Size, % Girls, and % English Ineptitude were significant. Interestingly, while Classroom Size and Percentage Girls were positively associated with the baseline T-Score, % English Ineptitude was negatively associated.

Table 3. Linear Multi-level Regression Results with Level-3 Covariates

<table>
<thead>
<tr>
<th>Intercept</th>
<th>Estimated Value</th>
<th>Std. Error</th>
<th>t-Value</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>52.53</td>
<td>2.66</td>
<td>19.75</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Launch vs. Outreach</td>
<td>-1.07</td>
<td>3.37</td>
<td>-0.32</td>
<td>0.76</td>
</tr>
<tr>
<td>Head Start vs. Outreach</td>
<td>-0.55</td>
<td>2.87</td>
<td>-0.19</td>
<td>0.85</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Slope</th>
<th>Estimated Value</th>
<th>Std. Error</th>
<th>t-Value</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>4.41</td>
<td>0.87</td>
<td>5.09</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Launch vs. Outreach</td>
<td>-3.07</td>
<td>1.113</td>
<td>-2.761</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Head Start vs. Outreach</td>
<td>-3.13</td>
<td>0.921</td>
<td>-3.398</td>
<td>&lt; 0.01</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level-3 Covariates</th>
<th>Estimated Value</th>
<th>Std. Error</th>
<th>t-Value</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom Size</td>
<td>0.50</td>
<td>0.21</td>
<td>2.42</td>
<td>0.02</td>
</tr>
<tr>
<td>Percentage Girls</td>
<td>0.11</td>
<td>0.05</td>
<td>2.41</td>
<td>0.03</td>
</tr>
<tr>
<td>Mean Age</td>
<td>1.11</td>
<td>2.69</td>
<td>0.41</td>
<td>0.68</td>
</tr>
<tr>
<td>Percentage English</td>
<td>-0.57</td>
<td>0.18</td>
<td>-3.27</td>
<td>&lt; 0.01</td>
</tr>
</tbody>
</table>

The same analysis was repeated with outliers deleted. Outliers were defined as |standardized residuals| greater than 3, which roughly corresponded to top 5% and bottom 5%. The analysis without outliers gave essentially the same results.

Analysis Excluding the “Questionable Teacher”

In one teacher, CCX10025a, in the Launch program, 94.5% of the Spring scores shared the same value as the Fall scores (Figure 4). This value is much higher than 13.7%, the mean of the other teachers in the Launch program, 3.8% in Outreach, and 12.2% in Head Start. Given this unlikely high value, it is possible that this teacher copied scores from the fall with a little random variation added. If so, this portion of the data has been compromised. Thus, I performed sensitivity analysis by repeating the same analysis after excluding the part of this teacher’s data, 40 children in 2 classrooms, out of 81 children in 6 classrooms in the entire Launch program.
Note: The Spring scores that share the same value as the Fall scores are highlighted in yellow.

The same model was fit with CCX10025a excluded. A few things are noteworthy. In terms of intercept, now Launch students have a much lower baseline mean Initiative T-Score than Outreach, even though this difference was not significant ($p = 0.10$, Table 4). In terms of slopes, Outreach still had a significantly greater slope than the other two groups despite much smaller Launch sample size. Finally, in terms of covariates, statistical significance and size of estimated values for % Girls and % English Ineptitude remained essentially unchanged. On the other hand, Classroom Size is no longer significant, while Mean Age became marginally significant. Given the stability of the effect of the program, % of girls, and % of students with limited English proficiency, we can be fairly confident in interpreting these results.
Table 4. Linear Multi-level Regression Results with Level-3 Covariates with CCX10025a excluded

<table>
<thead>
<tr>
<th></th>
<th>Estimated Value</th>
<th>Std. Error</th>
<th>t-Value</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>51.2</td>
<td>2.48</td>
<td>20.64</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Launch vs. Outreach</td>
<td>-6.57</td>
<td>3.58</td>
<td>-1.84</td>
<td>0.10</td>
</tr>
<tr>
<td>Head Start vs. Outreach</td>
<td>1.15</td>
<td>2.70</td>
<td>0.43</td>
<td>0.68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Level-3 Covariates</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom Size</td>
<td>0.02</td>
<td>0.25</td>
<td>0.07</td>
<td>0.95</td>
</tr>
<tr>
<td>Percentage Girls</td>
<td>0.11</td>
<td>0.05</td>
<td>2.41</td>
<td>0.03</td>
</tr>
<tr>
<td>Mean Age</td>
<td>5.99</td>
<td>3.29</td>
<td>1.82</td>
<td>0.08</td>
</tr>
<tr>
<td>Percentage English Ineptitude</td>
<td>-0.48</td>
<td>0.16</td>
<td>-2.94</td>
<td>&lt; 0.01</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Slope</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>4.43</td>
<td>0.88</td>
<td>5.04</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Launch vs. Outreach</td>
<td>-2.56</td>
<td>1.30</td>
<td>-1.97</td>
<td>0.049</td>
</tr>
<tr>
<td>Head Start vs. Outreach</td>
<td>-3.14</td>
<td>0.94</td>
<td>-3.36</td>
<td>&lt; 0.01</td>
</tr>
</tbody>
</table>

In this analysis, the standardized effect size (d) of the Outreach program effect relative to Launch was 0.39, whereas the same effect size was 0.44 in the analysis including all scores. This sensitivity analysis demonstrates the relatively stable effect of the Outreach program, since the effect sizes between the two sets of analyses were very similar (0.39 vs. 0.44).

Remaining DECA Subscales (Attachment, Self-Control, Total Protective Factors, and Behavioral Concerns)

In this analysis, I repeated the analytic procedure in all variables: fitting random effects, fitting a model, including level-3 covariates.

Some effects were remarkably consistent across the five variables. For example, Outreach did not significantly differ in baseline values from either Launch or Head Start in any of the variables, while its slopes significantly differed from Head Start’s in all variables.

In terms of random effects adding intercepts or slopes at the classroom level, but not at the school level, significantly improved the model in all variables, suggesting that classroom-level environments may be more important than school-level ones. Interestingly, adding children’s own slopes did not improve the model significantly in any variables either. This may suggest that, while different classrooms/teachers had
different rates of improvement (i.e., significant standard deviations of classroom random slopes), within a particular classroom children improved at a similar rate.

Other effects are not as consistent. Slope differences between Outreach and Launch were significant in Initiative, Attachment, and Protective Factor, even though in Self-Control and Behavioral Problem, the differences were in the consistent direction. In terms of Level-3 covariates, Classroom Size and % Girls were positively associated with the baseline scores in all but Behavioral Problem, while % English Ineptitude was negatively associated with the baseline scores. The mean age of children was not significantly associated in any of the variables.

### Table 1. Linear Multi-level Regression Results for All Variables (Mean ± Standard Error)

<table>
<thead>
<tr>
<th></th>
<th>Initiative</th>
<th>Self-Control</th>
<th>Attachment</th>
<th>Behavioral Problem</th>
<th>Protective Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intercept</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>52.53 ± 2.66**</td>
<td>54.42 ± 2.46**</td>
<td>50.87 ± 2.57**</td>
<td>50.54 ± 2.68**</td>
<td>52.84 ± 2.8**</td>
</tr>
<tr>
<td>Launch vs. Outreach</td>
<td>-1.07 ± 3.37</td>
<td>0.72 ± 3.12</td>
<td>2.66 ± 3.19</td>
<td>-3.07 ± 3.38</td>
<td>-0.09 ± 3.54</td>
</tr>
<tr>
<td>Head Start vs. Outreach</td>
<td>-0.55 ± 2.87</td>
<td>0.29 ± 2.65</td>
<td>-2.05 ± 2.77</td>
<td>-3.78 ± 2.9</td>
<td>-1.42 ± 3.02</td>
</tr>
<tr>
<td>Level-3 Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Classroom Size</td>
<td>0.5 ± 0.21*</td>
<td>0.4 ± 0.18*</td>
<td>0.46 ± 0.22*</td>
<td>-0.09 ± 0.23</td>
<td>0.52 ± 0.21*</td>
</tr>
<tr>
<td>% Girls</td>
<td>0.11 ± 0.05*</td>
<td>0.12 ± 0.04*</td>
<td>0.12 ± 0.05*</td>
<td>-0.11 ± 0.05</td>
<td>0.13 ± 0.05*</td>
</tr>
<tr>
<td>Mean Age</td>
<td>1.11 ± 2.69</td>
<td>3.67 ± 2.34</td>
<td>-0.22 ± 2.81</td>
<td>-0.92 ± 3.00</td>
<td>1.9 ± 2.73</td>
</tr>
<tr>
<td>% English Ineptitude</td>
<td>-0.57 ± 0.18**</td>
<td>-0.66 ± 0.15**</td>
<td>-0.58 ± 0.19**</td>
<td>0.18 ± 0.20</td>
<td>-0.71 ± 0.18**</td>
</tr>
<tr>
<td>Slope</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>4.41 ± 0.87**</td>
<td>2.92 ± 0.81**</td>
<td>4.91 ± 0.88**</td>
<td>-2.79 ± 0.93**</td>
<td>4.14 ± 0.92**</td>
</tr>
<tr>
<td>Launch vs. Outreach</td>
<td>-3.07 ± 1.11**</td>
<td>-1.67 ± 1.02</td>
<td>-4.35 ± 1.07**</td>
<td>1.87 ± 1.14</td>
<td>-3.12 ± 1.17*</td>
</tr>
<tr>
<td>Head Start vs. Outreach</td>
<td>-3.13 ± 0.92**</td>
<td>-2.4 ± 0.86*</td>
<td>-4.01 ± 0.93**</td>
<td>3.42 ± 0.98**</td>
<td>-3.05 ± 0.98**</td>
</tr>
</tbody>
</table>

Random Effects (Standard Deviation)

<table>
<thead>
<tr>
<th></th>
<th>Initiative</th>
<th>Self-Control</th>
<th>Attachment</th>
<th>Behavioral Problem</th>
<th>Protective Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Intercept</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>School Slope</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>School Correlation</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Classroom Intercept</td>
<td>4.64</td>
<td>4.13</td>
<td>4.29</td>
<td>4.44</td>
<td>4.92</td>
</tr>
<tr>
<td>Classroom Slope</td>
<td>1.53</td>
<td>1.26</td>
<td>1.37</td>
<td>1.46</td>
<td>1.62</td>
</tr>
<tr>
<td>Classroom Correlation</td>
<td>-0.56</td>
<td>-0.66</td>
<td>-0.28</td>
<td>-0.33</td>
<td>-0.61</td>
</tr>
<tr>
<td>Child Intercept</td>
<td>5.70</td>
<td>6.13</td>
<td>4.94</td>
<td>7.28</td>
<td>5.66</td>
</tr>
<tr>
<td>Child Slope</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Child Correlation</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Residual</td>
<td>2.01</td>
<td>3.26</td>
<td>3.34</td>
<td>5.19</td>
<td>1.91</td>
</tr>
</tbody>
</table>
Next, I repeated the same analysis after excluding teacher CCX100025a, for a reason I detailed in the previous section. Effects consistent across the two sets of analyses are the following: no significant difference between Outreach and Launch at the baseline, significant associations of % Girls and % English Ineptitude, and the significant differences in slopes in Initiative and Attitude between Outreach and Launch. I believe the effects of the Outreach program on these two variables are quite reliable. Also by comparing effect sizes across two sets of analyses, we can see to what extent CCX100025a influenced the results (with vs. without CCX100025a): Initiative, 0.44 vs. 0.39; Self-Control, 0.27 vs. 0.18; Attachment, 0.68 vs. 0.66; Behavioral Problem: 0.27 vs. 0.22; Protective Factor, 0.45 vs. 0.37. It seems that the effect of the Outreach program over Launch ranges from small (0.2) to medium-large (0.65) range, and CCX100025a appears to have inflated the effect. You may want to think about why Outreach may be more effective in some subscale (e.g., Attitude, Initiative) than the others (e.g., Self-Control).

Table 2. Linear Multi-level Regression Results for All Variables (Mean ± Standard Error) with Teacher CCX100025a Excluded

<table>
<thead>
<tr>
<th></th>
<th>Initiative</th>
<th>Self-Control</th>
<th>Attachment</th>
<th>Behavioral Problem</th>
<th>Protective Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>51.2 ± 2.48**</td>
<td>53.51 ± 2.38**</td>
<td>49.61 ± 2.43**</td>
<td>51.5 ± 2.63**</td>
<td>51.51 ± 2.58**</td>
</tr>
<tr>
<td>Launch vs.</td>
<td>-6.57 ± 3.58</td>
<td>-3.26 ± 3.45</td>
<td>-2.73 ± 3.42</td>
<td>1.62 ± 3.82</td>
<td>-5.78 ± 3.71</td>
</tr>
<tr>
<td>Outreach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Start vs.</td>
<td>1.15 ± 2.7</td>
<td>1.46 ± 2.58</td>
<td>-0.39 ± 2.64</td>
<td>-5.07 ± 2.88</td>
<td>0.28 ± 2.81</td>
</tr>
<tr>
<td>Outreach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level-3 Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Classroom Size</td>
<td>0.02 ± 0.25</td>
<td>0.09 ± 0.23</td>
<td>-0.09 ± 0.27</td>
<td>0.36 ± 0.3</td>
<td>-0.01 ± 0.26</td>
</tr>
<tr>
<td>% Girls</td>
<td>0.11 ± 0.05*</td>
<td>0.11 ± 0.04*</td>
<td>0.12 ± 0.05*</td>
<td>-0.1 ± 0.05</td>
<td>0.12 ± 0.05*</td>
</tr>
<tr>
<td>Mean Age</td>
<td>5.99 ± 3.29</td>
<td>7.01 ± 3*</td>
<td>4.71 ± 3.43</td>
<td>-4.93 ± 3.83</td>
<td>6.75 ± 3.36</td>
</tr>
<tr>
<td>% English Ineptitude</td>
<td>-0.48 ± 0.16**</td>
<td>-0.58 ± 0.15**</td>
<td>-0.47 ± 0.17*</td>
<td>0.09 ± 0.19</td>
<td>-0.58 ± 0.17**</td>
</tr>
<tr>
<td>Slope</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>4.43 ± 0.88**</td>
<td>2.93 ± 0.83**</td>
<td>4.87 ± 0.91**</td>
<td>-2.72 ± 0.97**</td>
<td>4.15 ± 0.95**</td>
</tr>
<tr>
<td>Launch vs.</td>
<td>-2.56 ± 1.3*</td>
<td>-1.12 ± 1.23</td>
<td>-4.1 ± 1.24**</td>
<td>1.48 ± 1.35</td>
<td>-2.58 ± 1.38</td>
</tr>
<tr>
<td>Outreach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Start vs.</td>
<td>-3.14 ± 0.94**</td>
<td>-2.41 ± 0.88*</td>
<td>-3.96 ± 0.96**</td>
<td>3.34 ± 1.03**</td>
<td>-3.05 ± 1.01**</td>
</tr>
<tr>
<td>Outreach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Random Effects (Standard Deviation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Intercept</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>School Slope</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>School Correlation</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Classroom Intercept</td>
<td>4.13</td>
<td>3.82</td>
<td>3.85</td>
<td>4.15</td>
<td>4.31</td>
</tr>
<tr>
<td>Classroom Slope</td>
<td>1.56</td>
<td>1.31</td>
<td>1.45</td>
<td>1.57</td>
<td>1.69</td>
</tr>
<tr>
<td>Classroom Correlation</td>
<td>-0.50</td>
<td>-0.60</td>
<td>-0.16</td>
<td>-0.24</td>
<td>-0.53</td>
</tr>
<tr>
<td>Child Intercept</td>
<td>5.39</td>
<td>5.95</td>
<td>4.63</td>
<td>7.25</td>
<td>5.39</td>
</tr>
</tbody>
</table>
Program Specific Results:

In this section, I looked at each program to see whether children improved significantly over time within each improvement, both with or without teacher CCX10025a.

- The Outreach program had a significant improvement over time (a significant slope) across all the five variables, with or without CCX10025a.
- The Launch program had a significant improvement only in Self-Control (ps < 0.05), and was marginally significant in Initiative (ps < 0.10). Removing CCX10025a reduced the sample size of this program, but often improved the effect size (i.e., the size of the slope). For example, the removal of CCX10025a improved the Initiative slope from 1.34 to 1.87.
- Head Start, despite its much bigger sample size, had a significant improvement only in Initiative, Attachment, and Protective Factor. In Behavioral Problem, it had almost a significant decrement over time (ps < 0.1).
- In terms of sizes of the slopes, Launch (without CCX10025a) had slopes greater than Head Start’s slopes, even though these differences are not significant (ps > 0.1). This may indicate that the Launch program is typically more effective than Head Start, even though demonstrating its higher effectiveness than Head Start requires much bigger sample sizes.

<table>
<thead>
<tr>
<th>Child Slope</th>
<th>NS</th>
<th>NS</th>
<th>NS</th>
<th>NS</th>
<th>NS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Correlation</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Residual</td>
<td>2.21</td>
<td>3.29</td>
<td>3.49</td>
<td>5.26</td>
<td>2.14</td>
</tr>
</tbody>
</table>
Appendix D: Partnerships for Early Childhood Mental Health
Early Childhood Mental Health Program – Year Three

Submitted by:
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April 2012

13 This is an unpublished program report belonging to the “Partnerships for Early Childhood Mental Health Program” It is reprinted for the purposes of this study with permission from Tri-County Mental Health and Counseling Services, Inc.
Acknowledgements
Many individuals contributed to the success of this project, and the Voinovich School of Leadership and Public Affairs is most grateful for the support and assistance of each and every one of them.

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   Lezlee J. Ware, Research Associate
   Holly A. Strickland, Undergraduate Voinovich Scholar

Tri-County Mental Health and Counseling Services
   Sherry Shamblin, Director of Early Childhood Programs

Ohio University – Heritage College of Osteopathic Medicine
   Jane Hamel-Lambert, Associate Professor of Family Medicine

Most importantly, we offer our sincerest appreciation to the superintendents, principals, and teachers who participated in the interview process. Without you, this evaluation would not have been possible.
Introduction

The Partnerships for Early Childhood Mental Health - Early Childhood Mental Health (ECMH) Program was established to improve early childhood outcomes and increase the capacity of early childhood educators to address mental health issues in the classroom. Four preschool classrooms in two schools—Coolville Elementary and Trimble Elementary—actively participated in the program during the 2011-2012 school year. The ECMH Program consisted of a three-tiered approach to service delivery: universal (delivered by the teacher and/or ECMH consultant to all children in the class), targeted (delivered by the teacher and/or ECMH consultant to meet the needs of a specific child) or intensive (delivered by the ECMH consultant to meet the needs of a specific child enrolled as a client in the local community health center, which may include a classroom component) interventions. Preschool teachers participated in the program on a voluntary basis. Parental consent and child assent were obtained for targeted and intensive service delivery.

As one component of the ECMH Program evaluation plan, the Voinovich School of Leadership and Public Affairs was commissioned to conduct a series of stakeholder interviews during the program’s third year of operation. Individuals involved in the program within the school districts—teachers, principals, and superintendents—provided feedback on the structure, strengths, and liabilities of the program. Additionally, recommendations were made for improving and expanding program services.

Method

The qualitative portion of the evaluation design consisted of a multi-perspective assessment of the third year of the ECMH Program. The needs assessment was framed as a case study (Patton, 2002). The case study focused on the informants’ perceptions of the deployment of the ECMH Program during the 2011-2012 school year. Informants included preschool teachers, building principals, and district superintendents. We acknowledge that the preschool teachers, building principals, and district superintendents are nested within school districts; however, due to the confidentiality issues that arise with small sample size, we are unable to present data at the school district level. As such, information collection began with individual perspectives and we then examined the data for patterns (i.e., similarities and differences) that occurred across school districts.
Guiding Questions

The guiding questions for this evaluation were:

1. How do teachers, principals, and superintendents perceive the structure, accessibility, and appropriateness of the Early Childhood Mental Health (ECMH) Program?
2. What qualities and outcomes are essential for teachers, principals, and superintendents to perceive an ECMH Program as valuable?
3. What do teachers and principals perceive as the strengths and liabilities of the “redesigned” ECMH Program?
4. How do teachers perceive their feedback was utilized during the “redesign” phase of the ECMH Program?
5. How do teachers, principals, and superintendents think the ECMH Program can be improved going forward?

Interview Protocol

For each interview, the research team utilized a standard, open-ended interview protocol to facilitate the interviews. Patton (2002) advocates the use of an interview guide for the following three reasons: (a) the limited time in an interview session is optimally utilized; (b) a systematic approach is more effective and comprehensive; and (c) an interview guide keeps the conversation focused. The facilitation guides (Appendices A-C) included questions designed to elicit responses regarding the questions guiding the evaluation.

Participants

Information from key informants (i.e., preschool teachers, building principals, and district superintendents) guided this case study. To collect information from the informants, we conducted one group interview (with four preschool teachers) and four individual interviews (with two building principals and two district superintendents).

The ECMH Program Director invited informants to participate in the interviews. The research team at the Voinovich School scheduled the interviews and coordinated the interview times and locations with the informants. Teachers participating in the group interview consented to participate by signing the initial consent form for the study (Appendix D). Principals signed a consent form before participating in the individual interviews (Appendix E). Superintendents, who participated in individual telephone interviews, verbally indicated consent by scheduling and agreeing to participate in the telephone interview. At the beginning of each interview, the research team read a script
that clearly stated that informants were participating in the interview voluntarily and had
the option to refuse to answer any of the questions.

For their participation in the study, each teacher received a $25 gift card to Wal-
Mart. Superintendents and principals were not compensated for their participation in the
evaluation.

This study was approved by Ohio University’s Institutional Review Board,
Protocol 90F035.

Data Analysis

Qualitative data analysis techniques were used to analyze the data collected from
the group and individual interviews. Content analysis was used to analyze responses to
the open-ended items. Patton (2002) describes content analysis as “searching for
recurring words or themes.” Text was analyzed to see what phrases, concepts, and words
are prevalent throughout the informants’ responses. During this stage of the analysis,
coding categories were identified. Through this coding process, data was sorted and
defined into categories that were applicable to the purpose of the research. Codes were
defined and redefined throughout the analysis process as themes emerged. At the end of
the analysis, major codes were identified as central ideas or concepts (Glesne, 2006).
These central ideas were assembled by pattern analysis for the development of major
themes. From the major themes, we drew conclusions (Patton, 2002). To ensure
credibility of both the procedures and the conclusions, we used analyst triangulation.
Patton (2002) defines analyst triangulation as “having two or more persons independently
analyze the same qualitative data and compare their findings.” Teamwork, as opposed to
individual work, is likely to increase the credibility of the findings (Lincoln & Guba,
1985).
Results

Evaluation Question #1: How do teachers, principals, and superintendents perceive the structure, accessibility, and appropriateness of the Early Childhood Mental Health (ECMH) Program?

The following section describes how informants understood the ECMH Program to work. This includes describing the program services that informants were aware of, how to access these services, and how well the program worked within the established structure of the schools.

Structure

The term *structure* encompasses the basic services provided by the ECMH Program, the roles and expectations of the participants, as well as the structure for communication among the participants. Informants described the structure of the program as providing three layers of *support services*: teacher support services, classroom support services, and specialized support services for targeted individuals or small groups. Typically, the ECMH consultant observed the classroom; identified individual and classroom issues to address; and designed a uniquely progressive plan of goals and support services for the teacher, classroom, and targeted child or children.

The three-tiered approach to support service delivery is adaptable, with different classrooms utilizing each layer of support as needed. For example, some schools reported having no children receiving specialized services, while others noted that the ECMH consultant made home visits and continued counseling services with children and families at Tri-County Mental Health and Counseling Services. This is a necessary structural feature of the program because classroom needs differ from year-to-year and from classroom-to-classroom.

**Teacher support services.** Teachers, principals, and superintendents indicated that services provided by the ECMH consultant to individual teachers were both personally and professionally beneficial. Professional support services included providing feedback on the overall classroom environment, establishing and pursuing classroom goals, and giving guidance for effective classroom and individual behavior management. These services culminated into what informants described as valuable professional

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14 It is important to note that informants at both school districts referred to the services provided by the ECMH consultant as *support services* rather than *consultation* services.
development, especially in regards to identifying and addressing mental health issues in the classroom.

Informants also indicated that the ECMH consultant provided general support in response to their own personal issues. Providing personal support encouraged teacher-consultant relationships and allowed teachers to feel more comfortable having someone work in their classrooms. Overall, informants felt that the combination of personal and professional support services contributed to a less stressful and more cooperative classroom environment for teachers.

**Classroom support services.** Classroom support services included any service provided by the ECMH consultant to the entire classroom. Teachers, principals, and superintendents highlighted several classroom support services, such as the Incredible Years Program (viz., DinoSchool) and writing center activities, as being both effective and well-received by the children. The ECMH consultant came to each classroom once a week to deliver classroom support services and provide follow-up activities for teachers to continue throughout the week at their discretion. According to informants, teachers frequently implemented these activities during the rest of each week because it helped to build classroom routine and consistency. Continued implementation also increased the rapport between children and the ECMH consultant.

Due to the strong presence of classroom support services, informants noted that many children viewed the ECMH consultant as a “friend” and felt comfortable talking to her at will. Informants suggested that classroom support services were highly effective in teaching children to: identify their feelings, develop emotional competence, build social skills, reduce aggressive behaviors, make friends, overcome shyness, and participate in class. Finally, under the guidance of the ECMH consultant, the entire classroom identified and worked on achieving classroom goals, which also contributed to a cohesive and cooperative classroom environment.

**Individual child or small group support services.** Teachers, principals, and superintendents reported cases for which targeted services were provided by the ECMH consultant to one child or to a small group of children. Because classroom needs varied, not all classrooms received targeted services. When necessary, these services focused on problem areas specifically related to whatever needs were present. Common problem areas addressed by targeted services were communication, classroom participation, shyness, anger, and the transition to preschool.

Informants indicated that available targeted services represented a range of ECMH consultant involvement, the need for which was largely determined at her
discretion. During school hours, the consultant could provide individual counseling inside the classroom or pull a child from class to provide individual services. In some cases, the ECMH consultant worked with families during the summer before preschool in order to build the trust necessary to effectively promote participation. Outside of school, the ECMH consultant was able to provide individual and family counseling, make home visits, and refer cases to Tri-County Mental Health and Counseling Services, as necessary.

Accessibility

The term *accessibility* includes the procedures through which a child could obtain program services, as understood by informants. This section describes informants’ perceptions of: service availability, the referral process, and parental contact procedures.

**Service availability.** Teachers, principals, and superintendents indicated that teachers and the ECMH consultant could refer as many children as necessary for targeted services.

**Referral process.** In most cases, children were referred for services by the ECMH consultant based on her classroom observations. Teachers could also make referrals to the ECMH consultant. Teacher referrals were primarily based on past experience or on formal evaluation ratings of the child15.

**Parent contact.** Teachers, principals, and superintendents indicated that methods for contacting parents varied among families. Teachers often first made contact with parents during face-to-face gatherings, such as parent-teacher conferences or the school’s Open House. Other contexts for first contact included phone calls and home visits. Informants indicated that face-to-face contact with families was ideal, especially if trying to orient them to the idea of receiving targeted services or participating in the ECMH Program. Finally, a face-to-face meeting with the ECMH consultant was instrumental in alleviating some families’ suspicions or concerns related to participating.

After being introduced to the program, and ideally to the ECMH consultant, by the teacher, the ECMH consultant took over parental communication. The ECMH consultant sent home an initial letter detailing the classroom support services, such as the DinoSchool program, and obtained consent from parents. In cases referred for targeted

15 It was more common for teachers to encourage child-consultant rapport via engagement with the classroom support services than to make individual referrals. By cultivating child-consultant relationships, an individual student could refer himself or herself informally by approaching the consultant.
services, the ECMH consultant sent a second letter home, describing the proposed targeted group or individual activities and obtaining parental consent.

**Appropriateness**

The *appropriateness* of the program refers to how well the program functions in relation to the existing school structure in which it is embedded. This section describes informants’ perceptions of teacher roles, service use, the ease of program use, and program-related meetings.

**Teacher roles.** Teachers, principals, and superintendents agreed that the program did not impose excessive responsibilities on teachers. Teachers were not responsible for preparing, initiating, sustaining, or cleaning up activities related to the ECMH Program. Furthermore, teachers were given the option to use follow-up activities, but were not required to do so.

Informants indicated that the minimal work required by teachers to participate in the program was greatly appreciated. It also allowed teachers to be more engaged with the program and more comfortable implementing it in their classrooms. While the paperwork requested of teachers was noted as being time-consuming, it was viewed as necessary in order to illustrate any progress made to both teachers and parents.

**School-specific services.** Teachers, principals, and superintendents did not feel that the ECMH Program repeated any existing school-specific services. Recent budget cuts have been consequential for both preschool and mental health services. Informants indicated that the need for mental health and behavior services was present and this need was only expected to increase over time.

Overall, informants felt that the ECMH Program was good for engaging the preschool age group, remediating individual issues, and appropriately addressing a range of family problems. Furthermore, teachers were familiar with some of the paperwork required by the ECMH Program because it was also required for children with Individualized Educational Plans.

**Ease of use.** Teachers, principals, and superintendents indicated that the program was very easy to use, although slightly difficult to understand and articulate to others. For teachers, there is a reasonable time commitment required to complete the necessary paperwork. The Program also requires that teachers be willing to work with someone else and to have someone else present in their classrooms.
Informants overwhelmingly suggested that the teacher-consultant match and rapport was especially important in determining ease of use for teachers. Overall, the program was viewed as being very “teacher-friendly” because the teachers did not incur any additional responsibilities to participate in the program, yet they received valuable personal and professional support. Finally, the program improved overall classroom functioning even when the ECMH consultant was not present, making teachers feel less stressed and more relaxed.

**Program-related meetings.** Teachers, principals, and superintendents reported that very few formal meetings took place with the ECMH Program. School district- and building-level administrators recalled one meeting at the beginning of the year with the project director and ECMH consultant to discuss the referral and consent procedure, they reported that there was not much formal communication after that. Teachers met with the ECMH consultant individually once a month. While there was not much in the way of formal meetings described, teachers and principals reported conversations with the project director and ECMH consultant on an ad-hoc basis. Teachers, principals, and superintendents reported that they felt comfortable initiating meetings with the ECMH consultant and/or director as needed.

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**Evaluation Question #2: What qualities and outcomes are essential for teachers, principals, and superintendents to perceive an ECMH Consultation Program as valuable?**

Informants provided feedback related to the program services and structure that they feel is essential for the program to run smoothly and be self-maintaining. Many of these essential qualities are already present within the program, while others are still developing.

**Organization**

Teachers, principals, and superintendents felt that organization was pivotal to the success of any school-based program. They need to have a concise but detailed understanding of the program, its staff, and its intended outcomes. There should be structured communication pathways for school personnel to provide both formal and informal feedback. Finally, classroom activities should be planned in advance with teacher awareness, and the ECMH consultant should arrive fully prepared to deliver each week’s activities.

Informants perceived that the day-to-day operations of the ECMH Program were well organized and executed flawlessly. However, superintendents and principals had
difficulty articulating the program’s design and outcomes. Teachers could describe their experiences with the program over the course of the school year, but also were unable to articulate the program’s design and intended outcomes. Providing school personnel with an “elevator speech” or key talking points about the ECMH Program may help them more clearly articulate the program’s design and intended outcomes to others.

While the informal nature of the communication pathways was appreciated by the teachers, superintendents and principals reported that they would appreciate some structure in their interactions with the ECMH Program Director and consultant. While the administrators reported they did not perceive the need for frequent meetings, they believed it would be appropriate and beneficial to have periodic check-ins with ECMH Program staff.

**Consistency**

Teachers, principals, and superintendents indicated that consistency helped to create value for the ECMH Program. Consistency with the ECMH consultant and with the delivery of classroom activities helped to develop a classroom routine, generate classroom rapport, and enhance teacher comfort.

**Adaptability**

Teachers, principals, and superintendents suggested that an ECMH Program needs to be highly adaptable in order to effectively address different classrooms, different levels of need, and different recipients of support (i.e., teachers, children, and families). Informants also noted that degrees of need are highly variable from year-to-year and from classroom-to-classroom. Teachers and principals, who were most keenly aware of the day-to-day operations of the ECMH Program, really appreciated the adaptability and flexibility of the program as implemented.

**Continuity**

Teachers, principals, and superintendents indicated that an ECMH Program should strive to operate during the summer before preschool, during preschool, and during the transition to Kindergarten. In some cases, program operation before preschool is necessary for families to meet the ECMH consultant and become comfortable enough with the program to participate. Operating in the summer before preschool also helps to ease the transition to preschool for children who may be feeling overwhelmed.

Continuity into Kindergarten is necessary to ensure that children receive appropriate support for the following year and beyond, especially given that the preschool system and K-12 system are somewhat disjointed. It is also ideal for gathering longitudinal data on academic and social outcomes experienced by preschoolers from the
ECMH Program. The ECMH Program should strive to establish either a physical presence or at least a communicative presence with the Kindergarten in order to effectively transition children.

**Family-focused**

Teachers, principals, and superintendents felt that family inclusion greatly influenced service receptivity and, ultimately, mental health outcomes. They frequently reported that family cooperation could either make or break even the best program. Including families before, during, and after preschool would help increase service access for children and families, as well as generate support for and reduce suspicions surrounding the ECMH Program.

**Experience**

Teachers, principals, and superintendents strongly indicated that ECMH staff experience, especially in regards to the ECMH consultant, was crucial for creating value in the program. ECMH personnel, including the ECMH consultant and program director, should have sufficient knowledge of schools, early childhood education, and mental health. The ECMH consultant should be well aware of current individual and family stressors, and have a well-developed sense of personal discretion regarding the release of private information. Finally, an ECMH consultant should be compassionate, approachable, likeable, and supportive.
Sustainability

Teachers, principals, and superintendents felt that sustainability was a serious concern regarding the continuation of the ECMH Program. Ultimately, an ECMH Program must be fiscally sustaining; given the state of school funding, particularly preschool funding, all understood this to be a difficult task. Concerns over program sustainability left informants feeling distressed over losing the ECMH Program and the beneficial services it provided to teachers, children, and families.

Outcomes

Teachers, principals, and superintendents recognized the need for outcomes. However, most informants had difficulty articulating specific outcomes. Most informants believed that it was the role of the ECMH Program Director to provide some sort of yearly report on outcomes to the school district. It seemed as if the informants perceived the interview questions regarding outcomes required some degree of mental health knowledge in order to be answered. As a result, the conversations surrounding outcomes were scant. That said, it was apparent that informants were not thinking of outcomes in terms of school outcomes such as traditional indicators of student performance and academic success.

Evaluation Question #3: What do teachers and principals perceive as the strengths and liabilities of the “redesigned” ECMH Program?

Strengths

The term strengths refers to the aspects of the program that informants believe made it valuable and worth continuing. Several different services provided by the program were mentioned as program strengths.

Teacher support. Teachers felt they had undergone valuable professional development by working with the ECMH consultant, especially in regards to addressing mental health issues in the classroom. Teachers noted that they learned new classroom management skills and strategies to address individual behavior issues. Finally, teachers welcomed both the personal and professional support provided by the ECMH consultant, and noted personal benefits of feeling less stressed.

Classroom management. Teachers repeatedly reported classroom-level benefits, such as social skills building and a calmer environment, as a result of participating in the ECMH Program. Examples of group benefit include children speaking up and participating in class, making friends, and fighting less. The overall classroom environment was also reported to have been less stressful and more controlled as a result of the ECMH consultant’s activities.
Counseling. Informants reported cases in which individual counseling sessions were particularly helpful for children, especially since not all schools consistently have a school counselor on-site. For example, some children receiving targeted services were pulled from class in order to deliver timely counseling and anger management strategies.

Tailoring program services. Tailoring program services was reported to be very important due to different needs posed by different classrooms, but also as a method of increasing sustainability.

Receptivity of children and families. Teachers felt that the ECMH Program was well received by both children and families. Children participating at the classroom- and targeted-levels bonded with the ECMH consultant and experienced noticeable social gains as a result of the services provided. Families, for the most part, were also receptive to the program.

ECMH Personnel. Teachers, principals, and administrators consistently expressed great satisfaction with the ECMH Program Director and ECMH consultant. Both individuals were seen as knowledgeable in early childhood and mental health, with a functional understanding of how schools operate. Furthermore, informants felt that ECMH personnel were supportive, approachable, and genuine in their efforts to implement the ECMH Program.

Liabilities

The liabilities of the ECMH Program are specific aspects of the program that hinder service delivery or could be improved to bolster the program’s success.

Insufficient outcomes data. Teachers, principals, and administrators agreed that outcomes data were imperative to show the progress made by individual children. Informants found it difficult to articulate intended outcomes of the program, yet felt that outcomes data are necessary to illustrate the program’s value and have any hope of being fiscally sustainable. Ideally, longitudinal data showing effective prevention efforts and individual change over time will be collected as ECMH preschoolers move to Kindergarten and beyond.

Ambiguous program structure. Although teachers, principals, and administrators felt that the ECMH Program was both valuable and beneficial to teachers, children, and families, informants struggled to articulate the program’s service delivery structure and intended outcomes.

Insufficient formal communication. District- and building-level administrators indicated that most communication between school personnel and ECMH staff occurred informally and somewhat haphazardly. Informal communication may be efficient and beneficial in some cases, but a formal feedback system with planned meetings is necessary to keep school administrators and superintendents abreast of the ECMH Program and staff members. Principals suggested 30-minute quarterly meetings and superintendents suggested one-to-two scheduled meeting per year.
Evaluation Question #4: How do teachers perceive their feedback was utilized during the “redesign” phase of the ECMH Program?

Teachers perceived that their feedback was heard and incorporated in the “redesign” of the ECMH Program. This was evidenced in how the ECMH Program was delivered this academic year. Teachers reported that the ECMH Program was more organized and consistent, the ECMH consultant was more prepared, and the ECMH consultant was more experienced and knowledgeable. Teachers also appreciated the “scaled down” version of the program. Because the program focused on fewer school districts and classrooms, teachers perceived they received more and better quality services from the ECMH consultant.

Evaluation Question #5: How do teachers, principals, and superintendents think the ECMH Program can be improved going forward?

In discussions regarding the ECMH Program, teachers, principals, and superintendents perceived the ECMH Program to be an asset. Most informants believed that there was little to be done in the way of improvement because they perceived the program to be successful. However, informants did note some areas that they wanted the ECMH Program Director to consider.

**Importance of Teacher-ECMH Consultant Match.**

The quality of the teacher-ECMH consultant match largely determines the success of an ECMH Program. Teachers must feel comfortable having an ECMH consultant work in their classrooms and trust that the ECMH consultant is both experienced and professionally appropriate. When a strong match is achieved, teachers feel personally and professionally supported by the ECMH consultant. Should the ECMH consultant from the 2011-2012 academic year leave the program, teachers would like to be involved in the hiring process for the new consultant.
Importance of Outcomes

Interestingly, most of the informants had difficulty articulating the outcomes they would need to see in order to determine that the program was valuable. This appears to be because there is no shared language between the mental health aspect of the project and the school aspect of the project. A facilitated discussion would likely result in the conclusion that the perceived outcomes for both groups is similar. Having mutually agreed upon outcomes may help superintendents, principals, and teachers better articulate the goals of the ECMH Program. When all stakeholders are aware of the goals and outcomes associated with a program, they are able to articulate the program’s value, show progress to families, and advocate for the program to continue within the district.

School districts exist in a data-driven culture. For a program to survive in a school district, it is essential that there is data to support that the program is effective. Once outcomes are identified, it is important to create a system to collect longitudinal data. For the most part, superintendents, principals, and teachers were willing to accept qualitative data indicating the program was working – for now. Most informants recognized that this particular project was about service delivery, not research. However, they would like to see success defined in a more quantitative way in the future.

Importance of Sustainability Planning

Teachers, principals, and superintendents alike were concerned about sustainability. While it was unanimously agreed that the ECMH Program was valuable to children, families, and teachers; all parties expressed concern about the program’s future. Having and articulating a sustainability plan would be helpful: superintendents could better advocate for the program, principals could better address ways to ensure the program coalesces with the way the school building operates, and teachers would have less anxiety about the program ceasing to exist.

Conclusion

As part of the ECMH Program evaluation plan, program leadership engaged in a multi-perspective assessment to collect thoughts and feelings about the first year of the ECMH Program. The key informants for this assessment were: preschool teachers, building principals, and district superintendents. The assessment was designed to investigate the general perception of the structure, availability, and appropriateness of the ECMH Program as well as uncover the program’s strengths, liabilities, and key lessons learned from the third year of operation. Additionally, the informants were asked to provide feedback regarding the qualities of an ECMH Program that they perceived as valuable as well as suggestions for improvement as the program. Some keys to success as the program moves forward appear to be developing a shared understanding of the
program’s design, creating a vision for outcomes; collecting, analyzing, and reporting outcomes data; and collectively developing a plan for sustainability.
References


Teacher Interview Guide

Key assessment questions guiding interview:
1. How do teachers perceive the structure, accessibility and appropriateness of the Early Childhood Mental Health (ECMH) Program?
2. What qualities of an ECMH Program are essential for teachers to perceive it as valuable?
3. What do teachers perceive as the strengths, liabilities, and key lessons learned from the “redesigned” ECMH Program?
4. How do teachers perceive their feedback was utilized during the “redesign” phase of the ECMH program?
5. How do teachers think the ECMH Program can be improved going forward?

Hello. Thank you for letting us to talk with you this morning/afternoon. My name is _____ and I work for Ohio University.

Today, we are using a focus group to collect your thoughts and feelings about the Early Childhood Mental Health Program. We hope this discussion can help us come to some conclusions about the teacher’s general perception of the structure, accessibility, and appropriateness of the Early Childhood Mental Health Program. We are also interested in what can be done to improve the program as it moves forward.

One important thing to remember during our conversation is that everyone’s ideas are important, and they should be allowed to freely express their thoughts and feelings. The ideas expressed here may be personal and should not be used against anyone inside or outside of this meeting. From time to time we may interrupt to allow someone to speak who may not have said anything for a while. Also, we may have to interrupt someone to move on to another question because of a time limit under which we are working. We apologize in advance if this happens.

The discussion will be digitally recorded. The recording will be used for our reference only and will be erased once the research report is complete. Additionally, _____ of Ohio University will be facilitating the process by taking notes. Our reports to the research team will not include names of participants, so your individual comments will be strictly confidential.

When you signed the original consent form to participate in the Early Childhood Mental Health Program, you consented to participate in this interview as well. As such, you will not be signing an additional consent form today. It is important to remember that should you feel uncomfortable at any time during the discussion, you do not have to contribute to the discussion. Does anyone have any questions or concerns about the interview or interview process? (Wait for responses) If not, then let’s begin.

ICEBREAKER: I’d like everyone to go around and say your name, your role in your school district and the “thing” that surprised you the most about being a teacher.
1. Introductory Questions:
   A. As you entered the program this year, what were your expectations for the ECMH Program?
   
   B. Now, please take a minute to reflect on the ECMH Program that was delivered in your school this past year. How would you describe the program to a co-worker, colleague, friend, or family member? Think of it this way: “We have this program at school this year that …”
      
      a. Probe for classroom-level support (i.e., “universal” support for all of the children in the classroom)
      b. Probe for individual child-level support
         i. Probe for in-class support (i.e., “targeted” support such as behavior plans, etc.)
         ii. Probe for out-of-class support (i.e., “intensive” support such as testing, counseling, etc.)
   
   C. What did the program require of you? That is, what did you have to do to participate in the program?
      
      a. Probe for DECAs
      b. Probe for Incredible Years
         i. Probe for activities by ECMH consultant
         ii. Probe for extension activities (i.e., “circle time” activities) provided for teachers
      c. Probe for teacher consultant observation (i.e., Mental Health Climate Scale) and associated feedback
      d. Probe for 1 Page Teacher Opinion Scale (done at beginning and end of year)

2. Transition Questions:
   A. After listening to your description of the ECMH Program, your colleague says, “That’s an interesting program. How did you decide which students needed to be involved with the program?”
      
      a. Once you decided that a student might benefit from the program, how did you initiate a conversation with his or her parents/guardians to discuss the program?
      b. How did parents receive these discussions?
         i. Probe for positive experiences
         ii. Probe for negative experiences
      c. What do you think is the best way to connect parents and the ECMH consultant (Jamie)?
   
   B. Following up, your colleague asks, “So, once a student was a part of the program, what happened? What services did they get?”
   
   C. Your colleague, who happens to be a teacher (and ask a lot of questions!) reflects for a minute and says, “Wait a minute – teachers are very busy, especially in an
early childhood environment. What did the program require of you? Meetings? Time commitment?”

D. This colleague, who always encourages you to think critically says, “So, how do you know if the program worked? How did you decide if it was “worth it” to have your students be part of the program?
   a. Probe for classroom impacts
   b. Probe for individual level (child) impacts
   c. Probe for teacher impacts

3. Key Questions:
   A. Let’s take a minute to focus on communication among teachers and the ECMH Program staff members.
      a. Let’s start by having you tell me the names of who you interacted with in the program. (List names.)
      b. I would like us to identify the roles and responsibilities of each team member. (For each name brought up in the group – process the perceived roles and responsibilities.)
         i. Probe for Teacher Consultant (Jamie)
         ii. Probe for Program Director (Sherry)
      c. What was the communication process that was used to keep everyone connected and informed about the project?
         i. Probe for child-level communication (i.e., progress of children receiving targeted and/or intensive support)
   B. Now, I would like to take a minute to talk about the program’s “redesign” process. What was the role of the teacher in the redesign of the ECMH Program?
      a. How much input would you say that teachers had in reshaping the program to what it looked like over the past year?
      b. What evidence do you have that your voice and/or input was effectively incorporated into the program’s redesign?
      c. At what points throughout the year were you given opportunities to provide additional feedback? Who did you deliver this feedback to?
      d. When you gave feedback, how did you know your voice was heard?
      e. How important is it for teachers to have continued input in an ECMH Program? Why / why not?

3. Ending Questions
   A. Let’s say you were on a committee that was tasked with improving the ECMH Program in your school. What elements do you believe are essential for the program to include?
      a. What would the program have to have for it to be valuable to children, families, and teachers?
         i. Probe for DECAs
         ii. Probe for Incredible Years
         iii. Probe for teacher consultant observation and feedback
         iv. Probe for 1-page teacher survey
b. What worked well from the ECMH Program that you would like to see continue?
c. What was missing from the ECMH Program this year that you would like to see added next year?
d. What did not work well from the ECMH Program and should be revisited or eliminated?
e. If another school was beginning an ECMH Program next year, what advice would you give them?

B. Are there any other comments or concerns you would like to share with us? Was there a question that you hoped I would ask that I didn’t ask?

This concludes our discussion. We would like to thank you all for participating. Your contribution is extremely helpful, and the ECMH Program team, our team at Ohio University, as well as your school district are greatly appreciative.
Principal Interview Guide

Key assessment questions guiding interview:

1. How do principals perceive the structure, accessibility and appropriateness of the Early Childhood Mental Health (ECMH) Program?
2. What qualities of an ECMH Program are essential for principals to perceive it as valuable?
3. What do principals perceive as the strengths, liabilities, and key lessons learned from the “redesigned” ECMH Program?
4. How do principals think the ECMH Program can be improved going forward?

Hello. Thank you for letting us to talk with you this morning/afternoon. My name is _____ and I work for Ohio University.

Today, we are using an interview to collect your thoughts and feelings about the Early Childhood Mental Health Program. We hope this discussion can help us come to some conclusions about the principal’s general perception of the structure, accessibility, and appropriateness of the Early Childhood Mental Health Program. We are also interested in what can be done to improve the program as it moves forward.

As stated in the consent document that you signed, our discussion will be digitally recorded. The recording will be used for my reference only and will be erased once the research report is complete. Our reports to the Early Childhood Mental Health Program project team will not include names of participants, so your individual comments will be strictly confidential. Should you feel uncomfortable at any time during the discussion, remember that you do not have to contribute to the discussion. Do you have any questions or concerns about this procedure? (Wait for responses) If not, then let us begin.

1. Introductory Questions:
   A. As you entered the program this year, what were your expectations for the ECMH Program?

   B. Now, please take a minute to reflect on the ECMH Program that was delivered in your school this past year. How would you describe the ECMH Program to a co-worker, colleague, friend, or family member? Think of it this way: “We have an early childhood mental health program in our school that …”

2. Transition Questions:
   A. Principals are very busy, especially in an elementary school environment. What did the program require of you? Meetings? Time commitment?

   B. After reflecting on your experience this year, how do you know if the program worked? How did you decide if it was “worth it” to have your teachers and students be part of the program?
      a. Probe for individual level (child) impacts
      b. Probe for classroom impacts
      c. Probe for teacher impacts

2. Key Questions:
A. Communication is important among those directly involved in a program’s success, but it’s also important to keep other building staff informed of the nature of the program.
   a. How often did you speak with your preschool teachers about the ECMH Program? What types of conversations did you have about the program?
   b. How often did you speak with the ECMH Consultant (Jamie)? What types of conversations did you have about the program?
   c. How often did you speak with ECMH Program Director (Sherry)? What types of conversations did you have about the program?
   d. How would you assess the quality and appropriateness of your current communication with teachers and ECMH personnel? Are these communications adequate for your purposes as principal?

B. Now, I would like to take a minute to talk about the program’s redesign.
   a. How much input would you say that principals had in reshaping the program to what it looked like over the past year?
   b. At what points throughout the year were you given opportunities to provide feedback?
   c. When you gave feedback, how did you know that your voice was heard?
   d. How important is it for principals to have input in an ECMH Program? Why / why not?

3. Ending Questions
   A. Let’s say you were on a committee that was tasked with improving the ECMH Program in your school. What elements do you believe are essential for the program to include?
      a. What would the program have to have for it to be valuable to children, families, and teachers?
      b. What worked well from the ECMH Program that you would like to see continue?
      c. What was missing from the ECMH Program this year that you would like to see added next year?
      d. What did not work well and should be revisited or eliminated from the ECMH Program?
      e. If another school was beginning an ECMH Program next year, what advice would you give them?
         i. What do you believe is the role of the principal in supporting an ECMH program?
         ii. In what ways would you recommend that principals show support for an ECMH program in their schools?

   B. Are there any other comments or concerns you would like to share with us? Was there a question that you hoped I would ask that I didn’t ask?
This concludes our discussion. I would like to thank you for participating. Your contribution is extremely helpful, and the ECMH Program team, our team at Ohio University, as well as your school district are greatly appreciative.

**Superintendent Interview Guide**

**Key assessment questions guiding interview:**

1. How do superintendents perceive the structure, accessibility and appropriateness of the Early Childhood Mental Health (ECMH) Consultation Program?
2. What qualities and outcomes are essential for superintendents to perceive an ECMH Consultation Program as valuable?
3. How do superintendents think the ECMH Program can be improved going forward?

Hello. Thank you for letting us talk with you this morning/afternoon. My name is _____ ____ and I work for Ohio University. Today, we are using a phone interview to collect your thoughts and feelings about the Early Childhood Mental Health Program. We hope this discussion can help us come to some conclusions about the superintendent’s general perception of the structure, accessibility, and appropriateness of the Early Childhood Mental Health Program. We are also interested in what can be done to improve the program as it moves forward. As stated in the consent document that you signed, our discussion will be digitally recorded. The recording will be used for my reference only and will be erased once the research report is complete. Our reports to the Early Childhood Mental Health Program project team will not include names of participants, so your individual comments will be strictly confidential. Should you feel uncomfortable at any time during the discussion, remember that you do not have to contribute to the discussion. Do you have any questions or concerns about this procedure? (Wait for responses) If not, then let us begin.

1. Introductory Questions:
   A. As you entered the program this year, what were your expectations for the ECMH Program?

   B. Now, please take a minute to reflect on the ECMH Program that was delivered in your school this past year. How would you describe the ECMH Program to a co-worker, colleague, friend, or family member? Think of it this way: “We have an early childhood mental health program in our school that …”

2. Transition Questions:
   A. After reflecting on your experience this year, how do you know if the program worked? How did you decide if it was “worth it” to have your principals, teachers, and students be part of the program?
      a. Probe for individual level (child) impacts
      b. Probe for classroom impacts
      c. Probe for teacher impacts
B. Now, I would like to take a minute to talk about your communication with the ECMH Program Director. At what points throughout the year were you given opportunities to provide feedback?
   a. How important is it for superintendents to have input in an ECMH Program? Why / why not?

3. Key Questions:
   A. Let’s say you were on a committee that was tasked with improving the ECMH Program in your school district. What elements do you believe are essential for the program to include in order for it to be valuable to children, families, and teachers?
      a. What worked well from the ECMH Program that you would like to see continue?
      b. What was missing from the ECMH Program this year that you would like to see added next year?
      c. What did not work well and should be revisited or eliminated from the ECMH Program?
   B. If another school was beginning an ECMH Program next year, what advice would you give them?
      a. What do you believe is the role of the superintendent in supporting an ECMH program?
         i. In what ways would you recommend that superintendents show support for an ECMH program in their district?
      b. What ideas do you have for how to sustain an ECMH Program within a school district?

4. Ending Questions:
   A. Are there any other comments or concerns you would like to share with us? Was there a question that you hoped I would ask that I didn’t ask?

This concludes our discussion. I would like to thank you for participating. Your contribution is extremely helpful, and the ECMH Program team, our team at Ohio University, as well as your school district are greatly appreciative.
Teacher Consent Form

Principal Investigator: Sherry Shamblin, PCC-S
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2011-2012 REVISED TEACHER CONSENT FORM

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the program is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

What is the purpose of the program?
Partnerships for Early Childhood Mental Health is aimed at improving early childhood outcomes and increasing the capacity of early childhood educators to address mental health issues in the classroom. This will be accomplished through the implementation of an Early Childhood Mental Health consultation program (ECMH-CP) in public preschools. The Early Childhood Mental Health Consultation program consultant and supervisor (aka Principal Investigator) are employees of Tri-County Mental Health and Counseling Center Inc. The Principal Investigator is also a doctoral student at Ohio University. Her Faculty Advisor is Dr. Tom Davis. Thus the project is a partnership between your school, Tri-County Mental Health and Ohio University.

Consultation services offered through Partnerships for Early Childhood Mental Health will provide universal (delivered by the teacher for all the children in the class), targeted (delivered by the teacher in the classroom to meet the needs of a specific child) or intensive (delivered by a specialized professional to meet the needs of a specific child enrolled as a client the local community mental health center, which may include a classroom component) interventions.

The Partnerships for Early Childhood Mental Health program involves a research and evaluation component. Specifically we are interested in evaluating whether having an early childhood mental health consultation program in preschool classrooms improves teacher skills (i.e., building capacity) and improves child outcomes for students receiving individualized services (i.e., raising resiliency). Staggering the start of services across the three years of the project allows us to compare the outcomes of the classrooms receiving services with the outcomes in the classrooms not receiving services. The classroom not receiving services, but agreeing to participate, serve as the Wait List Control classrooms. Partnerships for Early Childhood Mental Health is funded by the HRSA Outreach grant,
which is in its final and third year (May 2009 – April 2012).

Teachers with Early Childhood Mental Health Consultation Program services:

Teachers in preschool classrooms located in any Athens County or Athens City School System are eligible to participate in the ECMHC Program:

1. Teachers who consent to participate will be asked to complete rating scales. The Teacher Opinion Scale (TOS) is completed twice, at the time of consent and during the last month of school. The TOS is a 12-item survey instrument designed to assess teacher self-perception regarding teacher ability to affect the lives of children in the classroom. Items ask about the teacher's confidence in his/her ability to manage challenging behaviors, to respond effectively, and to influence the child's development. The Relationship Quality Scale is completed during the first and last month of school. This measures satisfaction with the consultation services and the quality of the relationship with a child’s caregiver.

2. The Early Childhood Mental Health Consultation Program offers universal services to the classroom and teacher. In the fall teachers agree to meet with the Early Childhood Mental Health consultant to discuss results of the Preschool Mental Health Climate Scale for classrooms, their own observations about the classroom and then develop a Classroom Plan with goals and objectives which they are agreeing to implement and track across the academic year.

3. Teachers who consent to participate agree to complete de-identified DECA’s for the children in their classroom in the fall, in the winter, and in the spring. The purpose of these DECA’s is to create an aggregated classroom profile of child strengths and challenges. This de-identified classroom profile will be used to analyze the consultation needs and create a plan for the year. The teacher is the only one who will have identifying information about individual child DECA’s completed for the purposes of this universal, teacher-focused consultation.

4. The Early Childhood Mental Health Consultation Program offers individualized services to child when parents give consent. Teachers, who are working with the consultant, agree to facilitate enrollment of students in individualized services when they are concerns about challenging behaviors in the classroom. Teachers are asked to initially discuss concerns with the child’s parents, and when interested provide parents with the contact information for the ECMH consultant. If a child in a classroom is consented for individual services, the teacher agrees to complete behavioral rating scales three times during the school year (at consent, Feb-Mar, May-June)

5. Teachers who participate in the programming are asked to participate in a focus group session conducted in January to evaluate the program, to be organized by the Principal Investigator. Your input will be used to make improvements in the
design and implementation of Partnerships for Early Childhood Mental Health in subsequent years, as well as provide information for others designing and implementing similar programs.

**Teachers in Wait List Control Classroom:**

**Teachers in preschool classrooms located in any Athens County or Athens City School System are eligible to serve as wait list control classrooms:**

6. Teachers who consent to participate as a Wait List Control classroom will be asked to complete rating scales. The Teacher Opinion Scale is a 12-item survey instrument designed to assess teacher self-perception regarding teacher ability to affect the lives of children in the classroom. Items ask about the teacher's confidence in his/her ability to manage challenging behaviors, to respond effectively, and to influence the child's development. This is completed twice; once at the time of consent, and again during the last month of school.

7. Teachers who consent to serve as wait-list control classrooms agree to complete de-identified DECA’s for the children in their classroom in the fall, in the winter, and in the spring. The purpose of these DECA’s is to create an aggregated classroom profile of child strengths and challenges. This de-identified classroom profile will be used to analyze the consultation needs and create a plan for the year. The teacher is the only one who will have identifying information about individual child DECA’s completed for the purposes of this universal, teacher-focused consultation.

8. Teacher who consent to participate as a wait list control group also agree to allow the Early Childhood Mental Health consultant observe the classroom during the last month of school to complete the Preschool Mental Health Climate Scale. This checklist scans the learning environment for interactions that facilitate the social-emotional development of young children.

**Risks and Discomforts**

There are few risks to teachers participating in this project. Teachers may find that completing the individual assessment measures takes a portion of their planning and paperwork time and that the task of completing the measures is not enjoyable. Teachers in the Early Childhood Mental Health Consultation Program may find some aspects of the classroom interventions challenging to implement. However, all strategies used in the program have been used with other teachers in preschool classrooms. Most teachers report that they find the strategies to be useful. Additionally, teachers may experience more frequent parent interactions in order to answer parent questions related to the program and as part of the project. However, many teachers find these more frequent parental interactions lead to a more collaborative relationship between the parents and themselves.

**Benefits**
Potential benefits to Teachers in the Early Childhood Mental Health Program may include a reduction in stress, a reduction in disruptive behavior in the classroom, improved resiliency factors for children in their class, and improved relationships with children and families participating. Finally, information that is obtained from this project, as well as lessons learned, may be useful to others engaged in early childhood mental health consultation programs.

Confidentiality and Records
Sherry Shamblin, PCC-S, employed by Tri-County Mental Health and Counseling, is the investigator on this project. All information gathered from teachers and the school will be kept strictly confidential. Teachers’ names will not appear on any of the project materials; instead, each teacher will be assigned a code number that will be used to identify materials. Similarly, consented students are assigned a code to protect the confidentiality.

De-identified teacher data (all teachers: Teacher Opinion Scales, Preschool Mental Health Climate Scale; and the Relationship Quality Scale) will be filed under the Teacher IDs. De-identified student data (DECA on all, and parent satisfaction surveys, Incredible Years data for consented students) will be filed under the student ID. In the wait list control group, students are not identified, not consented and therefore no student ids are assigned. Data entered into the database for analysis will be protected by a password; paper forms will be stored either by teacher id or student id by the investigator.

Teachers whose classroom received services through the ECMH program will be asked to participate in a focus group to evaluate the program. The focus group will be digitally recorded and transcribed. Prior to transcription that digital recording will be kept in a locked filing cabinet in the investigator’s office. The transcripts will be fully de-identified so that no names are in the transcript, which will be stored in a locked filing cabinet and electronically saved in a password protected file on the Investigator’s Computer. The digital tapes will be destroyed, following completion of the Focus Group report, which is disseminated the project’s advisory council.

The evaluation aspect of this program involves the completion of 3 assessments and the implementation of a classroom plan. Student data is collected for only those whose parents consent for individualized services. Teachers agree that scientific data not identifiable with any persons in the project may be presented at meetings and published so that the information from the project can be useful to others. Because the program is funded by the Federal Office of Rural Health Policy, a branch of the HRSA, progress reports requiring indicators of program progress are reported annually. Copies of the progress reports will be made available to any participate on request to Sherry Shamblin.

Compensation
Teachers who consent to participate and work with the ECMH Consultant will receive $100 to use for classroom resources to be received after the winter quarter DECA collection. Those teachers are also consenting to participate in the summer focus group, for which they will be paid an additional $25. Teachers who consent to participate as a Wait List Control group will receive $100 to use for classroom resources after the winter quarter DECA collection.
Ohio University Finance Office policy requires the name, address, and social security numbers of participants will need to be collected and provided to the Finance Office at OU when an individual is compensated $100 or more in a calendar year.

**Am I required to participate?**

Participation is completely voluntary. Teachers are free to stop participation at any time without prejudice. If teachers have any concerns regarding this project now, or during the course of the project, they may contact the Principal Investigator, Sherry Shamblin, PCC-S, at sshamblin@tcnhcs.org, or 740-592-3091, or her faculty advisor, Dr. Tom Davis at davist@ohio.edu, or 740-593-4460 Additionally, if you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

I certify that I have read and understand this consent from. I agree to participate in the project described. I agree that the known risks have been explained to my satisfaction. I understand that no compensation is available from Ohio University or Tri-County Mental Health and their employees for any injury resulting from my participation in this research. Finally, I certify that my participation in this research is given voluntarily and I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I or may otherwise be entitled. By accepting below, I freely agree to participate in this project. I certify that I have been given a copy of this consent form to take with me.

Signature_________________________________________ Date_____

Printed Name_________________________________________

Version Date: [August 15, 2011]
Dear Participant,

The Partnerships for Early Childhood Mental Health project team has commissioned an evaluation of the Early Childhood Mental Health (ECMH) Program. This evaluation will be led by Dr. Holly Raffle from Ohio University’s Voinovich School of Leadership and Public Affairs.

As part of the evaluation, we ask you to engage in an individual interview regarding your experiences with the ECMH Program at your school. The interview will take no longer than one-hour to conduct. Your participation in the interview is completely voluntary and you may elect not to take part in the interview. In addition, you may refuse to answer any question you chose not to answer, and you may withdraw from participation in the interview at any time without penalty or consequence. The study is unlikely to expose you to risks or discomforts, even though talking to an evaluator might be mildly disconcerting.

Interviews will be digitally recorded and recordings will be stored on a secure, password protected, server, accessible only to the evaluation team. All information gathered during the interview will be kept strictly confidential. No names will be associated with any data reported out in any form.

This form requests your consent to be interviewed prior to April 30, 2012. By signing the consent signature page and completing the interview, you indicate your consent to participate in this portion of the evaluation.

If you have questions regarding this evaluation, please contact Holly Raffle (740-597-1710). If you have any additional questions about participant rights, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University. Please keep this letter with you for future reference.

Thank you again for your participation.

Sincerely,

Holly Raffle, Ph.D., CHES
Voinovich School, Ohio University
By signing below, you agree that:

- you have read the attached consent form letter and have been given the opportunity to ask questions
- known risks to you have been explained to your satisfaction
- you are 18 years of age or older
- your participation in this evaluation is given voluntarily
- you may change your mind and stop participation at any time without penalty or consequence.

I have read the informed consent letter. By signing the consent signature page and participating in the interview, I agree that my responses may be used in the Evaluation of the Partnerships for Early Childhood Mental Health Program.

(Name of Participant)  (Signature)  (Date)
Appendix E: Robert Wood Johnson Retooling Professionals Evaluation Fellowship

\[16\] This is an unpublished program report belonging to the “Partnerships for Early Childhood Mental Health Program” It is reprinted for the purposes of this study with permission from Tri-County Mental Health and Counseling Services, Inc.
An Evaluation of the Collaborative Relationships between Teachers and Consultants in the Partnerships for Early Childhood Mental Health Program

Final Report for Robert Wood Johnson Retooling Professionals Evaluation Fellowship

8-3-12
Sherry Shamblin, PCC-S
sshamblin@tcmhcs.org
Introduction

The United States is home to approximately 25.5 million children under the age of five (Forum on Child and Family Statistics, 2012). Best estimates suggest that at least 44% of these children spend an average of 36 hours a week in childcare and preschool settings (National Association of Child Care Resources and Referral Agencies, 2011). Early care and education professionals serving these settings report that as many as 30% of the young children in their care exhibit social-emotional/behavioral challenges at a level significant enough to place them at risk of removal from their care settings (Ravner & Knitzer, 2002).

Young children with behavior problems are less accepted by peers and teachers, receive less interaction from teachers, participate in fewer learning activities, and have fewer opportunities to participate in enrichment activities (Ravner & Knitzer, 2002). On average, preschool children are expelled at a rate three times greater than any other grade level, K-12 (Gilliam, 2005). Preschool teachers who have ongoing access to early childhood mental health consultation (ECMHC) are 50% less likely to expel a child; but only 23% of teachers have access to this promising service (Gilliam, 2008). ECMHC has been linked to increased teacher competence, teacher efficacy, positive parenting, social-emotional child development, and decreased externalizing child behaviors (Green, 2009).

Over the last decade, Tri-County Mental Health and Counseling (TCMHC) has developed an ECMHC program, Partnerships for Early Childhood Mental Health, to meet the needs of young children living in the Southeast counties of Ohio’s Appalachian region. During 2011-2012, Partnerships for Early Childhood Mental Health’s school-based team served 240 children, 11 teachers, and 6 schools. While the program has incorporated evaluation components for assessing outcomes of participating children and teachers, there has been little focus on understanding “how” the program accomplishes these outcomes. An especially significant gap is information related to the development of teacher-consultant relationships, even though such relationships have been identified as critical for successful ECMHC consultation (Green 2006). These relationships may be even more crucial to Partnerships for Early Childhood Mental Health since Appalachian cultural values encompass a high regard for community-kinship networks, a focus on establishing horizontal relationships over hierarchical ones, a fear and distrust of outsiders, and a respect for solidarity (Keefe, 1989; Coyne, Demian-Popescu, & Friend, 2006).

In an effort to address this missing component, this evaluation project focused on studying the working relationships between participating teachers and the ECMH consultants staffing the program. The results will be used by the program director, staff, and stakeholders to make program improvements for the upcoming program year. Results will also be shared with interested local partners to inform them about program strengths and challenges, as well as other interested stakeholders to further inform their understanding of processes relevant to successful ECMH consultation.
Description of the program

Program Mission and Goals
Partnerships for Early Childhood Mental Health exists to build partnerships between parents, teachers, and early childhood mental health consultants to help promote the social-emotional wellness and school readiness of children in their care.

Program objectives include:
(1) Increased collaborative ventures between schools/ early childhood settings/ and ECMH consultants
(2) Increased capacity of participating early childhood professionals and parents for building resiliency and managing challenging behaviors for children in their care.
(3) Increased resiliency of participating children (Initiative, attachment, self-control, and reduced behavioral concerns).

Program Theory of Change
As part of this evaluation fellowship, the program director and staff developed a theory of change model to represent the program context, the key assumptions and activities supporting the program goals, and anticipated short and long term outcomes. The program theory of change model is outlined in Figure 1.
THEORY OF CHANGE: Partnerships for Early Childhood Mental Health Program

STRATEGIC FOCUS:
We build partnerships between EC Professionals, Parents, and ECMH consultants to increase the social-emotional resiliency of young children in their care

CONTEXT
Assets:
(5) Established relationships with the schools and our agency
(6) ECMH staff that are invested and interested in doing a good job
(7) ECMH Staff trained in relationship-based work
(8) We have data collection

Challenges
(5) Time investment for program evaluation falls on teachers/ECMH staff/ Program Director which takes focus away from delivering program
(6) Subjective nature of relationship-based work/ Difficult to measure
(7) Access to parents
(8) Do Schools/ Parents want to “Partner”?

ASSUMPTIONS
(8) If teachers, parents, and ECMH Consultants build partnerships, then children will have better SE outcomes
(9) IV/ Dina School provides structure opportunity for relationship building/ shared curriculum implementation
(10) DECA profiles lead to shared analysis of children/ shared planning
(11) Joint planning leads to shared goals/ improved partnering
(12) Being on site in schools/homes leads to strengthened partnerships
(13) Teachers/parents/ and ECMH consultants want to partner in
(14) They place great value in improving SE outcomes of children

PROGRAM GOALS
(4) To increase skill and capacity of participating teachers for building resiliency of all children in their classes and specifically for children with challenging behaviors.
(5) To increase resiliency of participating children (initiative, attachment, self-control, and reduced challenging behaviors).
(6) To increase collaborative ventures between schools, other EC settings, and ECMH.

PROGRAM ACTIVITIES
(10) ECMH’s on site/ in class minimum 3 hours a week
(11) Observation/feedback on teaching activities
(12) Weekly mentoring/ coaching to teachers
(13) Dina School script and make/bring materials
(14) Assist in classroom when appropriate
(15) Consultation meetings with teachers to review new information, answer questions from weekly coaching, and jointly plan upcoming activities
(16) Newsletter to provide updates and ideas for consultants and teachers
(17) Teacher lending library
(18) Administrative Updates

Short-Term Outcomes (6 mos.)
(8) Open communication between teachers/ ECMH’s
(9) ECMH’s and teachers will begin to jointly develop new activities for children
(10) Classroom DECA profiles show increase in resiliency skills and reduced behavioral concerns; decreased number of children in a “concern” range
(11) Teachers regularly consult with ECMH’s about children/ challenges through formal and informal methods
(12) ECMH’s feel comfortable in classrooms/ feel competent in their roles
(13) School Administrators know staff and program goals
(14) School staff and administration talk positively about the program to staff, parents, and other administrators

Long-Term Outcomes (2-3 years)
(4) ECMH Program Director and School Administrators jointly develop a plan for sustaining services
(5) ECMH’s are fully integrated team members of the school
(6) Bi-Directional capacity development between school personnel and mental health

Figure E1. Theory of Change Model
**Purpose of Evaluation**

The results of this evaluation will be used to: (1) Make program improvements for the next program year, (2) Improve strategies for training/preparing ECMHC consultants, (3) Inform supervision/management decisions to enhance development and satisfaction of current and future ECMH staff. Additionally, evaluation results will be used to communicate program strengths and areas of growth to ECMH staff, TCMHC program administrators, school partners, and appropriate/interested stakeholders.

**Evaluation Questions**

Questions which guided this evaluation were threefold: (1) In what ways do the ECMHC program activities establish and advance a positive working relationship between teachers and ECMHC’s; (2) What individual teacher and ECMHC factors are associated with the development of positive working relationships; and (3) What early challenges are associated with developing working relationships between teachers and ECMHC’s.

**Methodology**

These questions were addressed through quantitative and qualitative evaluation activities which included staff and teacher surveys, staff interviews, key findings from a recent teacher focus group, and analysis of consultation logs. Figure 2 summarizes the evaluation methods used in this project and how these methods align with evaluation questions and program key indicators.
Figure E2: Evaluation Activities

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Key Indicator</th>
<th>Evaluation Activity/ Data</th>
</tr>
</thead>
</table>
| (1) In what ways do the ECMH program activities establish and advance a positive working relationship between teachers and ECMHC’s | a. Increase in frequency of teacher/ECMH consultation contacts  
b. Increase in teacher-initiated consultations | a. Review of consultation logs for quantity of contacts  
b. Review Outreach focus group report  
c. Review of Teacher Satisfaction Surveys  
d. Administer Adapted Wilder Survey to teachers and consultants |
| (2) What individual teacher and ECMHC factors are associated with the development of positive working relationships | a. Teachers and ECMHC both report an increased level of trust; having (+) problem-solving conversations  
b. Teacher and ECMHC report working as a team and developing joint strategies to better serve children.  
c. Teachers and ECMHC are consistently cooperative and respectful of one another and work through conflicts | a. Administer Teacher Satisfaction at the end of the school year  
b. Review Outreach Focus Group Data  
c. Conduct ECMHC interviews through independent evaluator  
d. Administer Adapted Wilder to teachers and consultants  
e. Review ECMHC Professional logs |
| (3) What early challenges are associated with developing working relationships between teachers and ECMHC’s | a. Increase in frequency of teacher/ECMH consultation contacts  
b. Increase in the number of contacts recorded on consultation notes  
c. Increase in teacher-initiated consultations  
d. Teachers and ECMHC both report an increased level of trust; having (+) problem-solving conversations  
e. Teacher and ECMHC report working as a team and developing joint strategies to better serve children.  
f. Teachers and ECMHC are consistently cooperative and respectful of one another and work through conflicts | a. Review of consultation logs  
b. Review Outreach Focus Group data  
c. Review of Teacher Satisfaction Surveys  
d. Administer Adapted Wilder Survey to teachers and consultants  
e. Review Outreach Focus Group Data  
f. Conduct ECMHC interviews through independent evaluator |
To collect self-reported perceptions of various relationship components, a survey was created and administered to teachers and consultants. Copies of the surveys used are at the end of this report. Surveys were administered to the eleven participating teachers and four consultants. Completion of the survey was voluntary. Participants placed completed surveys in blank, sealed envelopes and left in agency/school reception areas for the evaluator to collect. Eight teacher surveys and four consultant surveys were returned. A chart with the survey responses is attached.

As a regular part of the program, staff collect the “Early Childhood Mental Health Consultation Staff/Provider Survey”, (Hepburn, K., Kaufman, R., Perry, D., Allen, M., Brennan, E., & Green, B., 2007). A copy of this survey is contained in Appendix 8. Surveys collected for the 2011-2012 school year were analyzed using descriptive statistics. Eleven teachers were given surveys, and eight were returned. Results are reviewed in a chart at the end of this report.

The program has obtained interview and focus group feedback from participating school personnel regarding program components, including relationships with the assigned consultant. However, there has not been an opportunity to obtain objective feedback from the ECMH consultation staff. To address this gap, the evaluator enlisted the help of a volunteer master’s psychology student intern from Ohio University’s Voinovich School of Leadership and Public Affairs. The volunteer and the evaluator developed an interview protocol which was used by the student volunteer to conduct one hour individual interviews with program consultants. The resulting protocol is at the end of this report. Participation in the interviews was voluntary. The student volunteer arranged interviews with each consultant. Three consultants elected to participate. The student volunteer and evaluator independently coded the interview transcripts, and then they both met to compare findings.

Qualitative data analysis techniques outlined by Thomas (2006) were used to analyze the data collected from the interviews, open-ended survey items, and documents.

A chart reviewing the themes that emerged during this process is located at the end of this report.

Consultation activities and time spent on each are logged by each consultant. These logs were reviewed and descriptive statistics were used to analyze consultation tasks completed this year. A copy of the log and analyses are at the end of this report.
Evaluation Findings

General Finding

- All teachers and consultants expressed feeling positive about the program and working with each other. 100% of teachers responded on the satisfaction survey that they “strongly disagreed” that the program needed improvement. Specific survey comments made by teachers attesting to this high satisfaction include, “We work really well together…she has great ideas and is always prepared to help in any way;” and “My consultant has been great. I don’t feel like there are any weaknesses in our team approach.” These sentiments were also echoed in the teacher focus group report, where it was noted that, “Teachers, principals, and administrators consistently expressed great satisfaction with the ECMH Program Director and ECMH consultant. Both individuals were seen as knowledgeable in early childhood and mental health, with a functional understanding of how schools operate. Furthermore, informants felt that the ECMH personnel were supportive, approachable, and genuine in their efforts to implement the ECMH program.” (p. 12 Voinovich, 2012). Likewise, all consultants participating in interviews discussed the successful formation of positive relationships with teachers.

- Teachers and consultants reported benefits for children, their organization, and themselves as a result of the program. This was supported by the teacher focus group report, consultant interviews, and both surveys. 100% consultants and teachers “agreed” or “strongly agreed” that the program was personally beneficial; 100% teachers and 90% consultants felt that it was also beneficial to their organizations. Teachers made numerous comments in both the focus group and on open-ended survey questions indicating that they felt less stressed, that children had improved behaviors, and that classrooms were calmer. Likewise, consultant interviewees pointed to reduced challenging behaviors for individual children and increased development in skills for their teachers and themselves. These views were exemplified by such teacher comments as, “Her personality and caring was helpful to build relationships with children. All children in the room enjoyed her presence. She offered me good advice. Parents who she contacted reported back positive comments.” and “She is very helpful with ALL children in the classroom! She is very caring to ALL of the children! I enjoyed having her in my classroom very much.” Both teachers and consultants felt that the program contributed to their own professional successes; and that they couldn’t have accomplished these professional successes on their own (90% teachers, 75% consultants).

- Teachers and consultants share commitment to the program’s success. This was reflected by comments in the teacher focus group, consultant interviews, and on the collaboration survey where 80% teachers and 75% consultants agreed that there was shared commitment.
Program Activities Advancing a Positive Working Relationship between Teachers and Consultants

These findings related to the evaluation question, “In what ways do the ECMH program activities establish and advance a positive working relationship between teachers and ECMHC’s?” Specific indicators addressed were: (1) Increase in frequency of teacher/ECMH consultation contacts, (2) Increase in teacher initiated consultations. Critical program components that were identified are listed below.

- **Presence of a fully integrated consultant.** In previous years, the program model utilized a consultation-by-request approach-- a consultant served multiple sites, had less time at each site, and was less involved in the school community. Although contact was consistent, consultants primarily focused on classrooms where there were many children receiving individual services. The consultant-teacher ratio of 1 consultant per 5 teachers. During this current program year, 2011-2012, the program switched to a service model incorporating an embedded consultant who was integrated into the school community. A consultant was assigned to a classroom for a minimum of one day a week reducing the ratio to 1 consultant for 3.5 teachers. This change led to a dramatic increase in average hours of consultation that each teacher received (217 average hours of consultation per teacher versus 53 average hours of consultation per teacher in the previous year). Because consultants weren’t traveling so much, they were also able to spend more time doing direct service: the average amount of consultation time per consultant increased from 268 hours to 796 hours for the school year. All teachers and consultants, across all data sources identified this as a major improvement over previous delivery models. One consultant respondent identified the ability to spend at least one full day a week in a class as particularly helpful to the program implementation.

- **Consultation for individual children with challenges.** All teachers and consultants cited the value of targeted consultation for individual challenging children. They reported that this was helpful, not only to these children, but was also beneficial for all children in the group because of an enhanced classroom environment. This was supported by teacher focus group responses, consultant interviews, and in satisfaction surveys where all teachers “strongly agreed” that the program had helped them feel less stressed, helped with the children, and improved the quality of their classroom. Specific examples identified by teachers participating in the focus group included, “children speaking up and participating in class, making friends, and fighting less” (p. 12 Voinovich, 2012).

- **Classroom consultation activities:*** All consultants participating in the interviews were able to accurately articulate all of the program components. They identified the critical nature of providing teachers with specific, concrete strategies to use in their classrooms. Teacher survey responses reinforced this view, reflecting that the greatest amount of consultation time was spent on discussing strategies for managing their own well-being and for handling challenging children. An analysis of consultant logs further revealed specific consultation activities that
were important. Eighty percent of classroom consultation involved four major activities: 20% observing classroom children/processes; 19% consulting with a teacher on an individually requested teacher topics, 18% modeling classroom behavior strategies, and 20% conducting Dina classroom activities.

- **Incredible Years Dina Classroom Curriculum.** Although consultants only spent 20% of their time conducting this program, it was prominently cited by teachers in the focus group, consultant interviewees, and in open-ended survey questions. Teachers felt this program assisted consultants in “fitting into” their classrooms and consultants viewed the program was as “door-opener” for them with participating teachers. Consultants specifically felt that the program led to increased teacher engagement in the program and improved child outcomes.

- **Adaptability of the program.** Teachers and school administrators who participated in the focus group responded that they appreciated that the program components were tailored to each classroom situation. This was cited as “being very important due to the different needs posed by different classrooms, but also as a method of increasing sustainability” ((p. 12 Voinovich, 2012). All consultant interviewees discussed the specific efforts they needed to make to accommodate the ability level and personal style of each teacher and school. One respondent specifically mentioned the importance of “individualizing to the teacher/situation” as a critical factor leading to success.

- **Importance of communication.** All teachers and consultants rated their communication as “good” and “consistent.” Consultants talk with teachers every time they are on site (at least once a week). Communication moved from predominantly consultant initiated early in the year, to a more equal distribution. All consultants described an increase in teacher-initiated communication by the mid-point of the program year (ranged from 50% to 75% being teacher initiated). All sources (teacher focus group, consultation interviews, and surveys) identified communication as mostly informal. However, consultants tended to value that the dominance of this informal communication whereas teachers reported a need for more formal communication. This was despite the reports by consultants that teachers were frequently not available or often missed formally scheduled communication opportunities.

**Individual Teacher and Consultant Factors Associated with Positive Relationships**

These findings related to the evaluation question, “What individual teacher and ECMHC factors are associated with the development of positive working relationships?” Specific indicators addressed were (1) Teachers and consultants report an increased level of trust, and (2) Both teachers and consultants report having positive problem-solving conversations.

- All teachers reported having a positive relationship with their consultant. This was supported not only by their unanimous positive endorsement of relationship components on the collaboration survey such as trust and respect, but also by “strong agreement” with such satisfaction survey items as “I have a good
relationship with my consultant,” “Consultant works as a partner with me,” and “Consultant seems like a member of the staff/Not an outsider.” Teachers also positively endorsed that they felt respected by the consultant and that the consultant had helped them feel less stressed in their jobs.

- Specifically, all teachers reported valuing consultants who bring mental health expertise and know how to make this information accessible and useable for teachers. This was best reflected by teacher comments such as, “She came to our school with lots of experience with counseling and working with schools. She was a great match. The program is strong when there is an experienced consultant. If the consultant is not experienced or not comfortable working with low SES families, the program is at risk of failure.” All consultant interviewees also cited the importance of this attribute, but described it as the ability “to assess the level and style of the teacher and match this”, and “being able to break mental health expertise into language that teachers can understand and can put into practice”. One consultant identified this ability as critical to successful engagement by teachers.

- A number of relationship qualities were mentioned by both teachers and consultants. There was 100% agreement that flexibility and adaptability of both parties is important to successful consultation relationships, and that both need to be open to different options (90% teachers, 75% consultants). Consultants particularly identified the bi-directional importance of flexibility and adaptability to forming working relationships with teachers, and that such relationships led to positive teacher and child outcomes. Other important qualities that also emerged: (a) Importance of Teacher-Consultant Match “My consultant is a good fit in my classroom—we have a similar philosophy about children and behavior,” (b) Communication was open and comfortable--90% teachers, 75% consultants surveyed, (c) Consistency was cited as very important by both parties. All consultant interviewees mentioned it as critical to establishing relationships. This was also reflected by teacher survey comments, such as “I feel like I can count on my consultant when I need her. She’s always willing to talk when I need it.”

Challenges Associated with Positive Relationships between Teachers and Consultants
These findings related to the evaluation question, “What early challenges are associated with developing working relationships between teachers and consultants.” Three main challenges were identified.

- **Adequately communicating the program structure and roles.** Despite the development of strategies and materials to explain the program and consultant-teacher roles, consultants unanimously identified their greatest challenge was clearly describing the program and their roles to school personnel and community members. They specifically found it challenging to develop shared expectations around roles and goals. All consultant interviewees and survey participants cited the successful navigation of this challenge as critical to their success with teachers. When consultants faced a specific problem with teacher engagement,
they linked it back to a misunderstanding the consultant’s role.

- **Establishing formal communication strategies.** Teachers and consultants were unanimous in their views that informal communication was very good, but that formal communication was more limited. However, these variations were valued differently by the respective groups. All consultant interviewees identified the predominance of informal communication as a program and relationship strength. They voiced frustration with difficulties in scheduling formal meetings with teachers and frequent cancellations of formalized meetings by school personnel. However, teachers expressed the desire for more formal communication despite expressing satisfaction with informal communication.

- **Creating a shared view of roles and expectations.** Consultant interviewees and survey participants described the challenge of negotiating roles and expectations with teachers. All examples of successful consultation included the positive agreement on these issues, and examples of negative experiences almost always included a failure to negotiate these critical components. This may be further supported by teachers-consultant differences on several items on the collaboration survey related to roles and expectations: Willingness to compromise (90% of teachers felt that consultants were willing to compromise, 25% of consultants felt that their teachers were willing); Time investment (100% teachers felt that there was enough time investment by both parties; only 25% of consultants agreed with this); and Keeping each other informed (100% of teachers felt that they were being adequately kept informed; only 50% consultants agreed).

### Conclusions and Recommendations

Findings of this program evaluation appear to indicate teachers and consultants agree that Partnerships for Early Childhood Mental Health is having a positive impact for participating teachers, school personnel, children, and staff. Findings also imply that consultants are successful in establishing positive working relationships with participating teachers a majority of the time. Results point to program components and personal qualities that enhance these relationships, as well as challenges faced with creating shared expectations. These outcomes have implications for the program in three main areas: communication, program components, and new staff. In order to build on their strong foundation and incorporate the conclusions documented in this report, the program director and staff should consider the following recommendations.

- **Communication:** While informal communication between teachers and consultants is strong, it cannot substitute for developing formalized communication strategies. The organizational culture of schools pays greater attention to formalized processes than those found within TCMHC. Additionally, it may be challenging for teachers to focus and attend without dedicated, formalized meeting structures. However, their schedules seldom allow for many meetings, and their days are often interrupted by child-related issues. Consultants and teachers may find it helpful to develop a meeting routine (i.e. the first
Wednesday morning of the month, etc.) so that they can prioritize them. Even with this strategy, it is likely to be challenging for teachers and consultants to formally meet frequently. It may be helpful to increase formal written communication strategies such as a brief weekly note with consultation activities conducted, progress for individual children, and discussions with parents. Finally, the program should continue developing communication materials and “talking points” that articulate program components, services, and staff-teacher roles. This is needed for school personnel at all levels and for new ECMH staff.

- **Program Components:** With the popularity and effectiveness of the Dina classroom curriculum, staff should consider increasing its implementation and consistency of implementation across sites. One strategy to consider is having experienced consultants create an implementation notebook identifying timelines, adaptations made, the most/least effective activities, etc. that can be used in tandem with the standardized curriculum materials. This would help existing staff and teachers be more consistent across sites and would help new staff make use of lessons learned by experienced staff. Although it is more expensive, every effort should be made to continue the integrated/“embedded” consultant that are able to spend at least one day a week at each participating classroom. This component seems to be the most critical change made by the program and has likely been the greatest contributor to the increased satisfaction by participants and staff, as well as improved outcomes. In order to best allocate resources associated with this type of staff arrangement, the program should consider developing a strategy for identifying “teacher-readiness” when new teachers request the program. This would maximize the best use of consultant time by ensuring that it is directed at teachers who are willing to work in this type of collaborative arrangement. In this same vein, creating a system for optimizing teacher-consultant match will also help ensure manpower resources are being best used.

- **New staff:** The success of Partnerships for Early Childhood Mental Health clearly lies in the quality of its staff. As such, it is critical moving forward that the program prioritize hiring staff that have experience with school settings, who have demonstrated abilities to translate behavior/mental health principles to early childhood professionals, and who are flexible, team-players. The program should consider including school representation during the interview process in order to increase shared decision-making with school partners, and to send a clear message to consultant-applicants about the collaborative nature of the work. Finally, once new consultants are hired, they need a high level of training and mentoring. The program should continue refining existing training materials and processes.
References:


Consent Form

Title of Project: Early Childhood Mental Health Consultant-Teacher Relationships

Researchers: Sherry Shamblin, PCC-S

You are being asked to contribute your opinions to a program evaluation of the Early Childhood Mental Health Program. This program evaluation is being conducted through Tri-County Mental Health and Counseling, Inc. as part of Sherry Shamblin’s participation in the Retooling Evaluation Fellowship Program. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the project are answered, you will be asked to sign it. This will allow your participation in this evaluation. You should receive a copy of this document to take with you.

Explanation of the Project

This study is being done because literature suggests that collaborative relationships are the most important component for the success of early childhood mental health consultation. This evaluation will help our team examine how relationships are formed with our preschool teachers, what are the challenges to forming these relationships, and what components lead to successful relationships.

If you agree to participate, you will be asked to participate in a one-hour interview conducted by a volunteer from Ohio University, who has agreed to help me with this project. Her name is Holly Strickland.

Risks and Discomforts

Although, efforts will be made to keep your responses confidential, Holly will be tapping the interviews and Sherry will receive these tapes to transcribe and analyze. She is likely to know who participated and to be able to identify interview comments. Please carefully weigh your decision to participate and your responses with full knowledge of this potential risk, and remember that participation in this process is voluntary. Your responses or your choice to not participate will not impact your work, employment evaluations, or position at Tri-County in any way.
Confidentiality and Records

Interview tapes will have no identifying information; and will be kept in a locked file cabinet in the Sherry’s office. Tapes will be destroyed immediately upon completion of the transcription which will occur within one month of the actual interview date. Transcriptions will have no identifying information and will be kept in a locked file cabinet in the Sherry’s office. A final report will be written that will have no identifying information or specific comments made by interviewees, only general themes and issues will be described.

Compensation
No compensation will be provided.

Contact Information

If you have any questions regarding this program evaluation, please contact: Sherry Shamblin at sshamblin@tcmhcs.org 740-592-3091 or Tri-County’s HR Department, Kendall Brown Clovis at kendallb@tcmhcs.org or 740-592-3091.

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered
- you have been informed of potential risks and they have been explained to your satisfaction.
- you understand Tri-County has no funds set aside for any injuries you might receive as a result of participating in this study
- you are 18 years of age or older
- your participation in this evaluation project is completely voluntary
- you may leave the interview at any time. If you decide to stop participating in this evaluation project at any time, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.

Signature__________________________________________ Date__________

Printed Name__________________________________________
ECMH-Teacher Collaboration Questionnaire: Teacher Version

This questionnaire will help our group identify strengths that research has shown are important for successful collaboration. There are no correct answers. We will not share individual responses, only group totals. Results will be used to help us make program improvements and will add to our understanding of the components that create successful working relationships between teachers and ECMH consultants.

1. I have a history of working with an ECMH consultant.
   
   |   |   |   |   |   |
   | 1 | 2 | 3 | 4 | 5 |
   | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |

2. Others in our school, who are not part of the ECMH program, seem hopeful about what we can accomplish.
   
   |   |   |   |   |   |
   | 1 | 2 | 3 | 4 | 5 |

3. I trust my ECMH consultant.
   
   |   |   |   |   |   |
   | 1 | 2 | 3 | 4 | 5 |

4. I have a lot of respect for my ECMH consultant.
   
   |   |   |   |   |   |
   | 1 | 2 | 3 | 4 | 5 |

5. I will benefit from working with an ECMH consultant.
   
   |   |   |   |   |   |
   | 1 | 2 | 3 | 4 | 5 |

6. Our school will benefit from being involved in this ECMH collaboration.
   
   |   |   |   |   |   |
   | 1 | 2 | 3 | 4 | 5 |

7. My ECMH consultant and I are willing to compromise on important aspects of our work.
   
   |   |   |   |   |   |
   | 1 | 2 | 3 | 4 | 5 |

8. My ECMH consultant and I are able to invest the right amount of time in our collaborative efforts.
   
   |   |   |   |   |   |
   | 1 | 2 | 3 | 4 | 5 |

9. My ECMH consultant and I share a high level commitment.
   
   |   |   |   |   |   |
   | 1 | 2 | 3 | 4 | 5 |
10. My ECMH consultant is open to discussing different options.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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11. My ECMH consultant and I share a clear sense of our roles and responsibilities.

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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12. My ECMH consultant and I have a clear process for making decisions.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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13. My ECMH consultant and I communicate openly with one another.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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14. My ECMH consultant and I keep each other informed as much as we should.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</table>

15. My ECMH consultant and I communicate both at formal meetings and in informal ways.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</table>

16. I have a clear sense of what my ECMH consultant and I are trying to accomplish.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
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</table>

17. What I am trying to accomplish with my ECMH consultant would be difficult for me to accomplish by myself.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</table>

18. What is working well in your teacher-ECMH consultant relationship?

19. What needs improvement in your consultation relationship?
ECMH-Teacher Collaboration Questionnaire: Consultant Version

This questionnaire will help our group identify strengths that research has shown are important for successful collaboration. There are no correct answers. We will not share individual responses, only group totals. Results will be used to help us make program improvements and will add to our understanding of the components that create successful working relationships between teachers and ECMH consultants.

1. I have a history of working with preschool teachers.
   - Strongly Disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly Agree

2. Others in our organization, who are not part of the ECMH program, seem hopeful about what we can accomplish.
   - Strongly Disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly Agree

3. On average, I trust the teachers with whom I work.
   - Strongly Disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly Agree

4. On average, I have a lot of respect for the teachers with whom I work.
   - Strongly Disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly Agree

5. My own professional development has benefited from working with teachers.
   - Strongly Disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly Agree

6. Our agency will benefit from being involved in school collaborations.
   - Strongly Disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly Agree

7. Overall, my teachers and I are willing to compromise on important aspects of our work.
   - Strongly Disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly Agree

8. In general, my teachers and I are able to invest the right amount of time in our collaborative efforts.
   - Strongly Disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly Agree

9. On average, my teachers and I share a high level commitment.
   - Strongly Disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly Agree
10. In general, my teachers are open to discussing different options.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

11. In general, my teachers and I share a clear sense of our roles and responsibilities.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

12. For the most part, my teachers and I have a clear process for making decisions.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

13. Most of my teachers and I communicate openly with one another.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

14. In general, my teachers and I keep each other informed as much as we should.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

15. On average, my teachers and I communicate both at formal meetings and in informal ways.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

16. For the most part, I have a clear sense of what my teachers and I are trying to accomplish.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

17. What I am trying to accomplish with my teachers would be difficult for me to accomplish by myself.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

18. What is working well in your teacher-ECMH consultant relationship?

19. What needs improvement in your consultation relationship?
### Collaboration Survey Results

<table>
<thead>
<tr>
<th>Item</th>
<th>Participant</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prior History</td>
<td>Teacher</td>
<td>10%</td>
<td>40%</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Others in organization hopeful about the program</td>
<td>Teacher</td>
<td>50%</td>
<td>10%</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>75%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trust</td>
<td>Teacher</td>
<td>30%</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Respect</td>
<td>Teacher</td>
<td>30%</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
<td></td>
<td></td>
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<tr>
<td>5. Personally Beneficial</td>
<td>Teacher</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. Beneficial for Organization</td>
<td>Teacher</td>
<td>10%</td>
<td>30%</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. Willingness to Compromise</td>
<td>Teacher</td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>75%</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Enough Time Investment</td>
<td>Teacher</td>
<td>10%</td>
<td>60%</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Shared High Level of Commitment</td>
<td>Teacher</td>
<td>10%</td>
<td>30%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Openness to Different Options</td>
<td>Teacher</td>
<td>10%</td>
<td>30%</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Clear Sense of Roles and Responsibilities</td>
<td>Teacher</td>
<td>10%</td>
<td>30%</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Clear Decision-Making Process</td>
<td>Teacher</td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Open Communication</td>
<td>Teacher</td>
<td>10%</td>
<td>20%</td>
<td>70%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Keeping Each Other Informed</td>
<td>Teacher</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td></td>
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<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>15. Formal and Informal Communication</td>
<td>Teacher</td>
<td>10%</td>
<td>10%</td>
<td>20%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>50%</td>
<td>50%</td>
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<tr>
<td>16. Clear, Shared Goal(s) to Accomplish</td>
<td>Teacher</td>
<td>10%</td>
<td>10%</td>
<td>20%</td>
<td>60%</td>
<td></td>
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<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>30%</td>
<td>25%</td>
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</tr>
<tr>
<td>17. Difficult to Accomplish Alone</td>
<td>Teacher</td>
<td>20%</td>
<td>30%</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant</td>
<td>25%</td>
<td>25%</td>
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## 18. What is working well?

**Teacher**
- My students know the consultant by name and trust her, which is vital when issues arise. Another professional is always needed.
- Dina School
- Our positive relationship—We get along very well
- Our consultant is easy to talk to and has shown that she is a very effective counselor.
- I feel like I can count on my consultant when I need her. She’s always willing to talk with me when I need it.
- My consultant is a good fit in my classroom—similar philosophy about children and behavior.
- She is willing to work informally in the classroom with students when I see problems.
- We work really well together...she has great ideas and is always prepared to help in any way.
- Someone to bounce ideas off of; Dina School; Hooking up to volatile parents/families.

**Consultant**
- Using the standardized tools more.
- Teachers really appreciate that someone else sees the behavior challenges that they face. When we have time to speak to each other without distractions then we can work out behavior plans.
- The opportunity to spend at least 1 full day a week in the class is helpful—having both formal and informal meetings is helpful.
- Established positive relationships with three of my teachers—These three better understand my role more than the fourth.

## 19. What could be improved?

**Teacher**
- My consultant has been great. I don’t feel like there are any weaknesses in our team approach.
- Formal meetings and help getting parents involved.
- Being in my classroom more than one day a week.
- As the year went on, I was worried that the consultant had too much work...our school has enough students rotating in/out that we could use a consultant four days a week.
- Would like more parent contact.
- I need to know more about how she sees progress or lack there of...in individual students, how/why/when would she like to meet with families and/or refer for counseling.
- I hope we get her right away to start the beginning of the year next year.
- Perhaps more information about what they are working on with targeted children.

**Consultant**
- Teachers need to understand the consultant role and function in the school and classroom. A clear plan based on the standardized tests would benefit and customize interventions for each class.
- More time for face-to-face with teachers.
- Some teachers and staff have unclear knowledge of what we do. Helping the rest of the school know how we help and things we do would help with overlap and gaps in services.
- Communication, role definition, time for discussion, referrals and follow-up.
Early Childhood Mental Health (ECMH) Program ECMH Program Staff Member

Script

Key assessment questions guiding interview:
6. How do ECMH consultants perceive the structure and appropriateness of the Early Childhood Mental Health (ECMH) Program?
7. Which interpersonal qualities support positive teacher-consultant relationships?
8. Which interpersonal qualities are essential for ECMH teacher-consultant teams to be successful?
9. What early challenges are associated with developing working relationships between teachers and ECMH consultants?
10. How do ECMH consultants think the program activities supported positive teacher-consultant relationships this year; can support them in the future going forward?

Hello. Thank you for letting me talk with you this morning/afternoon. My name is Holly Strickland and I work for Ohio University.

Today, I will be using an interview to collect your thoughts and feelings about the Early Childhood Mental Health Program. I hope this discussion can help us come to some conclusions about the teacher consultant’s general perception of the structure, accessibility, and appropriateness of the Early Childhood Mental Health Program. We are also interested in what can be done to improve the program as it moves forward.

As stated in the consent document that you signed, our discussion will be digitally recorded. The recording will be used for my reference only and will be erased once the research report is complete. Our reports to the Early Childhood Mental Health Program project team will not include names of participants, so your individual comments will be strictly confidential. Should you feel uncomfortable at any time during the discussion, remember that you do not have to contribute to the discussion. This interview will take approximately one hour. Do you have any questions or concerns about this procedure? (Wait for responses) If not, then let us begin.

1. Introductory Questions:
   D. As you entered the program this year, what were your expectations for the ECMH Program?
   E. Now, please take a minute to reflect on the ECMH Program you participated in this past year. How would you describe the ECMH Program to a co-worker, colleague, friend, or family member? Think of it this way: “I work(end) for an early childhood mental health program that … and my job was to … ”
      a. Probe for ECMH Program goals.
      b. Probe for individual roles and responsibilities.

2. Transition Questions:
A. It is clear that teacher consultants are a very important part of the ECMH Program. What did the program require of you? That is, what were your responsibilities for the Program?
   a. Probe for examples of program activity implementation
B. How often did you speak with your Preschool teacher(s) to conduct program activities?? What types of conversations did you have??
   a. Probe for formal meetings.
   b. Probe for informal meetings.
   c. Probe for who initiated each type of meeting.
   d. Probe for changes over time.
   e. Probe specifically for any type of teacher-initiated conversations
C. How would you assess the quality and content of your current communication with your teacher(s)?
   a. Probe for communication qualities, such as openness, trust, respect, teamwork
   b. Probe for adequacy and keeping each other informed
   c. Probe for content that relates to examples of joint problem solving of classroom and child issues
   d. Probe for a positive example
   e. Probe for challenging examples
   f. Probe for what interpersonal qualities were different between the two examples

3. Key Questions
   A. How would you describe your teacher (s)’s response to the ECMH Program?
      a. Probe for history of collaboration, recognized need
      b. Probe for qualities like hopefulness and anticipated success
   B. How would you assess the quality of your current relationships with your teacher (s)?
      a. Probe for interpersonal qualities, such as trust, compromise, collaboration, respect, team work etc.
      b. Probe for positive examples
      c. Probe for challenging examples
      d. Probe for the interpersonal qualities that were different between the two examples
   C. After reflecting on your experience this year, how do you think the program worked? How did you decide this??
      a. Probe for individual level (child) impacts.
      b. Probe for classroom impacts.
      c. Probe for teacher impacts.
      d. Probe for teacher consultant impacts.

4. Ending Questions
   C. Let’s say you were on a committee that was tasked with improving the ECMH Program in your school. You are responsible for both selecting and successfully pairing Preschool teachers with ECMH teacher consultants. What qualities do you
believe are essential for prospective ECMH teacher consultants to display in order to successfully work one-on-one with a participating Preschool teacher?

a. What qualities do you believe are essential for participating Preschool teachers to display in order to successfully work one-on-one with an ECMH teacher consultant?

b. What qualities in your current teacher-consultant team enhanced the relationship and would support future teacher-consultant pairings?

c. What qualities were missing from your current teacher-consultant team and should be considered in future teacher-consultant pairings?

d. What did not work well in your current teacher-consultant relationship and should be anticipated or avoided in the future?

e. If a new ECMH consultant joined your team at Tri-County, what advice would you give them?

D. Are there any other comments or concerns you would like to share with us? Was there a question that you hoped I would ask that I didn’t ask?

This concludes our discussion. I would like to thank you for participating. Your contribution is extremely helpful, and the ECMH Program team, Tri-County, our team at Ohio University, as well as your school district are greatly appreciative.
### Interview Analysis

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Key Indicator</th>
<th>Findings</th>
</tr>
</thead>
</table>
| In what ways do the ECMH program activities establish and advance a positive working | • Increase in frequency of teacher/ECMH consultation contacts  
• Increase in teacher-initiated consultations | • All consultants discussed the importance of the DINA program and how much teachers enjoyed the program  
• All consultants accurately described all components of the program model in detail, but discussed the challenges of effectively communicating what they do so it is understood by teachers and other school personnel.  
• Consultants talk with teachers every time they are at their sites (Minimum 1 day a week).  
• At the beginning of the year, consultants initiated most contact (by being on site), and communication was more formal.  
• By the end of the year, teachers were initiating contact: Respondent estimates vary ranging from 50-50...to 80% teacher initiated  
• In general, communication moved from more formal meetings to informal as the year progressed.  
• Although varies per teacher/per site, the majority of communication is informal conversations and is worked in between classroom activities  
• One respondent discussed having one school with quarterly structured, formal meetings with teachers/administration, but only informal teacher meetings at the second school...based on school “culture” and how it operates  
• Formal meetings do take place, but much less. One interviewee reported that this occurred primarily around discussion of tools (like the DECA), or around targeted children.  
• In general, interviewees felt that informal, on-going communication was better  
• Participants felt that communication between them and their teachers was adequate to good.  
• Other communication mentioned included e-mail (one respondent), texting (one respondent)  
• Teachers’ aides: One respondent discussed the inclusion of teacher aides and viewed this as essential; one reported working with one teacher aide. |
| d. What individual teacher and ECMHC factors are associated with the development of positive working relationships | e. Teachers and ECMHC both report an increased level of trust; having (+) problem-solving conversations. Teacher and ECMHC report working as a team and developing joint strategies to better serve children. Teachers and ECMHC are consistently cooperative and respectful of one another and work through conflicts. | • One participant discussed assessing teacher skill and matching the approach to that; and contributed in a way that complemented the teachers’ weaknesses. • Adaptability/Flexibility to the classroom/teacher mentioned by all participants. • Empathy to the teacher. • Self-awareness about own biases, abilities, etc. (one respondent) • Creativity • “You have to be a little extroverted in your approach.” • Patient, kind, good listener • The openness of the teacher, not just the consultant, is important to success • Teachers who are willing to “invest in this with me.” (one respondent); willingness to collaborate • One respondent discussed mutuality of flexibility, openness, creativity, and listening • Mutuality of respect • Importance of mutual focus of “putting child’s best interest first” mentioned by one respondent. • When teachers are under stress or have had a negative experience, then more time/care is needed in the relationship. • Importance of individualizing to the teacher/situation • Importance of consultants being consistent—being consistently present, consistent in communication strategies, etc. • Importance of building credibility as a consultant by having a few initial successes • Being willing to learn • “Pull your ego out of it.” • Voluntary nature of the program (one respondent). • Consultants perceived that the majority of teachers were receptive/interested in the program • Importance of giving teachers concrete, specific strategies to build investment and credibility. • One respondent mentioned the importance of being able to translate/communicate complex ideas about mental health and behavior in simple, concrete strategies for teachers. |

| (a) What early challenges are associated with developing working relationships between teachers and ECMHC’s | (b) Increase in frequency of teacher/ECMH consultation contacts. (c) Increase in the number of contacts recorded on consultation notes. | (d) Increase in teacher-initiated consultations. (e) Teachers and ECMHC both | • Challenge of communicating what the program is; the consultant’s role. When this isn’t understood well by a teacher it can lead to challenges/ differences in expectations. • When teachers are under stress or have had a negative experience, then more time/care is needed in the relationship (one respondent). • Challenge of two teachers at the same school who don’t get along with each other (one respondent). • Challenges with school administration in advocating for a child (one respondent). • One respondent mentioned the challenge of being new and building the relationship and credibility; felt it had been successfully achieved with three teachers through specific praise for teacher techniques and positive attribute identification. Mentioned credibility factors related to age/experience when this was misperceived by a very experienced teacher. • One respondent discussed how much easier the relationships developed with teachers who had similar personalities. |
(f) Teacher and ECMHC report working as a team and developing joint strategies to better serve children. Teachers and ECMHC are consistently cooperative and respectful of one another and work through conflicts.

- Developing comfortableness was mentioned by one respondent
- How to work with teachers who are less open, less friendly
- Challenge of understanding and managing different roles, “hats”
- One respondent discussed the special challenges with working with new teachers
- One respondent mentioned the challenge of “mental health” collaboration versus collaborations with speech, other specialized providers
- Challenge of teacher “buy-in” and establishing this; what are options when this isn’t happening.

(g) Teachers and ECMHC are consistently cooperative and respectful of one another and work through conflicts.

- Consultants were able to articulate the program components and their roles but all struggled with this early in the year, and continue to feel they and their teachers would benefit from continued clarification of these things
- All mentioned the critical importance of the ECMH team members to their work
- All mentioned that the Dina program was a key feature of the program that they valued and teachers valued
- All mentioned the impact to individual-targeted children as a measure of success as opposed to a change in a teacher/classroom construct....the importance of giving concrete behavior strategies for challenging children
- All interviewees felt that the program had been successful in forming relationships with teachers and positively impacting key children with challenges
- Challenge of working with parents/communicating with parents

Additional Findings about understanding of their ECMH Consultant role; and Program success
# Satisfaction Survey Results

(Total Teachers Responding: 8)

<table>
<thead>
<tr>
<th>Item</th>
<th>ECMHC Activities</th>
<th>Average Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Classroom screenings and observations</td>
<td>3 (Every Month)</td>
</tr>
<tr>
<td>2.</td>
<td>Individual child screenings</td>
<td>3 (Every Month)</td>
</tr>
<tr>
<td>3.</td>
<td>In-depth assessments of individual children</td>
<td>2 (Less than once a month)</td>
</tr>
<tr>
<td>4.</td>
<td>Developed service plans for children with special needs</td>
<td>2 (Less than once a month)</td>
</tr>
<tr>
<td>5.</td>
<td>Made referrals to community services</td>
<td>2 (Less than once a month)</td>
</tr>
<tr>
<td>6.</td>
<td>Attended management team meetings</td>
<td>3 (Every Month)</td>
</tr>
<tr>
<td>7.</td>
<td>Met with staff to discuss specific children</td>
<td>4 (More than once a month)</td>
</tr>
<tr>
<td>8.</td>
<td>Provided direct therapeutic/counseling to children/families</td>
<td>3 (Every Month)</td>
</tr>
<tr>
<td>9.</td>
<td>Conducted formal teacher trainings</td>
<td>2 (Less than once a month)</td>
</tr>
<tr>
<td>10.</td>
<td>Talked with parents</td>
<td>3 (Every Month)</td>
</tr>
<tr>
<td>11.</td>
<td>Provided support to staff for their own well-being</td>
<td>5 (Every Week)</td>
</tr>
<tr>
<td>12.</td>
<td>Provided informal training and assistance to teachers/staff</td>
<td>3 (Every Month)</td>
</tr>
<tr>
<td>13.</td>
<td>Met with staff to talk about general classroom issues</td>
<td>3 (Every Month)</td>
</tr>
<tr>
<td>14.</td>
<td>I have a good relationship with my consultant</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>15.</td>
<td>Consultant works as a partner with me</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>16.</td>
<td>Consultant seems like a member of the staff Not an outsider</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>17.</td>
<td>Consultant has good relationship with parents</td>
<td>2 (Somewhat Agree)</td>
</tr>
<tr>
<td>18.</td>
<td>Consultant works closely with parents</td>
<td>2 (Somewhat Agree)</td>
</tr>
<tr>
<td>19.</td>
<td>I regularly go to my consultant for help with children</td>
<td>2 (Somewhat Agree)</td>
</tr>
<tr>
<td>20.</td>
<td>Consultant is able to work with non-English speakers</td>
<td>NA</td>
</tr>
<tr>
<td>21.</td>
<td>Consultant respect’s my knowledge and perspectives on children’s issues</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>22.</td>
<td>The consultant is “part of the team.”</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>23.</td>
<td>Parents trust the consultant</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>24.</td>
<td>The consultant is available when I need him/her</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>25.</td>
<td>The consultant demonstrates an awareness of individual cultural factors</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>26.</td>
<td>Our program’s mental health consultation services have improved the quality of our classroom environment</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>27.</td>
<td>Our mental health consultation services help children with challenging behaviors</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>28.</td>
<td>Our mental health consultation services help families know how to cope with children’s challenging behaviors</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>29.</td>
<td>Our mental health services help staff feel less stressed</td>
<td>1 (Strongly Agree)</td>
</tr>
<tr>
<td>30.</td>
<td>Our mental health services and approach are in need of improvement</td>
<td>4 (Strongly Disagree)</td>
</tr>
</tbody>
</table>
## Comments on Open-Ended Questions

| 31. What does Consultant do that is most helpful | • Her personality and caring was helpful to build relationships with children. All children in the room enjoyed her presence. She offered me good advice. Parents she was able to contact reported back with positive comments  
• She is very helpful with ALL children in the classroom! She is very caring to ALL of the children! I enjoyed having her in my classroom very much  
• Works within classroom with certain children at center time; DINA program; targeted children and 1 on 1 with families  
• She does Dina school and introduces a lot of feelings awareness for kids. This has created a relationship with each student and the students look to her for guidance and support as much as the regular teachers  
• Easy access to mental health services for children and family support—families as they work through challenges raising young children  
• She is wonderful member of our classroom. She does so much that it’s impossible to pick just one  
• Consistently tries to reach parents to inform them of services available to help with their children |
| 32. Suggestions for improvement | • Work more with our parents  
• Start DINA program sooner in the school year  
• I hope we get her back next year  
• Figure out how to start right when the school year starts  
• More conversations about what parents are being taught  
• She came to our school with lots of experience with counseling and working in schools. She was a great match. The program is strong when there is an experienced consultant. The program is as good as the consultant. IF the consultant is not experienced or not comfortable working with low SES families the program is at risk of failure  
• This is a wonderful program this year. Many changes were made last year that made the program a success today. |
# Consultation Log

## Tri-County Mental Health ECMHC Evaluation Service Log

**Individual Mental Health Consultation-Specific Classroom Site Visit**

<table>
<thead>
<tr>
<th>Consultant Name:</th>
<th>School:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher Code:</td>
<td>Teacher:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th>Visit 1</th>
<th>Visit 2</th>
<th>Visit 3</th>
<th>Visit 4</th>
<th>Visit 5</th>
<th>Visit 6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Summary of Support Provided in Classroom** *(Fill in the bubbles for all that apply)*

- **Conduct Observation**
  - 0
- **Consult to parent(s) re: child specific issues**
  - 0
- **Consult to teacher(s)**
  - 0
- **Model classroom behavior management techniques**
  - 0
- **Train in formal workshop**
  - 0
- **Referral or collateral consultation**
  - 0
- **Other consultation**
  - 0
- **Other classroom activities**
  - 0

**Before/After Classroom Consultation**

<table>
<thead>
<tr>
<th>Total Minutes Before/After Classroom Consultation</th>
<th>Consult with principal</th>
<th>Consult with other school personnel (specify)</th>
<th>Phone calls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional Narratives:**

Adapted from Louisiana Service Log on 9/14/11
Consultation Data from Logs

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Total Teachers</th>
<th>Total Consultants</th>
<th>Consultant-Teacher Ratio</th>
<th>Total consultation time (hours)</th>
<th>Average hours of consultation per teacher</th>
<th>Average hours of consultation per consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-2011</td>
<td>10</td>
<td>2</td>
<td>1 to 5</td>
<td>535.5</td>
<td>53.5</td>
<td>268</td>
</tr>
<tr>
<td>2011-2012</td>
<td>11</td>
<td>3</td>
<td>1 to 3.5</td>
<td>2390</td>
<td>217</td>
<td>796</td>
</tr>
</tbody>
</table>

Consultation Break-Down

<table>
<thead>
<tr>
<th>Consultation Category</th>
<th>Percentage of Consultation Time Spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct Observations</td>
<td>20%</td>
</tr>
<tr>
<td>Consultation with individual parents (Not targeted children)</td>
<td>6%</td>
</tr>
<tr>
<td>Consultation to teacher on individual teacher requested topic</td>
<td>19%</td>
</tr>
<tr>
<td>Model classroom behavior management techniques</td>
<td>18%</td>
</tr>
<tr>
<td>Train through formal workshop</td>
<td>.9%</td>
</tr>
<tr>
<td>Consultation with a referral source/collateral school personnel</td>
<td>1%</td>
</tr>
<tr>
<td>Other types of consultation activities with teacher</td>
<td>16%</td>
</tr>
<tr>
<td>Conduct DINA/Incredible Years activities</td>
<td>20%</td>
</tr>
</tbody>
</table>
Appendix F: Building Capacity-Raising Resiliency

Outreach Grant The HRSA Outreach Grant Narrative
Submitted by Jane Hamel-Lambert, Sherry Shamblin, and Sue Meeks
NEEDS ASSESSMENT

National Need

Rural America, long known for its picturesque landscapes, often conjures images of quiet tranquility. This fabled portrait of rural life, however, masks the depths of hardship that many rural inhabitants face. Home to a vast array of stressors, rural America’s socioeconomic landscape is anything but idyllic. Poverty is pervasive, especially among more vulnerable populations such as the elderly and children. Relative to urban residents, rural Americans have fewer opportunities for employment; many who do work earn lower wages than their urban counterparts. Educational attainment is lower for rural residents as well; only 15% of rural Americans are college graduates as compared to 28% of urban adults (Office of Rural Health Policy, 2006). For those seeking mental health services, critical resources in rural areas are often unavailable, inaccessible or inadequate (New Freedom Commission on Mental Health, 2004), threatening the education and healthy development of our children.

In rural America, significant rural mental health workforce shortages are the rule rather than the exception; estimates indicate that 85% of mental health provider shortage areas are rural (Bird, Dempsey, & Hartley, 2001). Lacking human resources, rural mental health providers must manage higher caseloads across wider geographic areas than urban providers. Providers operating in shortage areas tend to focus on acute and emergent presentations, leaving preventive care to fall to the wayside (Office of Rural Health Policy, 2006). Mental health provider shortages also affect the general rural healthcare workforce, as primary care physicians, educators, nurses and other professionals struggle to treat consumers whose needs are complicated by socioemotional, developmental and mental health concerns.

It is estimated that eighty percent of all rural children live in areas without community mental health centers (Moore, Mink, Probst, Tompkins, Johnson & Hugley, 2005), and qualified specialty mental health providers are truly a scarcity in rural communities. Moreover, few mental health training programs emphasize the unique needs of serving rural children (U.S. DHHS, 1999). As a result, service delivery in rural areas is often fragmented and uncoordinated, and although a host of new evidence-based models of care offer hope to consumers and practitioners alike, the rural workforce often lacks the time and resources needed to learn them (www.annapoliscoalition.org, retrieved 9/24/08). The workforce serving these children faces demands that far exceed its capacity, and there is little evidence that this situation will improve in the near future (Huang, Macbeth, Dodge & Jacobstein, 2004; Huang, Stroul, Friedman, Mrazek, Friesen, Pires, & Maybert, 2005; McRee, Dowager, Briggance, Vance, Keane, & O’Neil, 2003).

Mental health, however, is fundamental to overall health and well-being. No one argues this statement put forth by The Surgeon General’s Report on Mental Health (1999). However, our nation has constructed a health care system that drives a wedge between health and mental health services. The divide runs deepest in our distressed and disadvantaged rural communities where health professional shortages, mental health professional shortage, unemployment, and stigma all contribute to growing health disparities. Innovative solutions that tightly align efforts to redesign the system that
delivers health and mental health care, while developing the capacity of the workforce to improve the quality of the care that consumers receive, hold the greatest potential for improving well-being (Wakefield and Moulton, 2008, unpublished).

Young Children: A population at-risk. For children, healthy development involves not only the absence of disease but also the ability to form healthy attachments, to cope with day-to-day challenges and to learn. Our nation is home to approximately 25 million children between the ages of birth and five years (http://childstats.gov, retrieved September 18, 2008) whom popular culture often depicts as infinitely resilient and well-equipped to survive adversity and stress. However, as many as 7-20% of preschool and early school aged-children exhibit behavioral problems that meet criteria for a mental health disorder (Ohio Department of Mental Health [ODMH], reported in Sites, Collopy, Velilla, Cayard & Graft, 2008). Despite these prevalence rates of mental health problems in childhood, national estimates indicate that 70% of children with diagnosable disorders do NOT receive mental health treatment (U.S. Public Health Service, 2000). Although many would protest the application of the term “mental health” to the population under age six, such a rebuttal fails to recognize the importance of early developmental experiences in establishing a solid foundation for relating to others and regulating one’s affect and behavior and for learning (Shonkoff & Phillips, 2000).

Furthermore, a growing body of evidence suggests that younger children are particularly vulnerable to the effects of psychosocial stressors, and that damaging effects on health are evidenced across the lifespan. In 1995, the Center for Disease Control and Prevention, in collaboration with Kaiser Permanente’s Health Appraisal Clinic, launched one of the largest epidemiological studies investigating the connections between exposure to traumatic childhood stressors and health in later life. Approximately 17,000 HMO members with an average age of 57 years participated in the Adverse Childhood Experiences (ACE) study, which collected information about adult patients’ current health status and self-reported experiences with traumatic stressors in childhood (Felitti, 2002). Researchers examined three main clusters of adverse experiences: Child Abuse (psychological, physical and sexual); Neglect (emotional and physical); and Household Dysfunction (domestic violence, substance abuse, household mental illness, incarcerated household members and parental separation or divorce).

Results indicated that:

- Adverse experiences in childhood are pervasive, with 66% of participants reporting at least 1 traumatic event, 25% reporting 2 events and 20% reporting 3 or more.
- Participants exposed to 1 adverse experience were 80% as likely to experience another.
- Greater exposure to adverse events is associated with worse health outcomes in adulthood. Those reporting ACE scores of 4 or more adverse events were 460% more likely to suffer from depression and 500% more likely to develop alcoholism than individuals with ACE scores of zero. Those reporting ACE scores of 6 or more were 250% more likely to smoke and 4,600% more likely to use intravenous drugs.
• With exposure to 7 or more adverse events, the risk of adult suicide attempts increases by 3,000% as compared to up to 5,100% for child/adolescent suicide attempts above the levels for ACE scores of zero.

• 60% of persons who report no adverse childhood events live to age 65 as compared to 3% of persons with 4 or more events (www.theAnnaInstitute.org, retrieved August 10, 2008; www.edc.gov/nccdphp/ace/findings.htm, retrieved September 24, 2008).

Investigators concluded that “without intervention, adverse childhood events result in long-term disease, disability, chronic social problems and early death” (emphasis added; www.theAnnaInstitute.org/ACE-HWB-CHART.htm, 8/23/08).

Recent developments in neurobiological research corroborate this conclusion and identify early childhood (ages zero to five) as a critical period in healthy brain development (Center on the Developing Child, 2007). Early childhood is considered a time of developmental “plasticity,” in which biological and environmental influences shape critical neural pathways in a child’s brain. The first three years of a child’s life build the foundation of cognitive, social and emotional development. During this time, children begin to learn how to identify and regulate emotions (www.developingchild.harvard.edu). From the ages of three to five, social, cognitive, and emotional development intensifies and a host of elaborate skills and behaviors appear. It is during this period that 85% of a child’s primary brain structure develops (PCSMAO Factbook, 2007-2008). Chronic exposure to adverse experiences can activate a series of prolonged physiological responses that could disrupt health brain development (www.developingchild.harvard.edu). “Toxic” stress, such as poverty, caregiver mental illness, household dysfunction and abuse “can result in a lifetime of greater susceptibility to physical illnesses…as well as mental health problems” (Center on the Developing Child, 2007, p. 9).

Social, Emotional, and Behavioral Problems in the Classroom. With 60% of younger children enrolled in daycare or preschool programs, it is not surprising that behavioral and emotional problems often manifest in these settings (Donahue, 2002; Huang et al., 2004). Many children arrive in preschool bearing the burden of multiple psychological and socioeconomic stressors, including household dysfunction, neglect, parental mental illness, and exposure to violence (Gilliam, 2005). By kindergarten, almost one-third of children across the nation have been exposed to three or more demographic risk factors associated with poor academic, social, and mental health outcomes later in life (National Summit on America’s Children, 2008, http://www.speaker.gov/issues?id=0032, retrieved 1/12/08). Social and developmental risks factors associated with early school failure include poor cognitive functioning, early behavioral problems, poor parenting skills, parental mental illness, and problematic relationships with parents, peers, and teachers (Huffman, Mehlinger & Kerivan, 2000). Strengthening the workforce’s capacity to help these children ensures healthy child development.

Too commonly, teachers and other school-based personnel are ill-equipped to manage the complicated psychological and behavioral problems emerging in their classrooms, a
problem further compounded by mental health professional shortages because childhood mental health providers are not readily available to assist teachers. When not properly trained, teacher, classroom aides and childcare providers may elect to punish “bad behavior,” which can re-traumatize the child or inadvertently reinforce the behaviors that the teacher sought to extinguish. Access to mental health consultation is one solution, but national research indicates that only 27% of preschool teachers have access to childhood mental health consultation services (Gilliam, 2008).

For preschool-aged children, the consequences of untreated behavioral and mental health problems are striking. A landmark study of preschool expulsion rates revealed that preschool-aged children are expelled at a rate three times greater than the national rate for students in grades kindergarten through twelve (Gilliam, 2005). Teachers with high expulsion rates also reported elevated levels of job stress and large (more than eight) class sizes.

Hope, however, remains. For children and the providers who serve them, one promising and innovative solution to early school failure is Early Childhood Mental Health Consultation. As Gilliam (2008) notes, “Early childhood mental health consultation (ECMH-CL) may be an effective means for decreasing the likelihood that children with challenging classroom behaviors will be expelled or suspended.”

Cohen and Kauffman (2000) define ECMH-CL as a “problem-solving and capacity-building intervention” that occurs between a qualified consultant and children, teachers, and other staff in a preschool or childcare setting (p. 4). ECMH-CL aims to improve the ability of staff, programs and families to prevent, identify and address mental health problems occurring in children ages zero to six. ECMH-CL consultants provide two broad levels of services: In Child/Family Consultation, school staff request guidance in managing problems that specific children or families pose. The consultant first identifies the problems that interfere with a child’s ability to function in a daycare or preschool setting and, in conjunction with the referring staff member, creates an individualized treatment plan. Child/Family Consultation may also result in individual assessment and treatment for children and families either on-site or in appropriate mental health settings. The second level of ECMH-CL service, Programmatic Consultation, aims to develop the capacity of early childhood providers to manage social, emotional, and behavioral issues (Green, Everhart, Gordon & Gettman, 2006). Examples of programmatic consultation services include creating staff development plans, helping staff to manage job-related stress, facilitating teacher-family communication, and train staff in the cognitive, emotional and psychological development of young children.

ECMH-CL has demonstrated effectiveness in significantly reducing teacher-rated behavioral problems (most notably, hyperactive and oppositional behavior) in the classroom. Five-year outcome data from Connecticut’s Early Childhood Consultation Partnership (ECCP) program, which provided consultation services to 111 classrooms serving 1,400 children each year, showed that 88% of teachers reported “modest” to “great” improvements in behavior for children targeted for poor behavior during the pilot year. Gains were sustained in subsequent years under a more rigorous randomized crossover design; significant decreases in teacher-rated behavioral problems (most notably, hyperactive and oppositional behavior) were observed in children in classes
receiving ECMH-CL as compared to children in classrooms without ECMH-CL services (Gilliam, 2007). In a qualitative investigation of three Head Start programs, Green, Simpson, Everhart, Vale and Gettman (2004) found that mental health consultation reduced negative behavior in children when the consultant shared a positive relationship with teachers and staff and was well-integrated into the daily functioning of the program.

Consultation programs have also been shown to improve teacher perception of classroom quality, as well as teacher confidence in dealing with behavior problems. In 2003, Alkon, Ramler and MacLennan’s evaluation of the California’s Early Childhood Mental Health Initiative (ECMHI) revealed that teacher and staff-perceptions of site quality improvement occurs only after repeated contacts with mental health consultation services. Alkon and colleagues (2003) also found significant increases in teacher self-efficacy over the course of their two-year ECMH-CL study, as measured by the Teacher Opinion Survey (TOS; Geller & Lynch, 1999).

Unfortunately, only 27% of Pre-K teachers report regular classroom access to a mental health consultant.” (Gilliam, 2008).

**State Mental Health and Preschool Initiatives.** In Ohio, approximately 240,000 children below age 18 need mental health treatment, [http://www.vfcoh.org/cms/resource_library/whitepapers](http://www.vfcoh.org/cms/resource_library/whitepapers), yet only half of them receive it. Nationally, as many as 7-20% of preschool and early school aged-children exhibit behavioral problems that meet criteria for a mental health disorder (ODMH, reported in Sites, Collopy, Velilla, Cayard & Graft, 2008), but estimates indicate that 70% of children with diagnosable disorders do NOT receive mental health treatment (U.S. Public Health Service, 2000).

Ohio public preschools served 1% of 3 year olds and 3% of 4 year olds in 2007. With federally funded Head Start programs added to the picture, 21% of eligible children are served. Initiated as the Ohio Public School Preschool Program in 1990, and renamed the Early Childhood Education program (ECE) in 2005, Ohio public programs offer free educational services to families with incomes up to 200 percent of federal poverty level. Families above 100% of the federal poverty level can enroll on a sliding fee basis. The National Institute for Early Education Research (NIEER) State of Preschool 2007 report indicates Ohio spent $2515 per 4-year-old pupil, less than the national per pupil average expenditure of $3642, and markedly below the nation’s leader, NJ, which spend over $10,000 per pupil. Ohio Head Start per pupil expenditures are reported at $6797. Not surprisingly, Ohio is ranked 36th in the nation for access to public preschools. (State of Preschool 2007 retrieved on October 12, 2008 from [http://nieer.org](http://nieer.org))

Improving access to public preschools and maintaining quality standards both top the agenda of the NIEER. Quality standards include adoption of early learning standards, teacher and staff educational levels, hours of available in-service training, class size, staff-teacher ratios, availability of supportive services (e.g., vision, hearing, developmental, dental and parent engagement), nutrition and oversight monitoring by the state. ([http://nieer.org](http://nieer.org)). Ohio only achieves four of these benchmarks.
“Mental health partnerships with schools are …an effective method of helping children succeed. By providing information and support to teachers about children’s mental health issues, mental health professionals in [schools] alleviate behavioral difficulties in both academic and home settings.” (ODMH, 2002)

In 2001, Ohio Access’s Strategic Plan called for an increased focus on (1) behavioral health, (2) prevention of disability, and (3) enabling every child to succeed. The strategic plan highlighted: expanding early intervention for children, serving more people in community programs, and providing additional training for teachers who work with children with disabilities. To meet these mental health needs of Ohio’s young children, ODMH invested in an ECMH-CL Initiative beginning in 2001. This Initiative primarily focused on mental health consultation as a service delivery model. The Initiative has since been expanded to all 88 of Ohio’s counties and continues to provide ECMH-CL services to young children and early childhood service providers. Despite its successes, the Initiative has much room for growth, especially increased availability of services. ODMH’s 2007 report identified that 433 childcare centers, 206 Head Start programs, 147 Public and Private Preschools, 63 public children’s services agencies and 170 other programs (Help Me Grow, Family Home Child Care providers, etc.) received ECMH-CL. During that year, Public Preschools comprised only 15% of the early care and education programs that received services. A 2006 report identified the most common barriers to the implementation of early childhood mental health services. These barriers included lack of funding, workforce shortages, and lack of qualified mental health workforce members experienced in young children and early childhood systems (Himmeger, 2006).

Despite limited availability of resources, the EMCH-CL Initiative launched by the ODMH has successfully served those children whom they reach. In 2006-07, across the state, consultations were provided to “1163 children at risk of removal from the early childhood setting….90% were maintained.” An additional 929 children were referred for further mental health intervention, the “most common referral” (p.9-10). Ohio’s experiences are echoed locally in Athens County. Our county shares one full-time ECMH consultant with two additional counties. Employed by the local community mental health clinic, in 2007-2008 she provided consultation for 40 early childhood settings predominantly serving Head Start classes and Help Me Grow, an agency serving children three years and younger with special needs. Although resources are limited, they effectively provided early childhood consultation to Head Start classes by offering classroom focused consultation, individual child consultation, a variety of staff trainings, and individual child consultation (Himmeger, 2006; 2007).

All local school superintendents (2 are consortium members for this proposal) strongly endorse improving access to mental health services in our community. In August 2008, in preparation for the Governor’s educational regional forums, “Governor Strickland’s Conversation on Education”, the superintendents from the Athens County school districts issued a formal statement of six principles for educational reform. First and foremost was:

“Implement policy changes that allow the delivery of social mental health and behavioral health services in public schools. (a) Adopt rule, regulation and
policies that allow schools and local service agencies high levels of flexibility in creating effective and efficient service delivery systems that meet local and regional needs (letter provided by John Constanzo, Superintendent, AMESC, personal communication, 9/7/2008).

Regional and Local Need

Of the 88 counties in Ohio, 29 are Appalachian, including Athens County, which is classified as an eligible rural community by its zip code (45701). Additionally, Athens County faces significant workforce shortages. It is classified as a Mental Health Professional Shortage Area (MHPSA), a dental health professional shortage area and a Medically Underserved Area (MUA). (http://bhpr.hrsa.gov/shortage; http://muafind.hrsa.gov/index.aspx). Additionally, the Appalachian Regional Commission classifies Athens as “At-Risk,” the second most severe economic classification (www.arc.gov, retrieved 9/18/08). At its best, the workforce that serves our region’s rural Appalachian children is heavily burdened. At worst, it is chronically beleaguered. Our local educators, human services professionals, pediatricians and childhood mental health professionals operate within a socio-economic landscape rich in risk but poor in resources, particularly human resources.

The complexity of the socioeconomic and mental health challenges confronting families in our region is best illustrated by the histories that accompany children into the welfare system, and by default into the classroom. In an unpublished report, *A Snapshot in Time*, written by the Athens County Family and Children First Council in 2007, open child welfare cases were characterized as follows: 66% involved alcohol and drug abuse, 46% involved domestic violence, 39% involved parental depression and 82% lacked appropriate social support placing children in these homes at high risk for child traumatic stress and subsequent developmental, academic, and mental health difficulties. Of the active child abuse cases in Athens County in 2007, 6.4% are estimated to involve children under the age of five. Reports of child abuse in 2007 reflected a 21% increase over the previous year in Athens County; 99% of the substantiated cases fell below the poverty guidelines (*Family & Children First Council Planning Guide*, 2005, unpublished report). Nine percent of the substantiated abuse cases were for physical abuse, 25% for neglect, 11% for sexual abuse, 2% for emotional maltreatment and 53% for dependency/other. (2007-08 Public Children Services Association of Ohio Factbook, retrieved electronically on Oct 3, 2008 from http://www.pcsao.org/factbook2007_2008.htm).

Persistent poverty compounds the risk for children in our region. Athens County’s 2005 poverty rate was 31.5%, the highest poverty rate in the state. The table below compares demographic characteristics of our area, to state and national data.

<table>
<thead>
<tr>
<th>Quick Facts</th>
<th>NATION</th>
<th>OHIO</th>
<th>Athens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population (2006)¹</td>
<td>299,398,484</td>
<td>11,478,006</td>
<td>62,062</td>
</tr>
<tr>
<td>% of all ages in poverty (2005)²</td>
<td>13.0</td>
<td>13.3</td>
<td>31.5</td>
</tr>
<tr>
<td>% families, with child &lt;5 yr. old, below poverty (2006)³</td>
<td>15.9%</td>
<td>15.9%</td>
<td>29.3% Congressional District 6,</td>
</tr>
</tbody>
</table>
Data collected through the Well-Child/Well Family community health program at Ohio University further demonstrates that a significant proportion of parents accessing care for their children’s behavioral health concerns report personal histories of mental health problems and trauma.

Well-Child/Well Family Data Summary, 2003 – 2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Child Referrals</th>
<th>% Child History of abuse</th>
<th>% Parent History of abuse</th>
<th>% Parent have Mental Health Diagnosis</th>
<th>% Family History of Domestic Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003-04</td>
<td>60</td>
<td>No data</td>
<td>37%</td>
<td>45%</td>
<td>45%</td>
</tr>
<tr>
<td>2004-05</td>
<td>56</td>
<td>11%</td>
<td>39%</td>
<td>52%</td>
<td>41%</td>
</tr>
<tr>
<td>2005-06</td>
<td>33</td>
<td>No data</td>
<td>27%</td>
<td>45%</td>
<td>33%</td>
</tr>
<tr>
<td>2006-07</td>
<td>37</td>
<td>11%</td>
<td>51%</td>
<td>73%</td>
<td>30%</td>
</tr>
<tr>
<td>2007-08</td>
<td>32</td>
<td>16%</td>
<td>34%</td>
<td>47%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Lastly, a similar profile emerges for children attending our local head start programs. The report identified the following risk factors for children involved with the regional behavioral health system (MACRO International, April 1999): history of family violence (56%), family history of mental illness (52%), family history of substance abuse (65%), parent/caregivers have a previous psychiatric hospitalization (40%), one parent who has a felony conviction (24%), sibling who was previously institutionalized (14%) and a sibling in foster care (13%). Child Risk Factors included history of suspected physical abuse (32%), history of suspected sexual abuse (23%), previous psychiatric hospitalization (15%), ran away from home (21%), abused drugs or alcohol (20%) and harmed themselves earlier in their lives (19%).

Taken together, the data challenge our community to create an innovative program that simultaneously improves the health outcomes for our youngest residents, many of whom are at risk for socioemotional, learning and health problems, while increasing the capacity of our workforce to address mental health needs of the population. This grant proposal expands the efforts of our rural health network, Integrating Professionals for Appalachian Children (IPAC), aimed at developing integrated health delivery systems
(e.g., public pre-schools and mental health agencies) and leveraging the infrastructure established and lessons learned through our RHND grant. Our consortium is composed of a subgroup of IPAC, bringing together our community mental health center, Ohio University’s College of Osteopathic Medicine and Psychology & Social Work Clinic, public school teachers and administrators, and families in a jointly planned initiative to demonstrate the feasibility and effectiveness of a school-based, early childhood consultation model for integrating education and mental health services.

Description of the Target Population

Our proposed activities, aimed at improving early childhood outcomes and increasing the capacity of early childhood educators to address mental health issues in the classroom, will be accomplished through two objectives: (1) the implementation of a comprehensive ECMH consultation program (ECMH-CP) and (2) a workforce development initiative.

First, the ECMH-CP will serve approximately 299 preschool-aged children between the ages of 3 and 5 each year enrolled in 19 classrooms. These classrooms are cooperatively managed by the Athens City School District and the Athens-Meigs Educational Service Center. In total, children from four school districts are included in this proposal: Athens City, Federal Hocking, Trimble and Alexander (see map, below). In addition, the 19 teachers, 8 aides, and other related school employees will receive training through consultation and intervention services in the public preschool classrooms. Consultation services will provide universal (delivered by the teacher for all the children in the class), targeted (delivered by the teacher to meet the needs of a specific child) or intensive (delivered by a specialized professional to meet the needs of a specific child) interventions depending on the child’s needs with a predicted rate of utilization of 80%, 15% and 5%, respectively. Parents and families of young children offered targeted or intensive services will be provided health education to build awareness, increase understanding of his/her child’s behavioral problems and facilitate participation in recommended mental health services. 22% of the children have enrolled in these public preschool have Individualized Education Plans (IEPs) for special education services (based on 08-09 enrollment data). Consistent with national data, the majority of students qualify for special education services for communication and language-based disorders. In Athens City and Athens County schools approximately 50% of the IEPs include behavioral goals, and 20% are specifically for children with severe emotional disorders. (S. Johanson, school psychologist, personal communication, October 3, 2008). Lastly, 41% of the children enrolled in these public preschools qualify for the federal free and reduced lunch program by meeting incomes guidelines (130% of the poverty level and 130-185%, respectively).
The second objective is to implement a workforce development initiative to strengthen and advance the competencies of our early childhood workforce. The workforce development initiative utilizes a mixed-matrix design recognized to best support professional development. Using high quality didactic trainings, videoconferencing, collaborative peer support groups, supervision and learning communities, our training activities build a range of competencies for our early childhood workforce including public school teachers, aides and administrators, mental health professionals and family care navigators. Nine of the preschool teachers have a Bachelor's Degree and hold certification as Highly Qualified teachers, one has a Bachelor's and is working toward certification, and 10 preschool teachers have Masters Degrees in a variety of areas. All 20 classroom aides have Paraprofessional Certification and an Educational Aide Permit from the state.

Community Involvement in Identifying Need

The proposed ECMH-CP will leverage the efforts of Integrating Professionals for Appalachian Children (IPAC), our rural health network, which serves as a regional planning body providing a platform for effective collaboration among its participating agencies. Maximizing the effectiveness and efficiency of scant resources through collaboration is valuable in the best of times; it is essential in the current economic climate.

IPAC, which began meeting in October 2003, is a community-consumer-university vertical network with representation from primary care physicians, mental health and allied health professionals, an early childhood specialist and intervi
superintendent, as well as consumers and agencies that provide oversight to the social service and mental health system. To advance our goal of becoming a self-sustaining network, IPAC incorporated in 2006 and was awarded 501c3 status in 2008. IPAC is governed by an independent board of directors. Its membership represents seven constituency groups, 15 community-based organizations, and four colleges from Ohio University. Initially a collaborative heavily weighted with university representation, our group membership currently is 70% community and 30% university.

IPAC’s vision is to ensure healthy development of all children. As a network of professionals and consumers working collaboratively to improve the health and mental health of children and families in Appalachia Ohio, IPAC aims to improve our community’s ability to meet the health and mental health needs of children by leveraging our expertise and integrating our resources. To achieve this vision, IPAC develops innovative, culturally sensitive programs that address the critical and complex challenges impacting the health and mental health of our region’s children and families. With the generous support of the Office of Rural Health Policy, IPAC has set forth an ambitious strategy for accomplishing clinical integration across partners that involves sharing clinical protocols, jointly conducted trainings, community-wide development surveillance efforts to foster early identification of young children with special needs and the development of programmatic infrastructure that supports (a) the co-location of mental health providers in primary care providers, (b) an interdisciplinary assessment team and (c) a Family Navigator Program. With significant progress in establishing secure infrastructures for each of these clinical programs, we now propose to expand our efforts and implementation an ECMH-CL, leveraging the Family Navigator Program and the Interdisciplinary Assessment team, as well as an early childhood workforce initiative.

Our planning efforts have been guided by our mission, our core values of collaboration, access, and integration and the principles of Community Based Participatory Research (CBPR), an approach to research that equitably involves community members and academic representatives in a collaborative process, informed our planning process (Israel, Eng, Schulz, & Parker, 2005).

Community Readiness Assessment. In 2006, IPAC commissioned the Ohio University Voinovich School of Leadership and Public Affairs to conduct a Community Readiness Evaluation which involved interviewing 20 professionals and 15 consumers. Most participants agreed that young children in need of services often do not receive the services they need. Qualitative data summarized below lists the reasons cited (Community Readiness Assessment, 2006):

* Providers and parents lack of knowledge about the specific behavioral and developmental needs of very young children;
* Providers operate in silos, providing services in their area of expertise with little connection to other professionals;
* Providers don’t have sufficient time or funding to provide all needed services;
* Communication gaps between providers in different disciplines;
Providers don’t have sufficient time to coordinate services among different systems, or coordination of activities cannot be billed or reimbursed under the current funding structure;
* Parents are overwhelmed and confused about what services are available and where;
* The system of care is difficult for a parent to manage without assistance;
* Rural isolation and transportation can serve as barriers.

**2008 Consumer Focus Groups.** In January and April of 2008, two focus groups were held. The first group involved 15 parents discussing individual experiences regarding communicating with health professionals about mental health issues. The second focus group involved 3 parents and 3 professionals developing questions for a moderator guide for use in understanding how health communications effect mental health service utilization by families of young children with developmental or behavioral health needs.

Results from the first group highlighted difficulties parents encountered when talking to physicians who they perceived as unwilling to take the time to explain the rationale behind a referral to mental health services, the justification for behavioral diagnoses, or to provide adequate anticipatory guidance to families to facilitate engagement of recommended. The second group highlighted three points: (1) it is difficult to know where to find services; (2) it is easier to think of your child’s difficulties as being related to school and learning, than mental health and behavior, which was related to stigma and (3) the supporting resources of specific community professionals provided valuable support and education to families who are struggling with decisions about recommended health care services.

Specific barriers to accessing recommended services were highlighted in both discussions. Issues that interfere with accessing mental health services include: privacy and confidentiality concerns; stigma; parents’ inability to discriminate between purposeful bad behavior vs. symptomatic behaviors (of ADHD, autistic spectrum disorders, traumatic stress); concerns that others will see you as a bad parent, or self-perceptions that you see yourself as a bad parent; self blame and guilt over past parenting mistakes or the decision to get divorces/separated; concerns that your child will be put on medication; beliefs that parents should be able to “work it out themselves;” and anxiety that Child Protective Services would get involved.

**Outreach Proposal Planning Activities.** In June 2008, participants of IPAC formed an Outreach Planning Committee to review the Rural Health Care Outreach guidelines, generate preliminary ideas and create a process for developing this proposal. Members included representatives from the Ohio University College of Osteopathic Medicine (OUCOM) and Psychology & Social Work Clinic (PSWC), Tri-County Mental Health and Counseling Services (TCMH-CS), Help Me Grow (HMG), Health Recovery Services (HRS), The Southeast Ohio branch and the Autism Society of America (SEO-ASA), and the Southern Consortium for Children (SCC). Email and phone communications complimented our planning meetings, as we moved through defining the scope of work, designing programs that blended together evidenced-based practices and community
needs, identifying existing resources that could be committed to the project, and ending with two meetings among the consortium members specific to sustainability issues requiring, not only acknowledgement at this point of planning, but also commitment to negotiating a contractual solution by the end of the grant period.

Without IPAC and our history of working collaboratively, the cooperative planning needed to support the development of this proposal would not have been possible. This is especially true with regard to addressing long-term sustainability. Direct communication regarding this issue was possible because of the trust that has been built among the agencies and in IPAC’s leadership. The resulting Consortium includes OUCOM and PSWC, TCMH-CS, Athens-Meigs Educational Service Center, the Athens City Schools, which are all IPAC-associated agencies. The table below presents a summary of the planning activities. The specific input of the preschool teachers follows, balancing the voice of the consumers – both who are target audiences for our project.

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Agencies/Constituencies Represented</th>
<th>Number Participants</th>
<th>Ratio of Attendees: Community to University</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/11</td>
<td>IPAC Board Meeting</td>
<td>OU, FCFC, SCC, TCMH-CS, Cooley, 2 Parents, AMESC, UMA, FHI, HMG, ACS</td>
<td>15</td>
<td>66% / 33%</td>
</tr>
<tr>
<td>6/11</td>
<td>Outreach Planning Committee Meeting</td>
<td>HMG, TCMH-CS, SCC, OUCOM, OU-PSWC</td>
<td>5</td>
<td>60% / 40%</td>
</tr>
<tr>
<td>6/26</td>
<td>Outreach Planning Committee Meeting</td>
<td>HMG, TCMH-CS, HRS, SCC, OUCOM, OU-PSWC</td>
<td>6</td>
<td>50% / 50%</td>
</tr>
<tr>
<td>7/2</td>
<td>IPAC Board Meeting</td>
<td>HMG, UMA, TCMH-CS, FCFC, SCC, AMESC, ACS, UMA, OU, HRS, Judge, SEO-ACA, PP</td>
<td>16</td>
<td>62% / 38%</td>
</tr>
<tr>
<td>7/10</td>
<td>Discussion CBPR Learning Group</td>
<td>FCFC, &amp; OUCOM, OU-PSWC</td>
<td>3</td>
<td>33% / 67%</td>
</tr>
<tr>
<td>7/17</td>
<td>Outreach Planning Committee Meeting</td>
<td>HMG, HRS, TCMH-CS, FCFC, OU</td>
<td>8</td>
<td>50% / 50%</td>
</tr>
<tr>
<td>7/24</td>
<td>Outreach Planning Committee Meeting</td>
<td>HMG, TCMH-CS, OU</td>
<td>5</td>
<td>40% / 60%</td>
</tr>
<tr>
<td>7/30</td>
<td>Consult. with FCFC</td>
<td>FCFC &amp; OU</td>
<td>2</td>
<td>50% / 50%</td>
</tr>
<tr>
<td>8/1</td>
<td>Outreach Planning Committee Meeting</td>
<td>SEO-ASA; HMG, TCMH-CS, OU</td>
<td>7</td>
<td>43% / 57%</td>
</tr>
<tr>
<td>8/5</td>
<td>IPAC Board Meeting</td>
<td>OU, FCFC, Accountant, HMG, TCMH-CS</td>
<td>10</td>
<td>50% / 50%</td>
</tr>
<tr>
<td>8/5</td>
<td>Workplan meeting</td>
<td>OU, TCMH-CS</td>
<td>2</td>
<td>50% / 50%</td>
</tr>
<tr>
<td>8/18</td>
<td>Meeting w/TCMH</td>
<td>TCMH-CS, OU</td>
<td>2</td>
<td>50% / 50%</td>
</tr>
<tr>
<td>8/21</td>
<td>Consult-Athens City</td>
<td>ACS, OU</td>
<td>3</td>
<td>33% / 66%</td>
</tr>
<tr>
<td>8/28</td>
<td>Consult. w/TCMH</td>
<td>TCMH-CS, OU-COM</td>
<td>2</td>
<td>50% / 50%</td>
</tr>
<tr>
<td>9/7</td>
<td>AMECS consult</td>
<td>AMECS, TCMH-CS, OU-COM</td>
<td>5</td>
<td>60% / 40%</td>
</tr>
<tr>
<td>9/2</td>
<td>IPAC Board Meeting</td>
<td>OU, HMG, TCMH-CS, AMESC, ACS, Parents, Judge, FHL, SCC, UMA</td>
<td>17</td>
<td>59% / 41%</td>
</tr>
<tr>
<td>9/10</td>
<td>Athens City School</td>
<td>ACS, OUCOM</td>
<td>7</td>
<td>72% / 28%</td>
</tr>
<tr>
<td>9/15</td>
<td>Preschool Meeting</td>
<td>AMECS, TCMH-CS, OUCOM</td>
<td>19</td>
<td>94% / 6%</td>
</tr>
<tr>
<td>10/1</td>
<td>IPAC Board Meeting</td>
<td>OUCOM, HMG, TCMH-CS, ACS, Parents, FHL, SCC, UMA, Accountant</td>
<td>13</td>
<td>85% / 15%</td>
</tr>
<tr>
<td>10/1</td>
<td>LOC meeting</td>
<td>TCMH-CS, OUCOM</td>
<td>3</td>
<td>67% / 33%</td>
</tr>
<tr>
<td>10/9</td>
<td>LOC meeting</td>
<td>TCMH-CS, AMESC, ACS, OUCOM</td>
<td>6</td>
<td>83% / 17%</td>
</tr>
</tbody>
</table>

ACS=Athens City Schools; AMESC=Athens-Meigs Educational Service Center; FCFC=Families and Children First Council; FHI=Family Healthcare Inc; HMG=Help Me Grow; HRS=Health Recovery Services, Inc.; OUCOM=Ohio University (Applicant Agency) College of Osteopathic Medicine; OU-HHS=OU College of Health and Human Services; OU-PSWC=Psychology & Social Work Clinic; Judge=IPAC ex-officio board member, Judge Robert Stewart; PARENT=IPAC Parent Board Member representative; PP=Planned Parenthood; SCC=Southern Consortium for Children; SEO-ASA=Southeastern Ohio Chapter of Autism Society of America; TCMH-CS=Tri County Mental Health and Counseling Services; UMA=University Medical Associates
**Teacher Input.** In September 2008, members of the Outreach Planning Committee joined preschool teachers and their coordinators at two district staff meetings. The first meeting involved three Athens City preschool teachers, a school psychologist and the Director of Special Services. Teachers identified several perennial problems ranging from oppositional behavior to the emotional sequelae of childhood trauma and neglect that compromise effective teaching. Yet despite the severity and urgency of these problems in the classroom, teachers framed them more as symptoms of a much larger challenge: family dysfunction. One teacher noted that many of her children are raised by single mothers, grandparents, or a revolving set of caregivers. Another teacher noted that substance abuse, mental health issues, deficits in parenting skills and overall economic hardships are becoming increasingly common in her students’ families. These problems, teachers noted, make it difficult to for them to actively involve parents in their children’s educational and developmental goals. Teachers often feel that gains made in the classroom have little chance of surviving the chaos and dysfunction of the family environment.

Results from the second meeting, which included 14 Athens County preschool teachers and their District Coordinator, corroborated these observations of their colleagues. Throughout the course of the discussion, four issues emerged: (1) teachers are often surprised by the frequency of substantiated or suspected cases of child abuse and trauma in their classrooms; (2) several children have incarcerated or drug-addicted members of their immediate families; (3) children with undiagnosed emotional and/or cognitive delays pose significant challenges for teachers and other students alike; and (3) coordinating care with parents and other family members is often anxiety provoking and frustrating for teachers.

Our findings indicate that our preschools teachers would welcome an ECMH consultant in the classroom to help them address behavioral challenges they encounter in their classrooms. Moreover, those supports should include outreach to families, not simply to address the specific of the child’s behavior, but to deal with the issues surround that child in the home. In their own words,

“.. I do have concerns about children who come to my classroom with social emotional delays and find that it is a challenge at the very least. Many things that I try in the classroom sometimes do not get intended results. ….The more support I can receive to help children who are in distress or are having such delays as social emotional problems, the better I learn about the best approach to serve them. K.B., 9/26/08.

“Wouldn't it be wonderful if we could get some mental health help for our students and their families …. (not to mention those of us teachers who also need support in order to encourage and support the children and their families!!) .... I had a student last year who displayed some autistic tenancies. I am not very knowledgeable about the autism spectrum, but I knew something was definitely going on with this student....How wonderful it would have been to have someone to ask to come and casually observe her, to interact with her, to inform and educate me and her parents...” S.W., 9/24/08.
“…We have needed this for years. I don't think a lot of people realize how many children at the preschool age have mental health issues. Actually after 16 years it still amazes me.” J.C., 9/25/08.

**Relevant Barriers to Services That We’ll Overcome**

Poverty, the stigma surrounding mental health, fragmentation of care, and a general lack of access to and awareness of services continue to separate Appalachian children and their families from the services they need. Efficient and effective use of existing resources, accomplished through clinical integration, is imperative. Transportation barriers and stigma are both minimized through the integration of our proposed ECMH consultation program into the schools. The cost of accessing services, incurred by the consumer, is also decreased by providing multiple services in the schools, particularly in light of escalating gas prices and a deteriorating economy. Additionally, the stigma associated with accessing mental health services are attenuated when those services are offered in non-mental health settings. The comprehensive inclusion of specialized diagnostic assessment services as part of our comprehensive early childhood consultation program will prevent families from having to travel to tertiary care settings for neuropsychological assessment services, which typically involves a waiting period of 12 months or longer, traveling long distances, and working with providers with little knowledge of local resources. Moreover, integrated services prevents children from being pulled out of school to receive mental health care resulting in less disruption to the child’s education.

The Institute of Medicine Report *Crossing the Quality Chasm* (2001) recommends workforce development strategies focus on improving the “health readiness” of rural residents. Our Family Care Navigator (FCN) ensures that local families receive the assistance required to fully understand the care they are receiving, the services they need, and how to access those services in a sensitive and culturally competent manner. In this proposal, we expand the role of the FCN, taking her out of her medical-school office setting and integrating her as part of our comprehensive, school-based ECMH consultation team, offering parent support and assistance in understanding child behaviors, especially those related to past trauma exposure. Being an Appalachian native, her understanding of the communication patterns and values of the region is critical to offering education and guidance in a manner that it is accepted by others. Providing information on the benefits of early intervention will assist parents in viewing ECMH services as valuable; seeing value is a fundamental step in engaging and participating in recommended services. Focusing on the topics identified through her experience working with families with extensive trauma histories and educating families about the insidious influence those experiences exert is central to this proposal. Designed to overcome the barriers of ignorance and denial, parent sessions with the FCN will build parent awareness of how the sequelae of trauma mimics many common childhood mental health disorders and how misidentification of disorders leads to the wrong intervention and continued problematic behaviors. Thus, her role enhances the health readiness of the community, in addition to facilitating access to recommended services.
Services Currently Available

Athens County’s mental health providers include Tri-County Mental Health and Counseling Services and Health Recovery Services, Inc. TCMH, our consortium member, serves Athens, Hocking and Vinton counties, providing the full range of mental health services to children, adults and families. Over the past seven years, TCMH has been developing its ECMH service continuum. Their ECMH specialist, who is funded by the state, has been providing consultation to Head Start Programs in Athens County and has led the IPAC efforts to continue to strengthen our community’s ability to identify and to provide comprehensive care to young children in our region. Through these efforts, IPAC has successfully developed a developmental surveillance program providing screenings to children through childcare and preschool settings across four counties.

Athens County residents are also served by Health Recovery Services, Inc., which also holds a seat on IPAC’s Board of Directors. Although the agency is involved in IPAC’s efforts to co-locate mental health providers in primary care setting and endorses this proposal, it is not involved in this ECMH proposal as the agency does not have ECMH providers. Therefore, it is not in direct competition in this market, and it is likely to benefit from referrals of parents in need of mental health and substance abuse treatment.

The proposed activities will positively impact the consortium members and the preschool children. Whereas preschool teachers will have supportive mental health services in the classroom, families will have readily available specialized services. The partnership between the mental health center and the schools enables enhanced programs to reach preschoolers and allows for business growth of community mental health centers.

Physicians and primary care providers in the community will also benefit from the integration of mental health services into preschool classrooms, because it will provide an expert opinion on disruptive and atypical childhood behaviors based on ecologically valid assessment of children in those settings. This expansion adds to IPAC’s efforts to improve access through the co-location of mental health providers in primary care settings. There are three health systems providing services University Medical Associates, Holzer Clinic, and Family Healthcare Inc, our region’s federally qualified health center; two are IPAC affiliated agencies with co-located mental health providers.

RESPONSE

Building Capacity – Raising Resiliency will accomplish its goal of improving early childhood outcomes and increasing the capacity of our early childhood workforce to ensure healthy young childhood development through implementation of a comprehensive early childhood mental health consultation program (ECMH-CP) and through an early childhood workforce initiative.

The ECMH-CP will serve approximately 299 preschool-aged children between the ages of 3 and 5 each year enrolled in the Athens City and Athens County public preschools and their families. In year one, our ECMH-CP will be implemented in the Alexander School District, Trimble School district and in the Chauncey Elementary
preschool classrooms, which is part of the Athens City District. Services will reach 11 classrooms, 168 students, 11 teachers and 8 classroom aides in year one. In year two, the Federal Hocking School District will receive services, reaching an additional four classrooms, 58 students, 4 teachers, and 8 aides. Finally, in year three, the remaining preschool classrooms in the Athens City School District will receive ECMH-CP programming, reaching 73 additional students, 4 teachers, and 4 aides. Classrooms enrolled into the program during the previous years remain eligible for consultation services throughout the grant period. These projections are based on 2008-09 enrollment.

Whereas several models of ECMH-CL have been developed, the “Georgetown Model” (Cohen and Kauffman, 2000) and the DECA system (Naglieri and LeBuffe, 1999) are two of the most widely adopted. We have elected to use both in our EMCH-CP.

In the Georgetown Model, an ECMH consultant provides two broad levels of services: Programmatic Consultation and Child/Family Consultation (see Need Assessment: Social, Emotional, and Behavioral Problems in the Classroom section for description of services) and mainly emphasizes the use of ECMH-CL as a supportive service for prevention or intervention of challenging behaviors. Alternatively, the Devereux Foundation in Pennsylvania has created a consultation system focusing on the use of ECMH-CL services to develop resiliency for all young children in preschool settings. The Devereux Early Childhood Assessment Program (DECA) is based on the idea that resiliency in early childhood is composed of three primary protective factors: self-control, attachment, and initiative. By working together, the ECMH consultant and early childhood staff identify strengths and weaknesses in these protective factors then design and implement strategies to strengthen protective factors for children in their care. (Naglieri and LeBuffe, 1999). The strategies may include universal, targeted, and intensive strategies. The DECA program has been shown to be effective in increasing protective factors and decreasing behavioral concerns in Head Start children (LeBuffe, 2002).

Adopting the language of the DECA program, our comprehensive ECMH-CP offers universal, targeted and intensive services. Through integration with existing community resources, we tailor those levels of services to include the integration of our FCN and a pediatric psychologist. The FCN will work specifically with the families of children nominated to receive targeted and intensive services, promoting parent participation in the pre-school ECMH program and communicating sensitive family information, including trauma related information, to teachers and the ECMH consultant. By assessing the family’s understanding and perception of their child’s behavior and addressing those perceptions through trauma specific education, families will be better equipped to view the child’s behavior as a result of the child’s experiences rather than a lack of parenting or teaching skills. By understanding the immediate and long-term difficulties facing a child with impaired development due to trauma exposure, parents will become “treatment ready” by having a better appreciation of the value of early intervention. The pediatric psychologist, who is a member of IPAC’s Interdisciplinary Assessment Team (IAT) will provide specialized assessment through neuropsychological measures, involving other professionals on the IAT when appropriate, to better differentiate the child’s diagnostic picture, improving clinical interventions
An illustration of the ECMH-CP follows:

**Comprehensive Early Childhood Mental Health Consultation Program**

1. **Child enters Preschool**
   - Readiness to Learn
   - ASQ:SE (socioemotional)
   - Brigance (academics)

2. **Universal Intervention**
   - Early Childhood Mental Health Consultation Program
   - ECMH Consultant
   - Teacher CL
   - Environment CL

3. **Target Intervention**
   - ECMH Consultant
   - Family Navigator
   - Teacher CL
   - Environment CL
   - Child CL
   - Parents/Guardian

4. **Intensive Intervention**
   - ECMH Consultant
   - ECMH Treatment
   - Family Navigator
   - Neuropsych Assessment
   - Teacher CL
   - Environment CL
   - Child/Family
   - Parents/Guardian
   - Child

The ECMH-CP will advance a range of professional competencies through mixed-matrix design including didactic trainings, collaborative peer group supervision, learning communities, journal readings, and program consultation through site visits and videoconferencing with state and national experts. Additionally, the ECMH-CP will deliver on-site training through directed instruction, modeling and coaching to the 19
teachers, 8 aides, and other related school employees serving the Athens City and Athens County19 public preschool and preschool special education classrooms. This enables staff to learn techniques through direct instruction and observation, implement them in the classroom, work with the consultant to modify its implementation to ensure the desired impact on the classroom, and then to generalize the results to the next situation. Extending the trainings across the school year, providing that training in an active classroom, and having the opportunity to move from theory to practice to refinement of techniques is evidenced in the literature to best support learning. (www.aalpd.org/documents/MatrixOfMethodsForPD.doc, retrieved Oct 8, 2008).

ECMH core competencies addressed through our initiative include:

* Provides mentoring to colleagues to enhance their understanding of child growth and development. Demonstrates knowledge of and experience with topics of specialized issues such as: Separation and loss, substance abuse, maternal depression, PTSD, working with fathers and adolescent parents, child abuse and neglect, failure to thrive, fetal alcohol spectrum disorder, infants with drug exposure.

* Demonstrates problem solving, negotiation, conflict resolution, and mediation strategies.

* Exhibits respect through non-judgmental communication, valuing staff; knowledge and skills address cultural differences.

* Establishes and practices effective communication and reflection among professionals, colleagues, and families. Exhibits empathy by conveying the consultant’s understanding of staff, parents /family’s subjective experiences.

* Effectively brings about change and the need for action. Designs learning opportunities that reflect principles of child and adult learning and that are meaningful to children and adults.

* Designs training to help parents learn about child development and deal with influence of their own child rearing practice and when appropriate, teaches family and staff strategies for promoting children’s social/emotional language.

* Establishes relationships with other professionals in other early childhood and mental health disciplines, working as a liaison to other health professionals and community organizations as needed.

* Has knowledge of licensing regulations, HIPAA, FERPA.

* Able to use adult learning principles to help caregivers strengthen relationships with children in their care through training, modeling, and intervention (ODMH), leveraging basic knowledge of other professions working with young children.

* Examines own values, bias, strengths, and thoughts in working with children, families, (modified from “Professional Development Competencies”, ODMH Early Childhood Mental Consultation, Core Competency Workgroup).
The Gantt chart below illustrates our workforce development initiative:

<table>
<thead>
<tr>
<th>Training Activity Timeline</th>
<th>May 09-April 2010</th>
<th>May 10-April 2011</th>
<th>May 11-April 2012</th>
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<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
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<tr>
<td>ECMH program consultation &amp; site visits</td>
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<td>ECMH consultant didactic training</td>
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<td>X</td>
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<tr>
<td>Collaborative Peer Group Supervision</td>
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<td>X X</td>
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<tr>
<td>ECMH individual supervision</td>
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<td>X</td>
<td>X X</td>
</tr>
<tr>
<td>Educators /ECMH directed instruction, modeling in the classroom</td>
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<td>X X</td>
<td>X X</td>
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<tr>
<td>Educators/positive behavioral support trainings</td>
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<td>X X</td>
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<tr>
<td>Learning Community: Topics in Mental Health</td>
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<td>X X</td>
</tr>
<tr>
<td>Early Childhood Conferences</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Policy and Advocacy Trainings</td>
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</tbody>
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**Sustainability**

The sustainability of the ECMH-CP hinges on blending revenue from billable clinical services and agency cost share for the time the consultant is engaged in non-billable activities. To facilitate this process, the grant salary support for the consultant gradually reduces from Year 1 through Year 3. This will illuminate what portion of the employee’s salary is likely to remain the responsibility of blended funded through contracts. Typically an employee of the community mental health center is expected to generate 1020 units of billable contacts per year. The units of billable service provide by the consultant across the year will be deducted from 1020 annually, leaving the remaining “units of time” to be cost shared between the three agencies. This was directly discussed individually with the core consortium members and then jointly addressed with all three agencies during our planning process. Both the Athens City Schools and the Athens-Meigs Education Service Center and the CEO of the community mental health center agreed to negotiate a contractual relationship by the end of the third year of the grant.

The second sustainability issue implicit in this proposal, is the sustainability of our rural health network. Although the sustainability of the network is not an explicit goal of the grant, the expectation is that the Year 2 Early Childhood Conference, featuring an national leader in the field will be organized and hosted by IPAC, with revenues from registration going to the network. It is expected that this money will seed a subsequent conference and that training revenue, combined with participation dues and fundraising efforts will comprise IPAC’s comprehensive sustainability plan.

**WORK PLAN**

*Objective One: Early Childhood Mental Health Consultation Program.* The comprehensive ECMH-CP will offer three tiers of intervention - universal, targeted and intensive. Services will be provided by an interdisciplinary team, which includes the
ECMH consultant, the FCN, and a pediatric neuropsychologist. Collaboratively will integrate data from teacher and environmental consultation, family advocacy and education, and specialized diagnostic assessments to optimize the child’s resiliency (initiative, self-control and attachment) while decreasing behavioral concerns ensuring readiness to learn.

**Year One: May 2009 - April 2010**

**Year 1, Activity 1:** In Year One, we will expand our local capacity to deliver ECMH services in our community by hiring a fulltime ECMH consultant to be employed by Tri-County Mental Health and Counseling Services, Inc. (TCMH-CS). The addition of this staff member will expand the early childhood team from 2.5-3.5 FTE serving the agency’s three-county service area. Ms. Wang, TCMH’s current ECMH intern has excellent skills in young child development, assessment, treatment and consultation and has written a letter expressing her interest in this project and an intent to apply, should the position be posted.

**Year 1, Activity 2:** At the beginning of the school year, we will introduce the consultation model to preschool teachers and staff through their initial and monthly staff meetings to facilitate adoption of program services. The consultant will attend meetings for two schools districts within Athens County that are cooperatively served through the Athens-Meigs Educational Service Center (Alexander and Trimble) and the Athens City School district. The consultant will provide an overview of the consultation model, answer questions, receive initial feedback from teachers as to their anticipated consultation needs and schedule classroom visits. Through classroom visits, the ECMH completes the Devereux Early Childhood Assessment Reflective Checklists for Teachers for each of the 11 classrooms.

**Year 1, Activity 3:** Following class visits, the consultant will attend the next monthly staff meeting at each participating school system and facilitate an exchange of ideas addressing consultation needs. The result of this discussion will be the establishment of a district-specific implementation plan for (1) the city school district and (2) the county schools, developed collaboratively with Preschool teachers, the district preschool coordinator, the Director of Special Education and consultant. The plan will include the selected consultation services for each classroom and timelines for implementation. Classrooms at Alexander Elementary, Trimble Elementary, and Chauncey Elementary are targeted for implementation the first year. This represents 168 students, 11 teachers, 8 classroom aides.

**Year 1, Activity 4:** The consultant will next meet individually with participating teachers to review the DECA Environmental Checklist results, group dynamics occurring in the class, and any additional teacher concerns. As a team, the consultant and the teacher will develop a classroom-specific consultation plan for the year, containing 2-4 measureable objectives, strategies for achieving these objectives, and time-on-site for the ECMH consultant. This plan will address universal interventions, and anticipating the possibility of serving a few students through targeted consultation services, a parent permission form will be developed.
Year 1, Activity 5: The consultant and teacher will spend the remainder of the school year implementing the agreed-upon service plan and integration of mental health in preschool classrooms. The consultant will develop a consistent scheduling system with the participating teachers. The consultant and the teachers will monitor plan implementation and make amendments as needed. The county school preschool coordinator and the project manager will assist in problem solving any difficulties that occur across the system. These concerns also will be discussed at the quarterly advisory council sessions involving the district administration.

Year 1, Activity 6: Throughout the year, teachers and the consultant will identify children who need a greater level of intervention to be successful in an early learning environment than those afforded at the Universal Intervention level. These are children who will need more targeted teacher-interventions in order to have their needs met. These children can qualify for individual child-family focused ECMH-CL with parent permission. In order for appropriate targeted interventions to be implemented, the teacher, parent, and consultant will further assess the child’s needs. Parents and teachers will complete a DECA and the consultant will complete individual classroom observations. Parents, teachers, and the consultant will develop a targeted plan for the child, which will include a measureable objective, strategies for accomplishment, and responsible parties.

Year 1, Activity 6b: When parental permission is sought for targeted-level interventions, FCN services will be offered to the family. In our area, parents have often had negative experiences with both the school system and with the mental health system. The FCN’s role will be to help provide education to the parent on the services available and provide assistance to the family to encourage the parent’s participation in completing the DECA, developing the plan, and any implementation pieces. Consenting parents will be screened with the Zung Self-Rating Depression Scale. Identified mothers are then referred to the early childhood mental health consultant, who completes a thorough interview and assists with accessing mental health treatment when needed.

Year 1, Activity 7: The consultant, teacher, and parent may recognize that a child needs more intensive interventions services beyond what is possible in a classroom setting. In the case of children needing mental health treatment services, parents will be given a choice of using the consultant for these treatment services or provided with alternative referrals. The treatment services provided by the consultant can be offered at the school site, where appropriate, or may take place at the TCMH-CS Athens clinic. In these cases, families who need transportation would be eligible to access these services through TCMH-CS’s driver. When the consultant is providing treatment services, parents will complete a clinical intake for their child with the consultant and develop a treatment plan. The consultant will discuss with the parent the appropriate confidentiality issues, which will then be outlined on a TCMH-CS HIPAA compliant release form. Families will also have the option of authorizing the consultant to collect existing medical records and other pertinent information to facilitate coordinated, comprehensive care.

Year 1, Activity 7b: Families not currently working with the FCN will be offered those services. Experience in our area has shown that the FCN serves an essential role in
helping families understand the value of the services their children are receiving and assisting them in accessing services in our resource poor-region.

**Year 1, Activity 7c:** Where appropriate, children who are receiving an intensive level of service will be offered further diagnostic assessment through the IPAC’s Interdisciplinary Assessment Team (IAT), neurological psychological assessment, school psychological services and/or other developmental services. With consent, the FCN will provide care coordination.

**Year 1, Activity 8:** At the end of the school year, the project evaluator will conduct a focus group with school employees to evaluate participants’ perspectives on the program’s value and effectiveness. Participants will be given a stipend $50 to participate with a minimum of 10 people attending the groups. Results will be examined and recommendations will be made to the consultant, the preschool coordinators for each district, and to the project manager.

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**Year Two: May 2010 - April 2011**

**Year 2, Activity 1:** During the summer of 2010, the consultant will conduct the Incredible Years Program-DINA, a small group program target parenting and child behaviors. Incredible Years is recognized by SAMSHA’s National Registry of Evidenced-based Programs and Practices. The program will be offered to children nominated by classroom teachers, FCN, and ECMH consultant as potentially benefiting from the development of social skills and anger management skills through group therapy. Ideally this program is for children who were receiving intensive intervention through the consultant. The group will meet 4-6 times over the summer months at a maximum of 8 preschoolers.

**Year 2, Activity 2:** The Program Evaluator and Project Director will analyze data from the focus group, the Teacher Opinion Survey, the teacher satisfaction survey, the pre/post DECA environmental checklist and individual student DECA (de-identified). Recommended programmatic modifications will be reported based on data and implementation plans written.

**Year 2, Activity 3:** The consultant and teacher champions from Year 1 will introduce the consultation model to preschool teachers and staff through staff meetings to facilitate receptivity to program services. In addition to continuing to serve Year One site, the program is introduced to Federal Hocking School district. The consultant will provide an overview of the consultation model, answer questions, receive initial feedback from teachers as to their anticipated consultation needs and schedule classroom visits. Through classroom visits, the ECMH completes the Devereux Early Childhood Assessment Reflective Checklists for Teachers

**Year 2, Activity 4-9:** For a description of activities, see Year 1, Activities 3-8. Classrooms at Amesville and Coolville Elementary Schools in the Federal Hocking District are targeted for implementation the second year. This represents 58 students, 4 teachers, 4 classroom aides.

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**Year Three: May 2011 – April 2012**

**Year 3, Activity 1-8:** For a description of activities, see Year 2, Activities 1-9. In addition to continuing to provide services to Year 1 and Year 2 classroom, the remaining preschools in the Athens City School District will be enrolled in the program.
Year 3, Activity 9: CEO of TCMH-CS, George Weigly, PhD and School Superintendents from the Amesville Elementary Schools, John Constanzo, PhD and the Athens City School District, Carl Martin will, through facilitated discussion lead by J. Hamel-Lambert, negotiate a contractual relationship to ensure program sustainability. Of importance is a cost share of expenses associated with the ECMH consultant position that cannot be recovered through billable activities, as permitted by third party and governmental payors at the time the proposal was written.

Objective Two: Early Childhood Workforce Development Initiative

Years 1 and 2, Activity 1: In order to fine-tune our service delivery model, we will obtain programmatic consultation and technical assistance from state-recognized ECMH-CP’s and HRSA grantees with relevant school-based experiences. This activity will occur in Summer 2009, prior to implementation of ECMH in Year One, and again in Summer 2010 prior to our 2nd year of implementation. 80% of the team will participate in the consultation activities. H. Jane Sites, Director of the Therapeutic Interagency Preschool under the auspices of Cincinnati Children’s Hospital Medical Center has agreed to provide technical assistance for Year One via teleconference and/or staff site visits to the program. John Kinsel, Director of the Young Child Assessment Treatment Services for Good Samaritan Hospital in Dayton Ohio has had a long collaborative relationship with the Project Director and currently participates in the regional ODMH peer supervision group. He is proposed to provide technical assistance in Year Two via teleconference and/or site visitation. Lastly, the HRSA-assigned GSU TA will facilitate additional consultation from HRSA grantees who have relevant school-based experience.

Years 1 and 2, Activity 2: The consultant will develop her skills and abilities to provide classroom-focused and child/family-focused consultation by attending empirically supported, classroom-based trainings, offered regionally by ODMH, once per year. It is anticipated that opportunities will include: The Incredible Years Program, the Georgetown Consultation Model, or DECA’s Face the Challenge/Challenging Behaviors.

Years 1-3, Activity 3: The consultant will further increase her knowledge of and skill for providing targeted and intensive interventions by participating in the ODMH-coordinated regional peer supervision group. Each year, referencing the core competencies for ECMH, the consultant will conduct a self-assessment and set personal goals. This group, composed of ECMH consultants and assessment/treatment providers, meets monthly to discuss cases. The consultant will discuss two cases per year, demonstrating an increased level of case conceptualization with each presentation. This group will also provide an avenue for the consultant to disseminate programmatic successes and knowledge learned. The EMCH-CL group supervision will also be complimented by individual supervision from the Program Director, 1 hour per week. The program director and the ECMH consultant will evaluate progress on competency annually.

Year 1, Activity 4: In Year One we will increase our region’s ability to diagnose and differentiate autistic spectrum disorders by sending three professionals to a two-day training event for the standardized, play-based assessment for autism, the ADOS. IAT team members Andrea Beebe, PhD Katherine Marshall, Early Intervention Specialist, and Pam Reese, MA, SPL-CCC, will all attend the training, creating a local interdisciplinary
team. This expertise is especially relevant to the consultant because early accurate diagnosis is critical. Following this training, there will be four professionals trained on the ADOS in our community. Early identification allows the preschool staff and the consultant to design appropriate interventions prior to children entering school, thus increasing the likelihood of the best outcomes for children.

**Year 2, Activity 5:** During Year Two, the consultant and the Project Director will conduct a 4-part workshop, DECA’s Face the Challenge: Challenging Behaviors. This program will give teachers skills in designing their own universal and targeted interventions for challenging children through the use of functional behavioral assessments and the implementation of positive behavioral supports. This training series will also give the teaching staff and the ECMH-CL staff a common language and framework in developing and implementing consultation plans which will further blend the early childhood education culture and mental health culture.

**Year 2, Activity 6:** Teachers will continue to increase their knowledge of and skill for designing universal and targeted classroom interventions by participating in a learning community group facilitated by Sue Johanson, School Psychologist. The group will meet monthly during the three years and will focus on selected topics of interest. In Year One the group will study the Ziggarut model for designing classroom interventions.

**Years 1 and 2, Activity 7:** In Year 1, we will host Jim Gill, MA a child development specialist who will present on the importance of a play-based curriculum to support child development and inclusion of children with special needs in the classroom. Mixing theory with practice, participants will acquire specific classroom activities that reinforce developmental and learning theory principles. Mr. Gill’s workshop will include a parent-child concert in addition to a presentation for professionals. In Year 2, we will host an Early Childhood Conference for the broader geographic region, featuring one of the following: Dr. Paul Donahue, who developed the early childhood mental health consultation concept and would address innovations in consultation programs and strategies for engaging parents or Dr. Perry, from the Trauma Academy, who would be our preferred expert if we decide to focus on increasing regional awareness of the developmental and health consequences of exposure to trauma, pending an evaluation of programmatic needs and participant interest.

**Year 3, Activity 8:** In Year Three, we will increase our region’s ability to influence state and federal policies that impact young children and young child-serving programs. We will send the Program Director and the PI, along with any other additional project participants, to policy and advocacy training. Additionally, participants will take advantage of appropriate forums to disseminate program findings to shape policy and advocate for additional assets for young children in our resource-poor region.
Below please find our detailed workplan.

**GOAL:** Improve early childhood outcomes and increase the capacity of our early childhood workforce to ensure healthy young child development through implementation of a comprehensive early childhood mental health consultation program (ECMH-CP) (Objective One), and an Early Childhood Workforce Initiative (Objective Two).

**Objective One:** The Comprehensive Early Childhood Mental Health Consultation Program (ECMH-CP) will offer three tiers of intervention - universal, targeted and intensive - accomplished by integrating the interdisciplinary expertise of the classroom early childhood consultant, the FCN, and a pediatric neuropsychologist who collaboratively can integrate data from teacher and environmental consultation, family advocacy and education, and specialized diagnostic assessments to optimize the child’s resiliency (initiative, self-control and attachment) while decreasing behavioral concerns ensuring readiness to learn.

Healthy People 2010: 1-6; 11-16; 16-14; 18-6,9,17

Evaluate Annually: # teachers receiving consultation; # children served at each tier of consultation; Teacher Outcomes: % items achieved on consultation plan, pre/post environmental checklists; pre/post Teacher Opinion Survey, ODMH Teacher Satisfaction Survey; Child/Parent Outcomes: pre/post DECA, % parents participating in services, Pre/Post Incredible Years parenting survey, # parents screened for depression, and referred when indicated and ODMH Parent Satisfaction Survey.

<table>
<thead>
<tr>
<th>Activities Year One: May 2009–April 2010</th>
<th>Dates</th>
<th>Outcome/Results</th>
<th>Evaluation</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1, Activity 1:</strong> Hire an Early Childhood Mental Health consultant, ideally from traineeship pool.</td>
<td>July 2009</td>
<td>ECMH consultant recruited</td>
<td>Employee hired.</td>
<td>S. Shamblin, PPC-S, program director</td>
</tr>
<tr>
<td><strong>Year 1, Activity 2:</strong> Introduce the consultation model to preschool teachers and staff through staff meetings to facilitate receptivity to program services. School Districts: Alexander, Trimble and Chauncey classrooms in Athens City.</td>
<td>Aug 09 - Sept 2009</td>
<td>ECMH consultant attends 4 staff meetings and presents model</td>
<td>85% of teachers introduced to the consultation model request on-site observation by ECMH consultant to understand the unique service needs and objectives for each preschool classroom.</td>
<td>S. Shamblin, PPC-S program director TBA,ECMH consultant</td>
</tr>
<tr>
<td><strong>Year 1, Activity 3:</strong> Establish district-specific implementation plan for (1) the city school district and (2) the county schools, collaboratively with Preschool teachers, district preschool coordinator, and ECMH consultant.</td>
<td>Sept. 2009 - Oct 2009</td>
<td>2 Implementation plans, one for the city schools and one for the county schools are accepted by identified stakeholders, including agreement regarding which specific classroom will receive services.</td>
<td>ECMH consultation established schedule for 6 - 11 identified classrooms.</td>
<td>S. Shamblin, PPC-S, program director TBA,ECMH consultant</td>
</tr>
<tr>
<td><strong>Year 1, Activity 4:</strong> Establish classroom-specific consultation plans delineating range of interventions desired and anticipated outcomes based on Devereux Reflective Checklists for Teachers.</td>
<td>Oct. 2009 - Dec 2009</td>
<td>2-4 goals identified for each classroom. Classroom-specific implementation authored by ECMH Consultant and teacher.</td>
<td>ECMH consultant delivers agreed-upon services. Number of children served through classroom consultation Devereux Reflective Checklists completed beginning and ending of the year for 100% of</td>
<td>S. Shamblin, PPC-S, program director TBA,ECMH consultant</td>
</tr>
</tbody>
</table>
### Year 1, Activity 5: ECMH consultant and preschool teachers facilitate implementation of service plan and integration of mental health culture in preschool classrooms

**Dec 2009 - May 2010**

- Increased familiarity with, and comfort established between EMCH provider, teacher, parents, and children
- Documented number of consultation questions posed by preschool teacher to ECMH provider
- Degree of teacher satisfaction with/agreement with ECMH Consultation Program
- Environmental assessments post-assessment completed.

S. Shamblin, PPC-S, program director
Becky Stone, Preschool Coordinator

### Targeted Intervention services include activity 6a and 6b.

**Year 1, Activity 6: Targeted consultation provided to children nominated by teacher**

**Dec 2009 – May 2010.**

- Parents consent to targeted consultation to individual child
- DECA resiliency score increases for 75% for children receiving at least four months of individualized CL (parent and teacher report)
- DECA problems scores decrease for 75% for children receiving at least four months of individualized CL (Parent and Teacher report)

S Shamblin, PPC-S
J Hamel-Lambert

**Year 1, Activity 6b: Family Care Navigator services offered as part of Targeted Level Services**

**Dec 2009–May 2010**

- Family Navigator meets with parent/guardian.
- Parent gains increased awareness, understanding of behavioral concerns, contributing family factors.
- 50% of Parents receiving FCN services participate in child’s treatment
- For participants, pre/post IY parenting measure, # parents screened for depression, and referred when indicated

S. Meeks, RN,C

### Optional Intensive Intervention services include activity 7a, 7b, and 7c.

**Year 1, Activity 7: Parent consent to individualized intervention / HIPAA compliant procedures apply.**

**Dec 2009–May 2010**

- Parents consent to fee-for-service treatment delivered either in the classroom, or at the community mental health center.
- 50% of children nominated for intensive services enroll accept the referral for ongoing mental health services.
- Clinical improvement, evidenced by pre–post DECA

S. Shamblin, PPC-S
TBA, ECMH consultant
### Year 1, Activity 7b: Family Care Navigator

**Services offered to families whose children are recommended for individualized intervention.**

- Jan – May 2010
- Parent/Guardian meets with Family Care Navigator
- Parent gains increased awareness, understanding of behavioral concerns, contributing family factors.
- 50% of Parents receiving FCN services participate in child’s treatment
- For participants, pre/post IY parenting measure, # parents screened for depression

**Scores on resiliency factors and behavioral concerns.**

S. Meeks, RN,C
Family Care Navigator

### Year 1, Activity 7c: Provide Diagnostic Assessment services to families whose children are recommended for enrollment in assessment and intervention services

- Jan – May 2010
- CL team in consult with teacher and school psychologist delineate referral question and develop an assessment plan, leveraging the resources of the Interdisciplinary Assessment Team.
- Diagnostic evaluation completed, recommendations are share with mental health provider and schools, with parent consent to release the test findings to the school.

**Outcome/Results**

A. Beebe, PhD
S. Johanson, MA
School Psychologist

### Year 1, Activity 8: Focus groups held with school employees to evaluate participants perspectives on the program’s value & effectiveness.

- Jun – July 2009
- Teacher and school aides participant in focus group (minimum of 10 participants)
- Teacher complete TOS Scale
- Modifications to program result from teacher feedback
- Teacher Confidence to Manage Challenging Behaviors increases by 25%.

**Outcome/Results**

Hamel-Lambert, PhD
Program Evaluator

### Activities Year Two: May 2010 – April 2011

<table>
<thead>
<tr>
<th>Dates</th>
<th>Outcome/Results</th>
<th>Evaluation</th>
<th>Partner Responsible</th>
</tr>
</thead>
</table>
| **Year 2, Activity 1:** Plan and implement a summer group using Incredible Years program to serve interested families. | May - Aug 2010 | Schedule and programmatic activities completed by late May | 85% participants report program satisfaction | S. Shamblin, PPC-S
TBA, ECMH consultant |
|       |                  | Families agree to participate in a fee-for-service Incredible Years group | For the IY Parent Group, 75% of parents demonstrate an increase in positive parenting practices on the Incredible Years Parent Scale given pre/post | |
|       |                  | With sufficient enrollment (6 or more families participate), program implemented | Reports are disseminated | |
|       |                  | Classroom-specific outcome reports are written | 65% of recommended improvements are put in place in classes that will continue to receive services | |
|       |                  | Recommendations for program improvements are written based on data collected | Data-driven program modifications are made where applicable. | |
| **Year 2, Activity 2:** Analyze program data collected during the first year of the Early Childhood Mental Health Consultation Program, from checklists and focus groups. | June 2010 | | Sherry Shamblin, PCC-S
J. Hamel-Lambert, PhD |
| Year 2, Activity 3: ECMH consultant and teacher champions introduce consultation model to preschool teachers and staff through staff meetings to facilitate receptivity to program services. Add classroom in Federal Hocking District: Amesville and Coolville | Aug - Sept 2010 | - ECMH consultant attends 4 staff meetings and presents model  
- 100% teachers/aides attending will articulate improved understanding and knowledge of the ECMH consultation model  
- 100% teachers/aides complete interest survey | - At least 2/3rd of classroom served during year one agree to continued participation in Early Childhood Mental Health Consultation Program  
- 85% of teacher not served indicate receptivity to the program | S. Shamblin, PPC-S TBA, ECMH consultant |
| Year 2, Activity 4: Establish district-specific implementation plan for (1) the city school district and (2) the county schools, collaboratively with preschool teachers, district preschool coordinator, and ECMH consultant. | Sept. - Oct 2009 | - 2 Implementation plans, one for the city schools and one for the county schools are accept by identified stakeholders, including agreement regarding which specific classroom will receive services. | - ECMH consultation established schedule for 4 new classrooms to receive Early Childhood Mental Health Consultation program. | S. Shamblin, PPC-S TBA, ECMH consultant |
| Year 2, Activity 5: Establish classroom-specific consultation plans delineating range of interventions desired and anticipated outcomes based on Devereux Reflective Checklists for Teachers. | Oct. - Dec 2009 | - Two – four goals identified for each classroom.  
- Classroom-specific implementation authored by ECMH Consultant and teacher. | - 100% of services desired, delivered.  
- Number of children served through classroom consultation  
- Devereux Reflective Checklists completed beginning and ending of the year for 100% of participating classrooms.  
- 75% of participating classrooms achieve 75% of the goals on their consultation plans. | S. Shamblin, PPC-S TBA, ECMH consultant |
| Year 2, Activity 6: ECMH consultant and preschool teachers facilitate implementation of service plan and integration of mental health culture in preschool classrooms | Dec 2009 - May 2010 | - Increased familiarity with, and comfort established between EMCH provider, teacher, parents, and children | - Documented number of consultation questions posed by preschool teacher to ECMH provider  
- Degree of teacher satisfaction with/agreement with ECMH Consultation Program  
- Environmental assessments post-assessment completed. | Sherry Shamblin, PPC-S Becky Stone, MA Preschool Coordinator |

**Targeted Intervention services include activity 7a and 7b.**

| Year 2, Activity 7: Targeted consultation provided to children nominated by teacher | Dec 2009 - May 2010. | - Parents consent to targeted consultation to individual child  
- Parents and Teacher complete DECA | - DECA resiliency score increases for 75% for children receiving at least four months of individualized CL (parent and teacher report)  
- DECA problems scores | S Shamblin, PPC-S J Hamel-Lambert |
<table>
<thead>
<tr>
<th>Year 2, Activity 7b: Family Care Navigator services offered as part of Targeted Level Services</th>
<th>Dec 2009- May 2010</th>
<th>Family Navigator meets with parent/guardian.</th>
<th>Parent gains increased awareness, understanding of behavioral concerns, contributing family factors. 50% of Parents receiving FCN services participate in child’s treatment. Pre/post IY parenting measure, # parents screened for depression, and referred when indicated.</th>
<th>S. Meeks, RN,C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optional Intensive Intervention services include activity 8a, 8b, and 8c.</td>
<td>Dec 2009– May 2010</td>
<td>Parents consent to fee-for-service treatment delivered either in the classroom, or at the community mental health center.</td>
<td>50% of children nominated for intensive services enroll accept the referral for ongoing mental health services. Clinical improvement, evidenced by pre–post DECA scores on resiliency factors and behavioral concerns.</td>
<td>S. Shamblin, PPC-S TBA,ECMH consultant</td>
</tr>
<tr>
<td>Year 2, Activity 8b: Provide Family Care Navigator services to families whose children are recommended for individualized intervention</td>
<td>Jan – May 2010</td>
<td>Parent/Guardian meets with Family Care Navigator</td>
<td>Parent gains increased awareness, understanding of behavioral concerns, contributing family factors. 50% of Parents receiving FCN services participate in child’s treatment. For participants, pre/post IY, # parents screened for depression parenting measure, and referred when indicated.</td>
<td>S. Meeks, RN,C</td>
</tr>
<tr>
<td>Year 2, Activity 8c: Provide Diagnostic Assessment services to families whose children are recommended for enrollment in assessment and intervention services</td>
<td>Jan – May 2010</td>
<td>CL team in consult with teacher and school psychologist delineate referral question and develop an assessment plan, leveraging the resources of the Interdisciplinary Assessment Team.</td>
<td>Diagnostic evaluation completed and recommendation are share with mental health provider and schools, with parent consent to release the test findings to the school.</td>
<td>A. Beebe, PhD S. Johanson, School Psychologist</td>
</tr>
<tr>
<td>Year 1, Activity 9: Focus groups held with school employees to evaluate participant perspectives on</td>
<td>Jun 2009 – July</td>
<td>Teacher and school aides participant in focus group (minimum of 10 participants)</td>
<td>Modifications to program result from teacher feedback</td>
<td>Hamel-Lambert, PhD, Program</td>
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</table>
the program’s value and effectiveness.

<table>
<thead>
<tr>
<th>Activities Year Three:</th>
<th>Dates</th>
<th>Outcome/Results</th>
<th>Evaluation</th>
<th>Partner Responsible</th>
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<tbody>
<tr>
<td><strong>May 2011– April 2012</strong></td>
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<tr>
<td><strong>Repeat Year 2 Activities 1 – 8</strong></td>
<td>May 2011 – April 2012</td>
<td>As listed above, by Activity, with new classroom being served in the Athens City School District, Morrison Elementary and The Plains.</td>
<td>As listed above, by activity</td>
<td>S. Shamblin, PPC-S TBA, ECMH consultant</td>
</tr>
<tr>
<td><strong>Year 3, Activity 9:</strong> CEO of TCMH-CS</td>
<td>May 2011- April 2012</td>
<td>Quarterly meetings across the year.</td>
<td>Contract signed</td>
<td>J Hamel-Lamert, MBA, PhD</td>
</tr>
<tr>
<td><strong>Objective Two:</strong> The Early Childhood Workforce Initiative advances a range of professional competencies through mixed-matrix design for professional development through didactic trainings, collaborative peer group supervision, learning communities, journal readings, and program consultation through site visits and videoconferencing with state and national experts. Healthy People 2010: 1-6; 16-14; 18-17</td>
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consultation, or DECA’s Face the Challenge/Challenging Behaviors

<table>
<thead>
<tr>
<th>Year 1 - Activity 3: ECMH consultant attends Ohio Department of Mental Health coordinated peer supervision group which is a case based-learning support group to build ECMH consultant’s competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2009 - April 2010</td>
</tr>
<tr>
<td>• ECMH attends monthly case-based peer consultation training program</td>
</tr>
<tr>
<td>• 85% of meetings attended. Presents two cases for discussion across year.</td>
</tr>
<tr>
<td>S. Shamblin, PPC-S TBA, ECMH consultant</td>
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<tr>
<th>Year 1, Activity 4: Three individuals attend 2-day workshop specific to the ADOS.</th>
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<tbody>
<tr>
<td>Spring 2010</td>
</tr>
<tr>
<td>• Beebe, PhD; Reese, MA, SPL-CCC and Marshall, MEd, Early Intervention Specialist</td>
</tr>
<tr>
<td>• Ability to locally assess children using the ADOS, enhancing diagnostic skills at differentiating early childhood disorders on the autistic spectrum.</td>
</tr>
<tr>
<td>A. Beebe, PhD</td>
</tr>
</tbody>
</table>

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<tr>
<th>Year 2, Activity 5: Teachers provided 4 part workshop, DECA’s face the Challenge: Challenging Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>June - August 2010</td>
</tr>
<tr>
<td>• Educators gain capacity in functional behavioral assessments and designing positive behavioral supports.</td>
</tr>
<tr>
<td>• Knowledge is transferred to classroom teacher refines new skill through classroom consultation</td>
</tr>
<tr>
<td>S. Shamblin, PPC-S TBA, ECMH consultant</td>
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</tbody>
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<thead>
<tr>
<th>Year 1 – 3, Activity 6: Topics in Mental Health, Learning Community</th>
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</thead>
<tbody>
<tr>
<td>2009-2012</td>
</tr>
<tr>
<td>• School psychologist, special education and regular ed. Teachers meet monthly for focused learning on selected topic of interest. Year One: Ziggarut Model</td>
</tr>
<tr>
<td>• Increased ability to conduct functional behavioral assessment and write behavioral goals in IEPs that are consistent with understanding early childhood behavioral disorders</td>
</tr>
<tr>
<td>S. Johanson, MA</td>
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<thead>
<tr>
<th>Year 1 - 2, Activity 7: Early Childhood Workforce Conferences held in April</th>
</tr>
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<tbody>
<tr>
<td>April 2011, April 2012</td>
</tr>
<tr>
<td>• Jim Gill, child development expert presents on importance of movement and play to foster development, to both professionals and parents.</td>
</tr>
<tr>
<td>• Dr. Perry, Trauma Academy expert or Dr. Donahue, founding father of ECMH consultation present</td>
</tr>
<tr>
<td>• 85% of relevant personnel attend regional training conferences</td>
</tr>
<tr>
<td>• Teachers adopt play-based activities in classroom; parents understand role of play in child’s development</td>
</tr>
<tr>
<td>• Trauma knowledge or ECMH knowledge enhanced.</td>
</tr>
<tr>
<td>Shamblin &amp; Hamel-Lambert</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Year 3, Activity 8: Policy and Advocacy training provided to CEOs, school administrator and superintendents, and other agency professionals interested in advancing understanding of how to disseminate evidence to effect policy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall 2012</td>
</tr>
<tr>
<td>• Program Director and PI, along with interested leaders from school district and mental health center attend training focused on impacting policy and effective advocacy</td>
</tr>
<tr>
<td>• Dissemination of programs findings to impact policy decisions</td>
</tr>
<tr>
<td>GSU TA Hamel-Lambert</td>
</tr>
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</table>
RESOLUTION OF CHALLENGES

One potential challenge is related to personnel. It is anticipated that the individual currently training with the ECMH specialist at the community mental health center will apply for the consultant position described within this proposal. She is recognized as fully qualified to assume the duties associated with the job; however, should she elect not to apply, then a successful search for a consultant would lie between the funding decision and the start of the ECMH-CP. Because the funding cycle starts in May, and school starts in late August, we do not anticipate the hiring process to interfere with the proposed start date for the project. Given the weak economy, the number of job applicants for most local positions, regardless of the field they are posted in, are overwhelmed with applications, of which many are to be deemed qualified.

A second potential challenge relates to the delivery of individual assessment and therapeutic services to children nominated to receive intensive services through the consultation program. Individual and family therapy will be delivered on a fee for service basis. This option requires families to enroll children with the mental health center, even though services can be delivered either at the school or at the agency itself. If referrals are few or parents are not willing to engage services through the community mental health center, two programmatic issues arrive. First we may have a scenario where a child is not receiving adequate clinical services through the consultation program, because the family only wishes to get the services that are available for free at the school. In this case, the team will need to work with school personnel, the FCN, the family and the mental health center to ensure that appropriate services can be obtained for the child. The second programmatic issue that emerges relates to sustainability. The expectation is that the program will generate sufficient individual therapy clients and that the consultant is able to bill for a portion of her salary expenses as the support from the grant declines. It becomes a management challenge to accurately describe the levels of services available through consultation and to teach staff to distinguish what clinical presentations require a more intensive level of care. To the extent that these distinctions are readily understood and referrals are appropriate, the issue will be averted.

The third management challenge that may emerge in the implementation of the consultation program relates to the integration of the FCN services with the diagnostic assessment services and the consultation program. Providers will have to cooperatively plan to serve the children identified as needing care. Establishing an effective process to ensure care is both coordinated and family-centered will be critical to offering a high quality service. To the extent that the providers involved in this program have a history of working cooperatively and jointly serving on IPAC’s board of directors, it is expected that as issues arise, open and honest dialogue will foster fair solutions.

EVALUATION
The Principal Investigator/Evaluator will be Jane Hamel-Lambert, Ph.D, M.B.A. Prior to implementation of the ECMH-CP, Dr. Hamel-Lambert will submit an application to Ohio University’s IRB. Implementation will begin upon approval of the IRB application. Dr. Hamel-Lambert will be responsible for tracking and evaluating the progress made toward meeting grant-funded goals. Dr. Hamel-Lambert was instrumental in designing the
proposed project and in the selection of outcome measures. Well-qualified to evaluate the project, she has earned a doctorate in clinical psychology, a Masters in Business Administration and she has a decade of experience working on interdisciplinary teams as a child psychologist.

**Process Measures and Quality Improvement Strategies.** Daily monitoring of the ECMH-CP will be the responsibility of Sherry Shamblin, PCC-S. To facilitate monitoring, each goal is subdivided into objectives, each of which is further subdivided into action steps, with expected outcomes and an associated timeline. It is the responsibility of the PI and Project Director to communicate frequently to ensure that activities are being undertaken within the set timelines, outcomes are being achieved as per specified target goals and budget, and issues are resolved in a timely manner to ensure the achievement of project objectives and goals. Should circumstances prevent activities from being completed, it is incumbent on Dr. Hamel-Lambert and S. Shamblin to evaluate the impact of this change on the consortium’s ability to accomplish the objective and ultimately the associated goal and address this situation with the consortium in a timely manner.

An advisory group will be established including the Director of Special Education at the Athens City Schools, the Director of the preschools for the Athens-Meigs Educational Service Center, the PI, and the Project Director who will represent Tri-County Mental Health and Counseling Services, Inc., and a parent. This group will meet quarterly, unless circumstances dictate the need to meet more frequently. It is vested with decision making authority, with Dr. Hamel-Lambert and S. Shamblin ultimately responsible for suggesting any necessary and appropriate programmatic changes. In addition, the progress on this grant will also be reported in the monthly IPAC meetings, as the consortium represents a subgroup of our larger rural health network. Therefore, monitoring progress at the activity level will allow the leadership to proactively adjust implementation efforts to ensure that the goals are accomplished.

This management strategy is predicated on keeping a constant and open dialogue between the Principal Investigator/Evaluator, the Project Director, and the school administrators. Weekly communication between consortium members with formal reporting at quarterly advisory meetings, as well as monthly review at the IPAC Board meetings will ensure partner awareness of potential issues, allow for input from all stakeholders, and ultimately the timely and appropriate resolution of issues as they arise.

Building Capacity – Raising Resiliency will accomplish its goal of improving early childhood outcomes and increasing the capacity of our early childhood workforce to ensure healthy young childhood development through (Objective One) implementation of a comprehensive early childhood mental health consultation program (ECMH-CP) and through (Objective Two) an early childhood workforce initiative. Next, we will discuss outcomes measures for each.

**Objective One:** The ECMH-CP will offer three tiers of intervention - universal, targeted and intensive - accomplished by integrating the interdisciplinary expertise of the classroom ECMH consultant, the FCN, and a pediatric neuropsychologist who collaboratively can integrate data from teacher and environmental consultation, family advocacy and education, and specialized diagnostic assessments to optimize the child’s
resiliency (initiative, self-control and attachment) while decreasing behavioral concerns ensuring readiness to learn. Objective One uses ORHP’s recommended evaluation measures:

- **Numbers served:**
  - What is the total number of people (unduplicated encounters) served at each tier of the ECMH-CP (Universal, Targeted, Intensive Services)?
  - What is the total number of encounters?
  - What is the total number of people with access to new/expanded programs/services?
  - What is the number of new and/or expanded services provided? ECMH-CP creates three: school-based consultation, family navigation, neuropsych assessments

- **Health Promotion/Disease Prevention:**
  - What is the number of health promotion/disease management activities offered to families through the project/Family Navigator Program?
  - What is the number of health screenings conducted? Social-emotional screening at preschool entry for children.

- **Mental Health:**
  - What percent of adult patients have been screened for depression?
  - What is the number of people receiving mental and/or behavioral health services?

An additional child outcome measure, the DECA, will be used to evaluate children receiving targeted and intensive intervention and environmental changes. The DECA is a nationally normed tool for assessing within-child protective factors in children age 2-5. Composed of a five-step strength-based system based on resiliency theory, the DECA supports early childhood teachers, parents, and professionals in promoting the development of healthy social-emotional skills while decreasing behavior problems. Pre-, post- administration will illustrate clinical change.

Additional parent outcome measures include percent of parents participating in services, percent of parents identified through depression screening as needing further evaluation, pre- post- changes reported on the Incredible Years Parenting Survey. “*The Incredible Years*” are research-based, proven effective programs for reducing children's aggression and behavior problems and increasing social competence at home and at school....” (http://www.incredibleyears.com/). Lastly, parents will complete the ODMH Satisfaction Survey.

The evaluator will conduct focus groups with school teachers and staff following the completion of the first and second year implementation of the ECMH-CP. The focus group will be co-moderated by a parent. Moderator guide questions will be developed by the advisory group with input from the ECMH consultant, the FCN, and the psychologist. Focus groups provide qualitative data on the quality and effectiveness of the program that cannot be captured with quantitative measures. The results will inform program modifications.

**Objective Two** The Early Childhood Workforce Initiative advances a range of
professional competencies through mixed-matrix design for professional development through didactic trainings, collaborative peer group supervision, learning communities, journal readings, and program consultation through site visits and videoconferencing with state and national experts.

Objective Two uses ORHP’s recommended evaluation measures:

- Workforce Recruitment & Retention:
  - What is the total number of new staff recruited to work on the project? One new position created at the community mental health center.
  - What are the types of new clinical staff recruited to work on the project? New mental health provider is specialized in early childhood mental health.
  - What is the number of staff positions shared between two or more Network partners? Sustainability of the ECMH-CP dependent on contract between community mental health center and public schools to cost share the new staff position.
  - What is the total number of people trained? Trainings involve educational and mental health professionals and others interested in early child development. Training opportunities include didactic seminars, a two-day team training, and ongoing Community Peer Support Groups across two years. It is our goal that 85% of our partners will attend each scheduled activity. This data will be extracted from attendance records for each training event.

An additional teacher outcome measure, the Teacher Opinion Survey (Geller and Lynch, 1999) will be completed in the fall and in the spring by preschool teachers. Teacher Opinion Survey (TOS) is a 12-item survey instrument designed to assess teacher self-perception regarding teacher ability to affect the lives of children in the classroom. Items ask about the teacher's confidence in his/her ability to manage challenging behaviors, to respond effectively, and to influence the child's development. Items are scored on a 1 -5 Likert Scale. Lastly, teachers complete the ODMH Teacher Satisfaction Survey.

It is anticipated that the ECMH-CP and the workforce initiative will reach 686 persons, resulting in over 8,000 encounters. Improving child outcomes is achieved through the seamless integration of mental health expertise in the preschool setting. The ECMH-CP is uniquely designed to simultaneously develop workforce capacity, while providing quality, accessible clinical services to children. Comprehensive in nature, our model integrates a Family Navigator Program, providing specialized intervention in the area of trauma, as well as routine screening and evaluation services. For children whose struggles in the classroom are likely the results of developmental challenges, access to specialized interdisciplinary assessment services augments evaluations typically provided by the schools. Running in tandem, are workforce developmental activities that build early childhood competencies through multiple learning methods. Each arm of the project holds unique potential impact, as discussed next.

**IMPACT**
Building Capacity - Raising Resiliency adopts two nationally recognized models, The Georgetown Model and the Devereaux Early Childhood Initiative as the basis for our comprehensive ECMH-CP. Our proposal modifies this model by strengthening its family outreach to be responsive to the needs identified by both parents and preschool teachers. Positive outcomes are anticipated for the youth, who will demonstrate increased resiliency and reduced behavioral problems and for the preschool teachers and staff, who will report greater confidence in their ability to address challenging behaviors in the classroom, as well as less stress – both positive correlates of positive socio-emotional development and learning. Moreover, the integration of mental health services into education settings that underlies the implementation of the ECMH-CP, strengthens the system of care for children in our community by improving the communication between providers and improving care coordination. The proposed workforce development activities reinforce the training that occurs within the classroom, providing opportunities for building additional knowledge, reflection and synthesis. National evidence supports our anticipated impact on the children and the educators, in addition to demonstrating economic impact. This evidence is reviewed next.

Systems of Care, a SAMSHA mental health initiative whose outcome evaluation is conducted by MACRO International, has demonstrated the positive impact of integrating education and mental health through a comprehensive, coordinated system of care which has significant impact for children 11 and older. Although targeting older children, the Systems of Care outcomes are relevant to our proposal. Strengthening communication between school systems and mental health systems was shown to increase referrals (i.e., schools referred 26% of all children participating in systems of care), reduce child pathology (e.g., 36% decrease in self-harm/suicide-related behaviors; emotional and behavior problems either significantly reduced or stabilized for 90% of the children); and improve academic outcomes (regular school attendance [i.e., 80 percent of the time or more] increased nearly 7%; percentage of children with a passing performance [i.e., C or better] increased 14%; delinquent behaviors decreased 17% among children and youth).

Extrapolating from the national data, our ECMH-CP will likely result in children with developmental and socio-emotional needs being identified and receiving services sooner because those services can be delivered in the setting the child is in. For those children receiving individualized consultation and for those children receiving mental health assessment and treatment, we anticipate an increase in pro-social behaviors and resiliency, as measured by the DECA.

In addition, outcomes demonstrated the associated alleviation of disability/burden of the child’s emotional problems on the family’s ability to work (i.e., 24 % obtained employment, over half in full time positions). Ohio data suggest 9% of children between zero and five years of age have special needs. The burden for caring for these children is significant for families, as evidenced by reports of financial problems (21.7%), spending over 11 hours per week meeting the child’s needs (31.7%) and reducing or stopping work (36.6%). An economic impact study commissioned by BUILD-OHIO (2004) described the impact that this burden has on our State’s economy:
“Unscheduled absences cost small business in Ohio an average of $60,000 annually and large companies an average of $3.6 million. Nearly one-quarter of unscheduled absences are due to family issues, including early care and education needs” (2004). Early identification and intervention potentially mitigates this impact by reducing the number of unscheduled absences, as well as the number of families who curtail work or simply stop working due to the burden of caring for a child with special needs.

Specific to EMCH consultation program effectiveness, "Together for Kids" in Central Massachusetts has demonstrated that ECMH programs not only substantially decreased children's challenging behaviors and increased developmental and self help skills, but also reduced costs to the school system in reduced special education costs: estimated $1.67 - $2.23 saved per every dollar invested in ECMH consultation (Warfield, M, 2006).

ECMH programs also hold the promise for reducing the costs associated with out-of-home placements. In Ohio, the costs for out-of-home placements are staggering: “an assessment of 993 youths entering service in FY 2007 showed that, ... in the 90 days following entry into the public mental health system, $1.76 million was spent on out-of-home placement” (ODMH, Bulletin 3, June 2008). Foster care placements are the most commonly utilized out-of home treatment option for young children. Addressing behavioral and socio-emotional concerns through ecologically valid models of care delivered in the schools, may reach children whose families’ struggles would have prevented them from accessing traditional outpatient services. Reducing foster home placements offers significant savings for society.

Given the potential economic impact associated with investing in early childhood initiatives, it isn’t surprising that the return-on-investment analyses are quite favorable. According to Economic Policy Institute (2004), investment in early childhood development generates cost-benefit ratios of 3:1; for each $1 invested, there is a $3 return.

Plans and methods for dissemination of our project results include efforts at the local, state and national level. Where appropriate, the data collected will be added to the ODMH ECMH Initiative database to improve evaluation of the effectiveness of consultation services. This would likely include DECA results and other outcomes measures, such as satisfaction surveys, selected because of the state’s use of those instruments. ODMH uses this data to make internal funding decisions and to request additional funding from the Ohio legislature. Therefore, contributing our data will help inform local program strategies, state policy, and funding decisions. Since Athens County is representative of Appalachian Ohio counties, the success of our ECMH-CP should be easily replicable in neighboring communities and other rural counties across the state. Further, rural communities nationally will benefit from the lessons we learn.

The project director serves on ODMH’s Core Competencies Workgroup (CCW), whose task is to develop statewide core competencies for ECMH consultants. The CCW is developing a two-tiered approach: entry level (associate and baccalaureate degree prepared) and advanced (master’s degree and above) and will work with universities across Ohio to assist in curriculum development. This program’s outcomes will inform that taskforce and its subsequent policy decisions, ultimately influencing educational curriculum development.
Communicating our success will involve presentations to the school boards as well as through our website (www.oucom.ohiou.edu/ipac/), build value and sustainability for IPAC.

Lastly, we anticipate presenting our project results in Year 2 and 3 through national conferences which would include a presentation on systems integration at National Rural Health Association, the value of EMCH consultation for successfully transitioning young children with special needs into preschool at the Zero-to-Three national conference, and/or a presentation focused on reducing disability and burden at the National Institute for People with Disabilities (NIPD) annual national conference.

RESOURCES AND CAPABILITIES
The success of this proposal hinges on the resources and capabilities of the members of the consortium. As a subgroup of our regional rural health network, Integrating Professionals for Appalachian Children (IPAC), the ECMH-CP partners bring a five-year history of working collaboratively to improve how health, mental health and allied health services are delivered in southeast Ohio. Through IPAC’s Network Development grant and Network Planning grant, the consortium partners have a proven track record for collaboration and a history of teamwork. The successful implementation of those projects was the impetus and momentum behind this current proposal. IPAC participating agencies that comprise the Consortium for this project are highlighted below with Letters of Commitment/Memoranda of Agreements appearing as Attachments.

This proposal focuses specifically on the integration of preschool education and early childhood mental health. Building Capacity – Raising Resiliency expands our prior network development efforts by developing a comprehensive early childhood mental health consultation program that leverages the infrastructure created to support the Family Care Navigator Program and the Interdisciplinary Assessment Team during the RHND grant. Additionally, we propose a workforce development initiative strengthening our developmental expertise. The organizational chart for the consortium, found in Attachment Five, illustrates its relationship to IPAC and the applicant agency, Ohio University. A separate organizational chart from the Department of Family Medicine is also provided in Attachment Five.

Jane Hamel-Lambert, PhD, MBA, Assistant Professor in Department of Family Medicine and President of IPAC, will be the Principal Investigator/Evaluator (50% FTE Year 1, 10% FTE Year 2&3) for this project.

Applicant Organization and Capabilities. Ohio University has repeatedly demonstrated its ability to successfully implement large multidisciplinary outreach programs, with more than $19 million in public service grants in FY2007. Moreover, Dr. Jane Hamel-Lambert has served as PI on four HRSA grants, two of which have underwritten the development of IPAC. Dr. Hamel-Lambert holds a doctorate in clinical psychology from Ohio University and a Masters in Business Administration, with a concentration in health care, from Case Western Reserve University. Licensed in 1991, she has 17 years of professional experience, with extensive work experience as a child psychologist within integrated specialty medicine and primary care teams. Prior to moving to southeast Ohio,
Dr. Hamel-Lambert was associate staff at The Cleveland Clinic Foundation. The combination of her clinical and business training qualify her to serve PI/Project Evaluator.

**Ohio University’s College of Osteopathic Medicine (OUCOM)** was created by an act of the Ohio General Assembly in 1975, with a mandate to train primary care physicians to practice in the medically underserved areas of the State of Ohio. In 2001, OUCOM was ranked number one among osteopathic colleges in family medicine residency graduates and number two among all medical schools in both family medicine and primary care residency graduates. Currently, over 56% of all OUCOM graduates are in primary care in Ohio and 15% are in communities of less than 10,000 people, many of which are medically underserved communities.

The **Department of Family Medicine’s (DFM)** organizational chart is in Attachment 5. The DFM is one of seven departments in the college; it is comprised of 15 FTE and two part-time Family Practice Board Certified physician faculty and four Ph.D. psychologists. The Chair of the Department, Dr. Simpson, reports directly to the Dr. Brose, the College Dean and a family physician who holds his faculty appointment in the DFM. DFM has administrative autonomy equal to the other OUCOM academic departments and units, and the Chair is responsible for operations, decision-making and budget control.

In addition to the Department of Family Medicine, **OUCOM’s Community Health Programs (CHP)** is a consortium member. CHP is a multi-program, grant-funded department that provides educational programs to area professionals and medical students. The CHP programs primarily serve children and adults who are uninsured or underinsured, offering medical care, immunizations, education, parenting information, behavioral and mental health referrals. Two medically equipped vans provide many on-site services, including Healthy Adult screenings, pre-school physicals, childhood and adult immunizations, breast and cervical cancer screenings and a free health clinic. The goal of CHP is to decrease health care disparities in rural Southeastern Ohio by providing free or low cost services in rural communities.

**Sue Meeks, RN,C** has over 20 years experience. She is the coordinator for two grant-funded programs which provide health education to community agencies, enabling services to families and children experiencing mental health and behavioral problems and coordinates referrals to medical, mental health, developmental and educational services. She is also one of two nurse consultants contracted by the Health Child Care Ohio/Ohio Childcare Resource and Referral Association (OCCRRA) to provide health, safety, developmental and behavioral education in southeastern Ohio. Ms. Meeks grew up locally and has lived here for the past 12 years. **Expected Role:** Sue Meeks, RN, C (25% FTE, all three years) will expand her role as the Family Care Navigator by becoming part of the comprehensive ECMH-CP to provide education and support for parents of children identified for targeted and intensive services. As a member of the comprehensive ECMH-CP, Ms. Meeks, RN,C will be available at the schools or she may visit parents in the homes to obtain family and child information on development, medical and mental health history, trauma exposure and assist the family in understanding how medical and environmental factors may impact their child’s behaviors. The FCN will address parent
health and behavioral concerns and encourage participation in their child’s treatment by providing anticipatory guidance and support during the service period and by acting as a communication bridge to physicians, school personnel and the ECMH consultant for the purpose of developing, implementing and evaluating a comprehensive service plan. Through advocacy, education and support Ms. Meeks will promote active parent participation and assist the family in building partnerships with teachers and the ECMH consultant. Expected Benefits: Collaboration with schools and the ECMH-CP will increase Community Health Programs’ ability to assist clients with additional resources for families and children entering through CHP’s well-child, childhood immunization and perinatal programs. The expanded services provided through the ECMH-CP foster better outcomes and opportunities for children and families who have been unable to access services elsewhere. Through the grant-supported workforce initiative, Meeks will strengthen her capabilities to address the needs of families and children.

Ohio University’s Psychology and Social Work Clinic (PSWC) is the third university-affiliated member of the consortium. Its tripartite mission focuses on training, service provision, and research. Its Graduate student clinicians, under direct supervision, provide virtually all of the services offered through the PSWC, including evaluation and therapy services. In FY 2008, the PSWC had an operating budget of approximately $140,000, with the Director’s salary divided between two departments. That year, the clinic trained 28 graduate students, who saw 92 clients in therapy, 12 child assessments and 150 adult neuropsychological evaluations. Andrea Beebe, PhD (10% FTE, all three years) has over 15 years of supervised clinical experience under Gerry Taylor, PhD, ABPP, in pediatric neuropsychology. Recently joining the PSWC, Dr. Beebe provides supervision to graduate students at the clinic. Dr. Beebe accepted a position on IPAC’s Board of Directors and has contributed to developing an infrastructure that supports the Interdisciplinary Assessment Team. Expected Role: Dr. Beebe will serve as the psychologist for our ECMH-CP. As such she will provide neuropsychological assessments for ECMH-CP children who are receiving an intensive level of service, bridging together the schools and interdisciplinary expertise of IPAC Interdisciplinary Assessment Team. Expected benefits: Participation in the ECMH-CP will strengthen the relationship between the Department of Psychology and county preschools, providing an interprofessional, community-based training platform for graduate students in psychology and social work that currently does not exist. The addition of this training opportunity will increase the PSWC’s local, state, and national visibility and attract prospective students and faculty to our graduate programs at Ohio University. Clinical care for families served through the PSWC will benefit from efforts to integrate referral and treatment protocols and improve coordinated, comprehensive care.

Ohio University Commitment. The PSWC commits 2% of Dr. Beebe’s time in Year 2 and 5% in Years 2 and 3 on the project. The OUCOM commits 5% of Dr. Hamel-Lambert’s time in Years 2 and 3. The Vice President of Research and Community Health Programs commit university resources to support conferences in Years 2 and 3, including $1500. Testing materials available through the PSWC are shared with the project, as are administration resources such as clinic space and infrastructure support for these activities (scheduling, reception, administrative oversight).
Three agencies join Ohio University to create this consortium:

**Tri-County Mental Health and Counseling Services, Inc. (TCMH-CS)** is a community mental health agency in operation since 1971 with a current annual operating budget of $8.6 million. TCMH-CS provides quality, cost effective behavioral healthcare services to an average of 4100 adults and children per year who reside in a 1,600 square mile area stretching from the Ohio River to the Hocking Hills in the Appalachian counties of Athens, Hocking, Vinton and Washington. **Sherry Shamblin, PCC-S** (50% FTE, all three years) has a M. Ed. in Community Counseling and is independently licensed with a supervision endorsement. She has over 15 years of experience working with young children and their families in rural Appalachia. In her current position she offers home-based and center-based consultation services to young children and provides clinical supervision to 2 early childhood staff and participants in the early childhood internship placement. She has managed the agency’s ODMH’s Early Childhood Initiative for 8 years. She is an active participant in both local and state level initiatives related to early childhood services and currently serves on the IPAC board. **Valerie Wang**, (100% FTE all three years) who has submitted a letter of intent, has a MS, B.Ed. in Elementary Education will complete her M.Ed in Community Counseling in spring 2009. She has experience as a teacher. She currently is a registered counselor trainee, providing consultation and clinical services for young children and their families through the internship program at TCMH-CS. **Expected Roles:** As Project Director S. Shamblin, PCC-S and will work closely with the Project Evaluator/PI, Dr. Hamel-Lambert to guarantee a strong university-community partnership which will ensure seamless implementation of the comprehensive early childhood mental health consultation program as well as the early childhood workforce development initiative. Having worked in the Athens community for over a decade, Ms. Shamblin is well-respected and has excellent working relations with both school districts involved in the consortium. Ms Shamblin participated in planning meetings with the teachers, school superintendants and Ohio University. Her working relationship with Dr. Hamel-Lambert spans 5 years and multiple IPAC projects. Ms. Shamblin will provide clinical supervision to the ECMH consultant. **Ms. Wang, or a TBA,** will serve as the Early Childhood Mental Health Consultant for the project and, as such, will work closely with public preschool staff to design and implement consultation activities in the participating classes and assessment, and treatment services for identified children. She, the Family Care Navigator and the neuropsychologist will form a working team to ensure that identified children receive appropriate assessment and treatment services with full participation of their parents. **Expected Benefits:** TCMH-CS fully expects increased referrals, better treatment outcomes and consumer satisfaction, financial savings related to a reduction in no-shows and administrative costs, cross training resulting in more qualified direct service providers and increased recruitment potential. Specifically, TCMH-CS will benefit by expanding their capacity to appropriately meet the mental health needs of young children in the area by an increase in early childhood staff from 2.5 positions to 3.5. Additionally, the project allows TCMH-CS to create an early childhood specialty unit functioning within their existing Child Team. **TCMH-CS Contributions:** TCMH-CS will hire the proposed full-time ECMH consultant and commit to the additional resources for the
position beyond those provided by the grant. TCMH’s CEO will provide administrative oversight and assistance to the ECMH-CP and Project Director, as well as absorb the additional administrative costs (e.g., mileage, assessment tools, program materials, staff time to attend trainings and meetings, space at the clinic for individual services). George Weigly, CEO, will work to negotiate a contractual partnership with the schools to ensure the sustainability of the ECMH program.

**Athens City School District** established by statute, is one of five school districts within Athens, County. Operating with an annual budget in 2008 of over $28,000,000 the Board of Education employs 235 full and part time teachers, 73% of whom have at least a masters degree and 39% of whom have 15 years or more of experience. The district operates 7 educational facilities: 5 elementary schools, a middle school and a high school. With 2,937 pupils (including preschool and open enrollment), it has the largest enrollment in the county but is geographically one of the smallest school districts in the county encompassing only 89 square miles. The State of Ohio designates the district: Effective. **Carl Martin, MA**, Superintendent of the Athens City School District, has extensive experience in education administration. Once recognized for being the youngest superintendent in the State, Mr. Martin has spent the majority of his career at the upper levels of management, serving as superintendent of the Athens City Schools for the past 14 years. **Jeremy Yehl, MA, SP.S.P.S.,** is the Director of Special Education for the Athens City School District. He has held this position for twenty-one years. Prior to coming to Athens City Schools, Mr. Yehl was a school psychologist in Michigan, Iowa and Louisiana, including the position of Supervisor of School Psychology Services for the Louisiana Department of Education. **Sue Johanson, MA** is a school psychologist for the district and she is the psychologist who serves the preschool classrooms. Prior to becoming a school psychologist Mrs. Johanson was a secondary mathematics teacher and program director for TOPS in Human Services, as state-wide training program for human services workers. **Expected role:** The Athens City School District will cooperate by facilitating access to 2 preschool classrooms serving 36 students, half of whom are qualified as special education students. Within this subgroup, roughly one fifth of the individualized education plans include behavioral goals. J. Yehl and S Johanson will provide assistance in developing policies and procedures for integrating the ECMH consultant into the classroom, including involving that provider in ongoing preschool meetings as indicated, and facilitating communication with building administrators. Whereas S. Johanson will participate in monthly IPAC meetings, J. Yehl will serve on the advisory committee for the ECMH-CP and attend quarterly meetings to monitor the implementation process. In addition, as the key personnel to the ECMH-CP, Ms. Johanson will work cooperatively with the consultant, S. Meeks and A. Beebe. **Expected benefits:** The proposed ECMH-CP will provide valuable assistance to school districts in identifying, referring, and delivering specialized services to students and families in our region. Additionally, the presence of the ECMH consultant in the classroom provides hands-on training for preschool teachers in the recognition, understanding and management of common behavioral and developmental challenges, building workforce capacity. For children requiring more intensive intervention, the formal connection to the mental center established through this integration project reduces barriers that may have
prevented staff from recommending services or families from pursuing recommended services. Additionally, the FCN program offers advocacy and educational services to families who need assistant understanding the needs of their children and the value of recommended intervention. Other anticipated benefits include the increased capacity to offer services locally and an overall reduction in costs for educational services. **Athens City School Contributions:** The City Schools are heavily contributing in the form of staff time including time to participate in the development of the ECMH-CP, to attend trainings and meetings, participate in the learning community activities, and time to work with the ECMH consultant and other project members. They will contribute space for the ECMH consultant and FCN to work with children and parents as needed. Additional time contributions are being made for Mrs. Johanson to provide assistance to the project and facilitate the learning community. The system also commits to developing strategies that will sustain the program after the grant period.

**Athens-Meigs Educational Service Center (AMESC),** established by statute, cooperates with public school districts to provide over 60 educational programs and services in Athens, Gallia, and Meigs Counties with a 2008 annual operating budget of over $12,000,000. The mission of the AMESC is to work with school and community partners to improve student achievement, build capacity, and raise expectations for all individuals in our service region.

**John D. Costanzo,** Ph.D., Superintendent of the AMESC, has extensive experience in educational administration related to the development and improvement of curriculum, instruction, and professional development in public schools. All of his 34 years of service have been in rural schools and communities in Southeast Ohio. **Becky Stone,** MA, Preschool Coordinator for the AMESC manages the operations of the 19 Athens County classes in the project. She is well experienced in the education of young children and served as a kindergarten teacher before assuming her current position. **Expected role:** Dr. Costanzo will attend monthly IPAC meetings to create a system to disseminate information about the project to public schools and work with participating district superintendents toward sustaining the project post-grant. Both Ms. Stone and Dr. Costanzo will serve on the advisory committee for the ECMH-CP and attend quarterly meetings to monitor the implementation process. **Expected benefits:** The ECMH-CP will provide valuable assistance to school districts in identifying, referring, and delivering specialized services to students and families in the region. The FCN will help foster parent participation, not only in a child’s specialized services, but also in their education. The anticipated final outcomes of the project include the increased capacity to offer services locally and an overall reduction in costs for educational services. **AMESC Contributions:** The AMESC is making significant staff time contributions including time to participate in the development of the ECMH-CP, to attend trainings and meetings, participate in the learning community activities, and time to work with the ECMH consultant and other project members. They will contribute space for the ECMH consultant and FCN to work with children and parents as needed

**Parent Partner:** To ensure the consumer voice influences programmatic decisions, a parent partner will be identified to serve on the ECMH-CP advisory board. **Expected Role:** The Parent Partner will attend quarterly meetings and advise the committee about
program modifications, strengths, weakness, and gaps in service. They will also assist with the development of moderator guides for the focus groups. **Expected Benefit:** Participation will create a mechanism for communicating the concerns of parents to the school district administrators and potentially impacting school policies.

A list of consortium members and organizational charts are in located in Attachment 5. Letters of Commitment delineating roles, responsibilities and substantial contributions for each consortium member listed above are located in Attachment 6. Staff Plan and biosketches are located in Attachments 3 and 4, respectively.

**Other Project Resources:**

This project has strong support from a number of regional and state entities. The Southern Consortium for Children, an IPAC participating agency, offers Continuing Education trainings, Videoconferences, and Internet-based training on a variety of early childhood mental health topics. Additionally, this organization provides technical support for teleconferencing which will allow the project to access national experts with very little cost. The Graphics Department at OUCOM has provided all graphics for this proposal and they will assist as needed on future projects. The ODMH is supporting the project by providing slots for the ECMH consultant in ODMH’s early childhood training track and peer supervision group. The department has also donated a DECA kit, Developmental Wheels, and informational brochures for the consultant to use in her work. Marla Himmeger, Director of Ohio’s ECMH Initiative, will provide technical assistance to the Project Director on current state practices that impact the project and its future sustainability. Ms. Heather Reed, from the State Office of Rural Health, has provided welcomed technical assistance to the PI on the development of this project and intends to continue giving additional support during the implementation phase. Finally, the Georgia State University Technical Assistance Team, provided through our HRSA Network Development Grant, has provided valuable aid in project design. They will continue this role during Year 1 and 2 of the project by facilitating contact with other HRSA grantees who are implementing similar projects.

**Management and Coordination Strategies**

Fundamentally the project will be guided by an advisory group which will include the Director of Special Education at the Athens City Schools, the Director of the preschools for the Athens-Meigs Educational Service Center, the PI, Parent Partner(s), and the Project Director who will represent Tri-County Mental Health and Counseling Services, Inc. This group will meet quarterly, unless circumstances dictate the need to meet more frequently. It is vested with decision-making authority in any global design/implementation changes. In addition, the progress on this grant will also be reported in the monthly IPAC meetings, as the consortium represents a subgroup of our larger rural health network. Therefore, monitoring progress at the activity level allows the leadership to proactively adjust implementation efforts to ensure that the goals are accomplished.
The Principal Investigator, Dr. Jane Hamel-Lambert, will be responsible for tracking and evaluating the progress made toward meeting grant-funded goals. To achieve this, she will work in tandem with Sherry Shamblin, PCC-S who will be the project director, responsible for implementation of the ECMH-CP and all proposed workforce development activities. Dr. Hamel-Lambert is well-qualified to evaluate the proposed integration project, which she was instrumental in designing. Dr. Hamel-Lambert has earned a doctorate in clinical psychology, a Masters in Business Administration and she has a decade of experience working on interdisciplinary team as a child psychologist.

Daily monitoring of the ECMH-CP will be the responsibility of Sherry Shamblin, PCC-S. To facilitate monitoring, each goal is subdivided into objectives, each of which is further subdivided into action steps, with expected outcomes and an associated timeline. It is the responsibility of the PI and Project Director to communicate frequently to ensure that activities are being undertaken within the set timelines, outcomes are being achieved as per specified target goals and budget, and issues are resolved in a timely manner to ensure the achievement of project objectives and goals. Should circumstances prevent activities from being completed, it is incumbent on Dr. Hamel-Lambert and S. Shamblin to evaluate the impact of this change on the consortium’s ability to accomplish the objective and ultimately the associated goal and address this situation with the consortium in a timely manner.

REQUEST FOR FUNDING PREFERENCE

Because Athens County, OH is a rural eligible community, a Mental Health Professional Shortage Area and Dental Health Professional Shortage area (Dental-HPSA, MHPSA), and MUA, we are requesting a funding preference under the first category, health professional shortage areas. Additionally, our consultation program and the workforce development trainings foster wellness and disease prevention through health education and provision of depression screenings also qualifying us for category 2 funding preference.

References

- Access to Better Care (ABC) Initiative, retrieved from [http://www.pcsao.org/abc.htm on 10/12/08](http://www.pcsao.org/abc.htm on 10/12/08).


- Western Interstate Commission for Higher Education, [www.wiche.org](http://www.wiche.org), retrieved on 10/7/08.
Appendix G: Project LAUNCH Grant Narrative

Abstract

Population to be Served: Project LAUNCH will serve over 11,000 children birth to age 8 living in four counties of rural Appalachian Ohio: Athens, Hocking, Vinton, and Meigs.

Summary: The goal of Project LAUNCH for Appalachian Ohio is to create a shared vision for young child wellness that builds a solid foundation for sustaining effective, integrated services and systems to support and promote the wellness of young children and their families. To achieve that goal, Ohio has two objectives: (1) to build our infrastructure and (2) to enhance and expand service delivery by coordinating physical and behavioral health services for young children across systems and develop and implement a model for coordination of physical and behavioral health services that is appropriate for Ohio’s Appalachian region.

Goals and Objectives:
The purpose of Project LAUNCH at both the state and local level is to promote the wellness of young children birth to age 8. Wellness is a state of positive physical, emotional, social and behavioral health; behavioral health includes mental health and positive development free from substance abuse and other negative behaviors. At the state and local levels, we will map out all systems that serve children birth to 8; create a strategic plan which emerges from the environmental scan and needs assessment information; focus on infrastructure building, financial mapping, policy development, workforce development, and oversight of Project LAUNCH.

Locally, Project LAUNCH has two goals. Goal 1 addresses services and will (a) increase the number of sites and the types of developmental screening tools used in the region, (b) increase the number of primary care sites with integrated behavioral health services offering evidenced based treatments (PCIT, TF-CBT, IMPACT), (c) implement EBPs Home Visiting program, (d) provide EMCH consultation in primary care, preschools, homes, and early childcare settings, and (e) strengthen families through the Family Navigator Program, parent skills training, nutrition counseling, & art and recreation programs. Goal 2 strengthens the local infrastructure and develops workforce capacity. Working together the State and Local Young Child Wellness Council will accomplish systems integration and advance the public’s understanding of the multiple determinants informing child wellness.

Project LAUNCH will allow Ohio to:

- Build awareness about the importance of early identification through evidenced-based screenings in primary care across all provider systems (medicine, education, etc.),

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18 This is an unpublished program report belonging to the “Partnerships for Early Childhood Mental Health Program.” It is reprinted for the purposes of this study with permission from Tri-County Mental Health and Counseling Services, Inc.
• Improve coordination of care from the point of identification, through the referral process, and the provision of evidenced-based services so that consumers and those who serve young children share a vision of the components of strong families and young child wellness, and
• Develop policies and infrastructure to solidify supports that enable local communities to transform systems by leveraging community assets and cultural values
Section A: Statement of Need

Meet Joey. When he was nine, his mother went to a pediatric nurse in rural Ohio. His medical history revealed long-standing concerns about his behavior and development that began when he was three years old. Despite two local emergency room visits, two evaluations by local physicians, two subspecialty evaluations at the regional children’s hospital, an auditory processing evaluation, in-home services and sensory integration intervention over the past six years, Joey’s mother is still looking for help.

When interviewed, Joey’s mother says that she doesn’t understand what diagnoses had been offered and the goals that were set by the providers who had intervened with her son. Furthermore, the reports hadn’t been sent to his local physician or to her. Services were not integrated nor were sufficient efforts extended to ensure his mother understood what to do. The resources invested were large; the rate of return… if you ask Joey’s mom, “nothing has helped.”

Joey’s story is our challenge. By employing the mechanism of state and local Child Wellness Councils, Ohio will create a shared vision for young child wellness that builds a solid foundation for sustaining effective, integrated services and systems to support and promote the wellness of young children and families.

Innovative solutions which align efforts to redesign the health and mental health care delivery systems, while developing the capacity of the workforce to improve the quality of care that consumers receive, hold the greatest potential for improving well-being (Wakefield and Moulton, 2008, unpublished).

Rural America often conjures images of quiet tranquility; however, home to a vast array of stressors, rural America’s socioeconomic landscape is anything but idyllic. Poverty is pervasive, and relative to urban residents, rural Americans have fewer opportunities for employment than their urban counterparts, educational attainment is lower for rural residents as well; only 15% of rural Americans are college graduates as compared to 28% of urban adults (Office of Rural Health Policy, 2006). Estimates indicate that 85% of mental health provider shortage areas are rural (Bird, Dempsey, & Hartley, 2001), impacting the general rural healthcare workforce, as primary care physicians, educators, and other professionals struggle to treat consumers whose needs are complicated by mental health concerns. Service delivery is often fragmented and although a host of new evidence-based models of care offer hope to consumers and practitioners alike, the rural workforce often lacks the time and resources needed to learn them (www.annapoliscoalition.org, retrieved 9/24/08; Huang, Macbeth, Dodge & Jacobstein, 2004; Huang, Stroul, Friedman, Mrazek, Friesen, Pires, & Mayberg, 2005; McRee, et al., 2003).

For children, healthy development involves not only the absence of disease but also the ability to form healthy attachments, to cope with day-to-day challenges and to learn. Popular culture often depicts young children as infinitely resilient; however, as many as 7-20% of preschool and early school aged-children exhibit behavioral problems that meet criteria for a mental health disorder (Sites, Collopy, Velilla, Cayard & Graft, 2008). Despite these prevalence rates, national estimates indicate that 70% of children with diagnosable disorders do NOT receive mental health treatment (U.S. Public Health Service, 2000). Although many would protest the application of the term “mental health”
to kids under age six, such a rebuttal fails to recognize the importance of early
developmental experiences in establishing a solid foundation for healthy development
(Shonkoff & Phillips, 2000).

**Regional and Local Need in the Selected Locality**

Athens, Hocking, Vinton, and Meigs counties fall within the 29 Appalachian counties in
the State of Ohio. This southeast region is marked by hilly terrain, lack of economic
development, poor tax base, non-existent public transportation, and a homogeneous
population that is 97% Caucasian. 128,501 people reside in a service area that is
approximately 1,773.2 square miles. All are Mental Health Professional Shortage Areas
(MHPSA), represent a full or partial Medically Underserved Area/Population
(MUA/MUP), and all but Athens County are Health Professional Shortage Area (HPSA)
([http://bhpr.hrsa.gov/shortage](http://bhpr.hrsa.gov/shortage)). Additionally, the Appalachian Regional Commission
classifies Athens, Meigs and Vinton counties (2009) as distressed ([www.arc.gov](http://www.arc.gov),
retrieved 5/13/09). Table 1 below provides further detail:

**Table 1: Demographic Characteristics of 4 Appalachian Counties and the State of Ohio**

<table>
<thead>
<tr>
<th>Demographics</th>
<th>OHIO</th>
<th>Athens County</th>
<th>Meigs County</th>
<th>Hocking County</th>
<th>Vinton County</th>
</tr>
</thead>
<tbody>
<tr>
<td>% &lt; 8 yr old (2007)</td>
<td>10.7%</td>
<td>7.5%</td>
<td>8.7%</td>
<td>10.1%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Number &lt; 8 yr old, '07</td>
<td>1,230,595</td>
<td>4,748</td>
<td>2,007</td>
<td>2,938</td>
<td>1,498</td>
</tr>
<tr>
<td>Average Size Household (2000)</td>
<td>2.49</td>
<td>2.4</td>
<td>2.47</td>
<td>2.54</td>
<td>2.59</td>
</tr>
<tr>
<td>Unemployment rate, '09</td>
<td>10.1%</td>
<td>8.0%</td>
<td>15.4%</td>
<td>11.6%</td>
<td>14.2%</td>
</tr>
<tr>
<td>% Below poverty, '07</td>
<td>13.1%</td>
<td>29.4%</td>
<td>19.8%</td>
<td>16.0%</td>
<td>18.9%</td>
</tr>
<tr>
<td>% Completing less than High School. (05-06)</td>
<td>13.9%</td>
<td>6.3%</td>
<td>21.5%</td>
<td>2.3%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>


Our local system delivery challenges are highlighted in Ohio University’s Voinovich
Most participants agreed that young children were not receiving the services they needed
because of early identification barriers (lack of screening and an awareness of its
importance), professional barriers (working in silos, lack of coordination), and family
factors (overwhelmed and lack of access) (Johnson, McMath, Collins & Richerson, 2006,
p.3).

The system challenges are compounded by the complexity of the socioeconomic and
mental health challenges confronting families in our region described in an unpublished
report, *A Snapshot in Time*, written by the Athens County Family and Children First
Council in 2007. 66% of the open child welfare cases involved alcohol and drug abuse,
46% involved domestic violence, 39% involved parental depression and 82% lacked
appropriate social support placing children at risk. Of the active child abuse cases in
Athens County in 2007, 6.4% are estimated to involve children under the age of five.
Among the child abuse cases, 99% of the substantiated cases fell below the poverty guidelines (Family & Children First Council Planning Guide, 2005, unpublished report). A similar profile occurs for children attending our local Head Start programs. MACRO International (1999) identified the following risk factors for children involved with the SE Ohio regional behavioral health system: history of family violence (56%), family history of mental illness (52%), family history of substance abuse (65%), parent/caregivers have a previous psychiatric hospitalization (40%), one parent who has a felony conviction (24%), sibling who was previously institutionalized (14%) and a sibling in foster care (13%). Child risk factors included history of suspected physical abuse (32%), history of suspected sexual abuse (23%), ran away from home (21%), abused drugs or alcohol (20%) and previously harmed self (19%).

A growing body of evidence suggests that younger children are particularly vulnerable to the effects of psychosocial stressors, and that damaging effects are evidenced across the lifespan. The Adverse Childhood Experiences (ACE) study, which collected information about adult patients’ current health status and self-reported experiences with traumatic stressors in childhood (Felitti, 2002). Results indicated that:

- Adverse experiences in childhood are pervasive, with 66% of participants reporting at least one traumatic event, 25% reporting two events and 20% reporting three or more
- Participants exposed to one adverse experience were 80% likely to experience another
- Greater exposure to adverse events is associated with worse health outcomes in adulthood
- With seven or more adverse events, the risk of adult suicide attempt increases by 3,000%
- 60% of persons who report no adverse childhood events live to age 65 as compared to 3% of persons with 4 or more events (www.theAnnInstitute.org, retrieved August 10, 2008; www.cdc.gov/nccdphp/ace/findings.htm, retrieved September 24, 2008)

The negative effects of parental depression on child well-being are well documented. Consistently, depression in parents is recognized as a risk factor for childhood internalizing and externalizing disorders. As the evidence for the efficacy of psychotherapy and psychotropic medication for treating adult depression has grown, the field has shifted its focus of inquiry to examine whether treating depression in parents can improve behavioral symptoms for children under their care. Furthermore, the ability to deliver an efficacious treatment for depression through an integrated care model involving collaboration between primary care, psychiatric care and psychotherapeutic interventions has also been substantiated. (Butler, Kane, McAlpine, et al., 2008; Weissman, Pilowsky, Wickramaratne et al., 2006).

Collectively, this information underscores the importance of an ecological approach to assessment and intervention (Bronfenbrenner, 1986), recognizing the multiple contextual influences impacting young child wellness. The high poverty rates in this rural Appalachian region argue strongly for increasing our community capacity to provide mental health services to young children and their families.

Sensitivity to the cultural values and history of the region is essential when designing local solutions. The cultural identification of much of the target population is
Appalachian. Individualism, self-reliance, and pride of the population are mixed with a reliance on personal experience and distrust of authority. Local attitudes are influenced by exploitation of the land by absentee owners and by the bitter labor struggles in the area when mining was the predominant industry there. Participants from an Appalachian background are likely to base their response to a program based primarily on their personal experience with the “front line” clinician. Moreover, the people in Appalachian Ohio will not be concerned with evidence-based models or the research behind this project. Rather the value of the program will be judged by the attitude of those delivery services and the program’s local reputation. Although the Appalachian culture presents unique challenges to providing services, because of the values of fierce self-reliance, “making do” with available resources, and a distrust of outsiders; the strong values of kinship and the pride within the region provide a powerful, positive energy once it is harnessed.

Current Systems and Cross-System Coordination: State Level

Ohio has made substantial progress in addressing young children’s mental health needs, strengthening the quality and scope of our early care and education system, and closing the gap in children’s access to health insurance coverage. Since 2004, through the Early Childhood Comprehensive Systems (ECCS) grant, Ohio has increased young children’s access to health insurance and a medical home, as well as invested in social-emotional development, early care and education/child care, parenting education and family support.

In March 2007, Ohio’s Governor Strickland created, through executive order, the Early Childhood Cabinet charged with uniting key state agencies around the common goal of promoting school readiness by setting and coordinating state policy and programs that serve Ohio’s young children. Appendix 1 includes the MOA from these participant agencies.

Figure G1: Diagram of Ohio’s Early Childhood Systems
Consistent with the goals of SAMHSA’s Project LAUNCH initiative, Ohio’s Early Childhood Cabinet aims to ensure that all Ohio children have access to early childhood experiences that optimally support development -- socially, emotionally, physically and intellectually. To accomplish this vision, efforts have focused on increasing access to screening, early childhood consultation and treatment to address their social, emotional and physical development needs. The Cabinet’s structure challenges previously siloed systems to collaborate and diverse stakeholders have the opportunity to identify common agendas and leverage synergies.

The Cabinet has created the Early Childhood Advisory Council, a 45-member body comprised of parents, early childhood service providers, representatives of local social service, governmental and education agencies and advocacy organizations. A workgroup created from the Advisory Council will serve as the Project LAUNCH State Council with representation from our Local Child Wellness Council. Specifically, Project LAUNCH will allow Ohio to:

- Build awareness about the importance of early identification through evidenced-based screenings in primary care across all provider systems (medicine, education, etc.),
- Improve coordination of care from the point of identification, through the referral process, and the provision of evidence-based services so that consumers and those who serve young children share a vision of the components of strong families and young child wellness, and
- Develop policies and infrastructure to solidify supports that enable local communities to transform systems by leveraging community assets and cultural values.

**Current Systems and Cross-System Coordination: Local Level**

Holding forth the vision of ensuring healthy development for all children, Integrating Professionals for Appalachian Children (IPAC) brings enthusiasm, a focused vision and a history of successful collaboration to our State’s proposal. IPAC, which began meeting in October 2003, is a community-consumer-university rural health network. Incorporated in 2006, IPAC is governed by a 15 member board of directors representing seven constituency groups: Early Childhood and Education, Mental Health and Community Health Programs, Medical and Nursing, Allied Health, Consumers, Community Businesses, System Oversight agencies. Project LAUNCH offers an opportunity to collaborate for State policy and infrastructure reform.

IPAC’s development has been guided by two SAMSHA Programs, Circles of Care and Starting Early, Starting Smart. Whereas our Circles of Care underscored the importance of assessing community readiness (reported above) and monitoring potentially conflicting missions and core values; Starting Early, Starting Smart highlighted the importance of strengthening cross-program relationships through “joint staffing, … cross-training and family involvement” (2001, p 6) – all goals IPAC shares. IPAC’s capacity to effect change has grown as we’ve evolved from meeting to “hear” about what is going on, to “planning” to do things together. To date, we have been awarded four grants, three from the HRSA’s Office of Rural Health Policy to formalize our network and strengthen our local efforts to identify, to refer and to provide comprehensive coordinated care to young children with socio-emotional and
developmental needs. The chart below lists the agencies, representatives, roles and responsibilities, and prior relation to IPAC for each participant who has committed to serving on our Local Young Child Wellness Council. The Local Council Memorandum Of Agreement is found in Attachment 1.

Table G2: Local Young Child Wellness Council

<table>
<thead>
<tr>
<th>ROLE/RESPONSIBILITY</th>
<th>REPRESENTATIVE</th>
<th>IPAC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MENTAL HEALTH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Mental Health Center, TriCounty Mental Health</td>
<td>Sherry Shamblin, P.C.C-S EMCH Consultant, <a href="mailto:sshamblin@ecmhes.org">sshamblin@ecmhes.org</a></td>
</tr>
<tr>
<td></td>
<td>University, PI, IPAC President; Psychologist</td>
<td>Jane Hamel-Lambert, PhD <a href="mailto:Hamel-Lj@ohio.edu">Hamel-Lj@ohio.edu</a></td>
</tr>
<tr>
<td><strong>SUBSTANCE ABUSE</strong></td>
<td>Health Recovery Services INC</td>
<td>Pam Ramage, LISW, Clinical Director, <a href="mailto:pramage@hrs.org">pramage@hrs.org</a></td>
</tr>
<tr>
<td><strong>CHILD WELFARE</strong></td>
<td>Child Welfare; Athens Co. Children’s Services</td>
<td>Andrea Reik, Exec Director <a href="mailto:reika@odjfs.state.oh.us">reika@odjfs.state.oh.us</a></td>
</tr>
<tr>
<td><strong>CHILDHOOD EDUCATION</strong></td>
<td>Early Intervention, Athens Co Help Me Grow</td>
<td>David Hunter, MSW, LISW, Project Director <a href="mailto:HUNETD02@odjfs.state.oh.us">HUNETD02@odjfs.state.oh.us</a></td>
</tr>
<tr>
<td></td>
<td>Local Education, Athens-Meigs Educational Services Center</td>
<td>John Constanzo, Superintendent <a href="mailto:91_jconstanzo@seovec.org">91_jconstanzo@seovec.org</a></td>
</tr>
<tr>
<td></td>
<td>Early Intervention, Vinton Co. Help Me Grow, FCFC</td>
<td>Laura Harms, Project Director <a href="mailto:harms@vintonhealth.org">harms@vintonhealth.org</a></td>
</tr>
<tr>
<td></td>
<td>Pre-School, Hocking-Athens-Perry Head Start</td>
<td>Chris DeLamatre, MSW, Child Development Director</td>
</tr>
<tr>
<td><strong>HEALTH/ALLIED HEALTH</strong></td>
<td>Community Health Outreach/Family Navigator at OU</td>
<td>Sue Meeks, RN,C <a href="mailto:meeks@ohio.edu">meeks@ohio.edu</a></td>
</tr>
<tr>
<td></td>
<td>Physician, Family Healthcare (FQHC)</td>
<td>Dawn Murray, DO Medical Director <a href="mailto:murraydoc@yahoo.com">murraydoc@yahoo.com</a></td>
</tr>
<tr>
<td></td>
<td>Physician, University Medical Associates</td>
<td>Karen Montgomery-Reagan, DO, Pediatrics</td>
</tr>
<tr>
<td></td>
<td>Food and Nutrition Service, WIC</td>
<td>Jodi Shriver Director, Athens Clinic</td>
</tr>
<tr>
<td></td>
<td>Public Health, Athens City-County Health Dept.</td>
<td>James Gaskell, MD Health Commissioner</td>
</tr>
</tbody>
</table>
Three years ago, behavioral health services for children were not delivered through primary care in our four county region. Today, because of the efforts of IPAC, four primary care offices now have mental health providers on-site. Given the complexities of the financial reimbursement structures, two fiscal models have emerged dependent on the type of organizations involved. The federal reimbursement system that supports integration of services through the federally qualified health centers enables a contractual partnership between one of our community mental health centers and the FQHC. Those advantages disappear for group practices that are not FQHCs. Our local integration efforts have had to blend together community mental health center providers and private practitioners to create access for all children.

Challenges to integrating mental health providers into primary care are not just limited to financial barriers. Organizational dynamics which include cultural differences inherent in discipline-specific assumptions and biases, time considerations, infrastructure issues (scheduling, billing, communication) and expectations regarding outcomes also inform outcomes. Whereas shared planning and jointly defined goals are essential to advancing collaborative models of care, they will not prevent tensions that arise. However, the power of holding a shared vision for change will encourage participants to examine and learn from the tensions that do emerge and will inform successful integration efforts (Hamel-Lambert J. & Murphy C., 2008).

Section B: Proposed Evidence-Based Service/Practice

Project LAUNCH for Appalachian Ohio will create a shared vision for young child wellness that builds a solid foundation for sustaining effective, integrated services and systems to support and promote the wellness of young children and their families. In response to the local needs, notable for high levels of poverty, low educational attainment and family risk factors, we propose the following evidenced-based assessment and treatment strategies. Whereas the selected screening tools and early intervention and
consultation practices target the individual child, treatment strategies and home visiting programs are aimed at improving the well-being of parents, optimizing their ability to parent. Situated within Appalachia, our efforts respect the strong family values, fierce independence and pride of its people. We aim to empower families, not only by building their capacity of caregivers and the knowledge and skills of local providers, but also by strengthening the integration across systems to reduce fragmentation which has historically burdened families to coordinate their own care.

**ASQ/ASQ-SE:** The Ages & Stages Questionnaires® (ASQ) and ASQ:SE are a parent-completed, child-monitoring system that screens and monitors a child’s development between 4 months and 5 years of age. The ASQ has been rigorously tested and validated by nearly 30 years of research, and a 2006 American Academy of Pediatrics Policy Statement and a 2001 AAP article in Pediatrics support its use in pediatric settings. Squires, Potter, Bricker & LaMore (1998) confirm its use with low- and middle-income parents. ASQ and ASQ-SE address the risk factors of low education and cultural norms against mental health treatment and promote the protective factor of strong family connections by providing an accessible instrument for parents to use as the primary source of information about their child.

**M-CHAT:** The Modified Checklist for Autism in Toddlers (M-CHAT) is a 23 item parent report checklist developed to screen children ages 16 months to 30 months old. The M-CHAT was one of the first broadly tested screening instruments specifically for autism. Sensitivity was found to be good (Robins, Fine, Barton & Green, 2001). Additional research on the MCHAT continues, funded by the National Institute of Child Health and Development (NICHD). The M-CHAT addresses the risk factor of low education and promotes the protective factor of strong family connections.

**Edinburgh Scales:** The Edinburgh Postnatal Depression Scale was originally designed to screen for maternal depression at the 6 – 8 week postpartum examination. The 10 item questionnaire can usually be completed in less than five minutes. Its validity has been discussed in various journal publications (Wisner, Perry, & Piontek, 2002; Nielsen, Videbech & Hededgaard, 2000). Modified in 1990, The Edinburgh Depression Scale (EDS) was adopted for used in the general adult population, using a cutoff score of 13 for non-postnatal women. Gaynes et al. (2005) (http://www.ahrq.gov/downloads/pib/evidence/pdf/peridepr/peridep.pdf, retrieved on May 18, 2009) endorsed the validity of this tool. Successful treatment of depression can promote healthy bonds between mothers and newborns: and identification is the first step in the process.

**PHQ-9:** Patient health Questionnaire-9 is based directly on the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). It has been widely validated, has a sensitivity of 88%, and a specificity for 88% for major depression (Kroenke, Sptizer, & Williams, 2001). This tool has a number of advantages for primary care-behavioral health care integration teams: it was designed to be used by physicians with their patients, it is short, can be used to make an initial diagnosis or to monitor treatment, and is free www.depression-primarycare.org.

**The Devereux Early Childhood Assessment (DECA) Tools** are standardized, norm-referenced behavior rating scales for children. The DECA system is based on three
protective factors: attachment, self-control, and initiative and also includes a behavioral concerns screener. Tools can be completed by parents, teachers, and other caregivers. The DECA was normed on a sample of children that accurately reflects the diversity of children in the country and was found to be culturally neutral. The DECA is designed for children 2-5. The Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T) is designed for use with infants and toddlers. The Devereux Student Strengths Assessment (DESSA) is designed for children in grades K-8. The Devereux Early Childhood Assessment Clinical Form (DECA-C) is intended to use with selected children already showing significant emotional/behavioral concerns. It is completed by both teachers and parents and interpreted by a behavioral specialist.

**Early Childhood Mental Health Consultation (ECMHC):** Ohio’s Early Childhood Mental Health Consultation program has been recognized by experts at the National Technical Assistance Center for Children’s Mental Health, Center for Child Health and Mental Health Policy at Georgetown University Child Development Center and supported by SAMHSA; the Child, Adolescent and Family Branch of the Federal Center for Mental Health Services; and the Zero to Three Association for Early Childhood Programs. The primary goal of ECMHC is to increase knowledge, awareness, resources and skills necessary for communities to meet the behavioral health needs of young children and their families. The program’s objectives are to build protective factors in young children, increase skills of parents and promote the competencies of early childhood providers, especially for young children who are at risk.

**The Incredible Years:** The Incredible Years is an award-winning parent, teacher, and child social skills training and has been selected by the U.S. Office of Juvenile Justice and Delinquency Prevention as an “exemplary” best practice program, a “Blueprints” program, and a “Model” program by the Center for Substance Abuse Prevention (CSAP). The American Psychological Division 12 Task force has recommended The Incredible Years as a well-established treatment for children with conduct problems. The Incredible Years has two long-range goals. The first goal is to develop comprehensive treatment programs for young children with early onset conduct problems. The second goal is the development of cost-effective, community-based, universal prevention programs that all families and teachers of young children can use to promote social competence and to prevent conduct problems. The program targets parents, caregivers and children ages 2 to 12. The Incredible Years addresses risk factors in parenting practices and child social competence. Training in effective parenting can not only reduce violence and boost parents' self-confidence but also contribute to children's enhanced social competence, which in turn promotes the protective factors of stronger bonding and relationships with parents. Young children with poor social skills are more likely to be rejected by their peer group and to become lonely, isolated and unhappy—risk factors that can be exacerbated by the geographic isolation of rural Appalachia. Providing children who have poor social competence with skills including how to play with other children, affective awareness, how to be friendly and talk to peers as well as in self-control and how to problem solve conflict situations can result in less- aggressive responses and the development of protective factors including more positive friendships and more pro-social groups.
Parents As Teachers (PAT) is a program that provides parents with knowledge about their child’s development and offers parent groups, activities for parents to complete with their child, and information about parenting skills. The curriculum is provided to parents in their own homes and in group settings with other parents. Believing that the early years of a child's life are critical for development, PAT seeks to provide the foundation for success in school and in life by educating parents. The PAT materials are culturally sensitive, and they offer additional materials for working with teen parents and/or parents whose child has a disability. Since 1984, 13 outcomes studies on 16,000 parents and children have been conducted on PAT with varying levels of support for increased knowledge of child development and parenting, reduced risk for abuse and neglect, and early detection of delays (Shaklee, Hardin, Clinton, & Demarest, 2003).

PCIT/PCIT-A: Parent-Child Interaction Therapy (PCIT) is a play-based, empirically-supported treatment for young children at risk for developing conduct disorders. It emphasizes the parent-child relationship by intervening at two levels: strengthening a parent’s behavior management techniques through direct teaching by the therapist, and strengthening the parent-child relationship by the therapist coaching during play sessions. PCIT has demonstrated statistically and clinically significant improvements in the conduct-disordered behavior of preschool age children in a number of ways on behavior rating scales, on parent ratings and observational measures, in the interactional style, and increased parental reflective listening, physical proximity, and pro-social verbalization (www.pcit.phhp.ufl.edu). PCIT Applications (A) was developed to further expand the use of PCIT to families where children have experienced trauma, up to age 12 (www.cincinnatichildrens.org). These criteria make PCIT-A an appropriate selection for southeastern Ohio families who can experience high levels of stress and children at high risk for exposure to domestic violence and/or abuse.

PCIT standard protocols include the use of two therapists, parent coaching by the therapist from an observational room with an “in-the-ear” microphone, participation of two parents/ caregivers, and a number of parent-completed rating sheets. Modifications will include the use of one provider offering PCIT coaching to participating caregivers while in the room with the families and sessions will be videotaped. In follow-up session time, the parent and therapist will code the video taped session together and discuss changes to be made during the next play session with the child. This will create an extended treatment schedule for participating families. Additionally, because we will be offering this treatment in non-clinic locations, the richness of the play choices for the child may be reduced. Again this is appropriate for many of the low-income Appalachian families participating in this project.

Ounce of Prevention: Ounce of Prevention is Worth a Pound is a toolkit developed by the Ohio Department of Health in partnership with the Ohio Chapter of The American Academy of Pediatrics, the Ohio Dietetic Association, the Columbus Children’s Hospital Center for Healthy Weight and Nutrition, and the American Dairy Association Mid-East. This toolkit was developed to address childhood obesity and makes use of anticipatory guidance during well-child visits. In follow-up surveys, physicians reported that the materials were easy to use (80% were using the materials), and 100% of participating
parents were receptive to the materials. This project proposes to use the materials through Women, Infants, and Children (WIC) during well-child and coupon dissemination contacts. The 90% readability parental rating makes this an ideal tool for WIC participants in the 4-county Appalachian region covered by this project.

TF-CBT: Trauma-Focused Cognitive Behavior Therapy (TF-CBT) has been recognized by SAMHSA (http://www.modelprograms.samhsa.gov/pdfs/model/TFCBT.pdf) as a model program. This therapeutic intervention was designed to help children and their families cope with exposure to trauma. The program is effective for children 3-18 and targets symptoms of PTSD, co-occurring depression, and co-occurring behavior problems. Developed and tested at the Allegheny General Hospital for Traumatic Stress in Children and Adolescents, the tool has shown reductions in the challenging behaviors associated with trauma-exposure, improvement in behaviors related to protective factors, and increases in the competency of adult caregivers (www.pittsburghchildtrauma.org).

IMPACT: Improving Mood--Promoting Access to Collaborative Treatment (IMPACT) (http://impactuw.org/about/key.html) is an evidenced based treatment protocol for depression. The model blends together the collective expertise of primary care physicians, mental health clinicians, and psychiatrists. Randomized control trials have demonstrated that IMPACT produced a 45% reduction in depressive symptoms, compared to a 19% reduction expected from usual standard of care. Working together, the mental health clinician and the primary care provider engage the consumer in treatment that includes medication management, psycho-educational sessions, behavioral activation, and brief counseling. Depression symptoms are monitored using the PHQ-9 (http://muskie.usm.maine.edu/clinicalfusion/DHHS/phq9.pdf) screening tool and psychiatric consultation is indicated if symptoms have not remitted by 50%. In November of 2007, following an extensive independent review of the evidence supporting IMPACT, it was entered into the SAMHSA-sponsored national registry for EBPs (http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=130).

The implementation of the evidenced based depression intervention program, IMPACT, will be modified due to our regional shortage of local community–based psychiatrists. The initial patient-psychiatry case planning session will occur between the primary care physician and the Master’s degree-trained therapist. To balance the absence of psychiatric mental health expertise, providers in the care coordination role will not be paraprofessionals. Instead, the therapeutic services will be delivered by a master’s-prepared mental health clinician. The primary care physician will prescribe the first round of medication if needed, and then consultation with the community psychiatrist will be employed for medication review and management consultation if the patient’s symptoms have not remitted by 50% as advised in the model. Additionally, we are implementing this with a young adult population; the original study used older adults (55+), however, subsequent research has been done with general adult populations (Butler et al, 2008).

Section C: Proposed Implementation Approach

The goal of Project LAUNCH is to create a shared vision for young child wellness that builds a solid foundation for sustaining effective, integrated services and systems to
support and promote the wellness of young children and their families. At the state level, Project LAUNCH will allow Ohio to (a) Build awareness about the importance of early identification through evidenced-based screenings in primary care across all provider systems (medicine, education, etc.) (b) Improve coordination of care from the point of identification, through referrals and the provision of evidenced-based services such that consumers and those who serve young children share a vision of what strengthens families and optimizes young child wellness, and (c) Develop policies and infrastructure to solidify supports that enable local communities to design system reforms that leverage community assets and respect local cultural values.

Locally, Project LAUNCH has two goals. Goal 1 addresses services and will (a) increase the number of sites and the types of developmental screening tools used in the region, (b) increase the number of primary care sites with integrated behavioral health services offering evidenced based treatments (PCIT, TF-CBT, IMPACT), (c) implement EBPs Home Visiting program, (d) provide EMCH-CL in primary care, preschools, homes, and early childcare settings, and (e) strengthen families through expansion of the Family Navigator Program, parent skills training, nutrition counseling, art and recreation programs. Goal 2 strengthens local infrastructure and develops workforce capacity. Working together the State and Local Young Child Wellness Council will accomplish systems integration and advance public understanding of the multiple determinants of child wellness.

Figure G2: Ohio’s State Logic Model for Early Childhood
Next follows a detailed work plan that serves as a draft of our strategic plan. This work plan will be refined following environmental scan activities via coordinated planning with the State Council. It includes two local goals; one addresses services, the second addresses infrastructure and capacity development.
Goal 1: IPAC Young Child Wellness Council will expand using evidence-based programs and practices to promote the wellness of young children and their families in five programmatic areas: Developmental Assessments (Objective A), Home Visits (Objective B), Early Childhood Mental Health Consultations (Objective C), Integration of Behavioral Health/Primary Care (Objective D), and Family Strengthening and Parent Skill Training (Objective E).


Part One: Increase the number of sites conducting development screenings from 4 to 12. Expand types of screening provided in primary care in all 12 sites EBP Tools are ASQ, ASQ:SE, MCHAT, Edinburgh and PHQ-9 Depression screens (see Section B). Improve coordination through on site mental health providers, referrals to indicated agencies, including family navigator.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Dates</th>
<th>Expected Outcome</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1, Activity 1: Random chart review at all twelve sites to identify current screenings and to identify training needs.</td>
<td>Oct 09 – May 09</td>
<td>• Existing profile used to develop training plan for each site</td>
<td>Carole Lannon, MPH, MD/ local support</td>
</tr>
<tr>
<td>Year 1, Activity 2: Booster training session for 4 sites previously trained on ASQ and ASQ:SE; introductory training for 8 new doc sites and 1MH site</td>
<td>Jun 09 – Dec 10</td>
<td>• Sites commit to implementation schedule • Random chart evaluation of adherence to implementation schedule (goal 80%)</td>
<td>Carole Lannon, MPH, MD</td>
</tr>
<tr>
<td>Year 1.5 – 2.5, Activity 2: 12 primary care sites participate in ½ day workshop with didactic presentation on depression and introduction to depression screening tools.</td>
<td>Feb 11 – Feb 12</td>
<td>• 3 – 5 key primary care staff trained • Sites adapt procedures for depression • Algorithm include referral procedures</td>
<td>Carole Lannon, MPH, MD</td>
</tr>
<tr>
<td>Year 2.5 – 3.5, Activity 3: 6 – 8 sites who provide the pediatric well-child care in our four county region participate in ½ day workshop with didactic presentation on autism, MCHAT screening tool, its interview and concordance data</td>
<td>Feb 12 – Feb 13</td>
<td>• 3 – 5 key primary care staff trained • Sites adapt procedures in place to include an algorithm for screening for autism • Algorithm include referral procedures</td>
<td>Carole Lannon, MPH, MD / local trainer</td>
</tr>
<tr>
<td>Year 1,2,3; Activity 4: Ongoing implementation support provided to problem solve challenges in workflow changes.</td>
<td>May 10 - April 12</td>
<td>• staff utilize support tools (webinars, teleconferences, phone consultation, sites visits); Policies and procedures modified</td>
<td>Carole Lannon, MPH, MD / local trainer</td>
</tr>
<tr>
<td>Years 3.5 – 5.0, Activity 5: Monitoring and site evaluation; additional didactic trainings offered as needed on topics of interest (autism intervention, depression treatment studies)</td>
<td>Feb 12 – Aug 14</td>
<td>• Referrals and care coordination strengthened through capacity develop</td>
<td>Carole Lannon, MPH, MD / local trainer</td>
</tr>
</tbody>
</table>
Part Two: Enhance local Interdisciplinary Assessment Team (IAT) via telemedicine link to Nationwide Children’s Hospital Developmental and Behavioral Pediatrics and Clinical Psychologist, both autism experts. Expansion through telemedicine offers coordinated services with Nationwide Children’s Hospital without travel/time expenses. Evaluations annually: 24 children.

<table>
<thead>
<tr>
<th>Objective A, Part Two</th>
<th>Evaluation</th>
<th>Year 1, Activity 1: Purchase equipment to negotiate installation with university IT.</th>
<th>Year 2, Activity 3: Doc/MH teams integrate forms and procedures (e.g., scheduling, record storage, permission to share information) to facilitate service delivery in EBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>To expand the services of the Interdisciplinary Assessment Team, telemedicine linkage will be established with Nationwide Children’s Hospital HP18-6, HP 16-23, HP 1-6</td>
<td>Evaluate annually:</td>
<td>Oct 09 – Feb 10</td>
<td>Oct 09 – Feb 10</td>
</tr>
<tr>
<td></td>
<td>• % of evaluations that involve telemedicine services</td>
<td>• Equipment in place, acclimatize to telemedicine, use for meetings</td>
<td>• Equipment in place, acclimatize to telemedicine, use for meetings</td>
</tr>
<tr>
<td></td>
<td>• The number of sub-specialist link to local team via telemedicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Costs effectiveness (costs saved consumers, cost involved in implementation)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• % family satisfaction with teledicine services utilized. (Goal 90%)</td>
<td></td>
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</tr>
<tr>
<td>Year 1, Activity 2: Infrastructure developed: identify types of services that can be delivered via telemedicine, billing, legal releases, reimbursement issues</td>
<td></td>
<td>Mar 09 – Sept 09</td>
<td>Sept 09</td>
</tr>
<tr>
<td></td>
<td>Telemed schedule established</td>
<td></td>
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<tr>
<td></td>
<td>Identify provider/services available</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Billing procedures established</td>
<td></td>
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</tr>
<tr>
<td>Year 1, Activity 3: Interdisciplinary Assessment Team delivers a portion of the team evaluation via telemedicine link to Nationwide specialists.</td>
<td></td>
<td>June 10 – Sept 10</td>
<td>Sept 10</td>
</tr>
<tr>
<td></td>
<td>6 children served via telemed by Behavioral and developers and psychologist</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Year 3, 4, 5, Activity 4: Evaluate reimbursement, cost structure, sustainability. Expand if feasible.</td>
<td></td>
<td>Oct 11 – Sept 14</td>
<td>Sept 14</td>
</tr>
<tr>
<td></td>
<td>Procedures and services modified</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>New professions added to the team</td>
<td></td>
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</tr>
<tr>
<td>Year 3, Activity 5: Administer a survey to assess consumer and referral satisfaction with program.</td>
<td></td>
<td>Oct 11 – Feb 12</td>
<td>Feb 12</td>
</tr>
<tr>
<td></td>
<td>Modify procedures based on consumer feedback.</td>
<td></td>
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</tr>
<tr>
<td>Year 4,5, Activity 6: Expand capacity as needed</td>
<td></td>
<td>Oct 12 – Sept 14</td>
<td>Sept 14</td>
</tr>
<tr>
<td></td>
<td>Increase number of consumers tested; Diversify types of consults</td>
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</tbody>
</table>

Objective B: Integration of behavioral health programs and practices in primary care. To improve our ability to provide comprehensive care, we will expand the number of primary care sites which have a co-located mental health provider from a community mental health center or from private practice groups. To improve access to evidenced-based intervention programs, providers will be trained in three evidenced-based programs: Parent Child Interaction Therapy (PCIT), IMPACT evidence-based depression care, and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). PCIT is an intervention appropriate for young children; IMPACT and TF-CBT address adolescent and adult patient needs, addressing whole family mental health needs.

<table>
<thead>
<tr>
<th>Objective B: To improve our ability to provide comprehensive care, we will embed mental health providers in primary care settings and develop the infrastructure to support the co-location of providers to offer coordinated, interdisciplinary services. Strengthened by providing training in three evidenced-based treatment programs: PCIT-A, TF-CBT, and IMPACT Dep. HP 18-6, HP 16-23, HP 18-17, HP 1-6</th>
<th>Evaluation:</th>
<th>Year 1, Activity 1: Available mental health staff assigned primary care settings. Increasing sites or type of services in 9 sites, 6 are new locations. Inc capacity at existing.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annually</td>
<td>Oct 09 – Feb 09</td>
</tr>
<tr>
<td></td>
<td>• % of primary care partners with integrated mental health services</td>
<td>• Mental health services available in 3 solo practices, 3 sites of FQHCs, and 3 sites in university-affiliated group practice</td>
</tr>
<tr>
<td></td>
<td>• % of sites delivering evidenced based practices</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• % of consumers satisfied with integrated services delivery (85%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Council Coordinator, TCMH-CS, FQHC, UMA, private physician groups, HRS</td>
</tr>
<tr>
<td>Year 1, Activity 2: EBP training in model IMPACT offered in local region; online program option available.</td>
<td></td>
<td>Spring 09</td>
</tr>
<tr>
<td></td>
<td>U Washington trains 20 professionals on IMPACT, EBP for depression</td>
<td></td>
</tr>
<tr>
<td>Year 2, Activity 3: Doc/MH teams integrate forms and procedures (e.g., scheduling, record storage, permission to share information) to facilitate service delivery in EBP</td>
<td></td>
<td>Oct 09 – Feb 10</td>
</tr>
<tr>
<td></td>
<td>Site-specific models designed to fit composition and population served</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practitioners from doc offices and MH providers</td>
</tr>
</tbody>
</table>
Objective C: Home Visits. The Help Me Grow ongoing home visiting program helps to promote the well being of children who are at risk for developmental delay and their families. Estimated contacts: 419 families. Part One: Regional Outreach Specialist: Beginning July 1, 2009 the HMG eligibility for At Risk will be significantly modified. Identifying these very high risk moms requires new and more targeted child find activities including hiring a regional HMG Outreach Specialist serving 4 counties. This person would develop and implement strategies to identify at risk women from all medical practices serving pregnant woman and infants in the four county area; coordinate referrals to the appropriate County HMG and for additional assessment and services; help develop a coordinated public awareness campaign regarding child wellness and other child find strategies to be used throughout the region. Part Two: Parents as Teachers is being adopted by all Ohio HMG agencies to strengthen families/improve parenting skills through home visits, parent group meetings, screenings, and providing resources to families. Emphasis is on understanding developmental trajectories, setting appropriate expectations, and supporting optimal development. Screenings coordinated with primary care, interdisciplinary assessment team, family navigator, ECMH consultant for the county, or other indicated specialists.

| Year 2,3 Activity 4: EBP training in Parent Child Interaction Therapy completed by 8 providers; EBP training in Trauma-Focused- Cognitive Behavior Therapy completed by 4 providers. Year 3, 4 more attend TFCBT. | Oct 10 – Aug 12 | • U Cinci Mayerson Center five day PCT-A completed by 8 mh provider  
• Pittsburg offering of TF-CBT completed by 8 mental health providers | Hamel-Lambert, Local Council Coordinator |
| Year 2,3 Activity 3: Administer consumer satisfaction survey to assess satisfaction with program. | Jan 09 - April 09 | • 75% of consumers receiving services in primary care settings complete survey | Hamel-Lambert, Local Council Coordinator |
| Year 3, Activity 4: Refine procedures and infrastructure based on survey data. | May 09 – April 10 | • Changes implemented  
• Re-administer survey | Hamel-Lambert, Local Council Coordinator |

### Objective C: Expand and enhance capacity of our region’s HMG programs to offer home-based parent education and service coordination by (1) developing a regional outreach/public awareness campaign (2) adoption of an evidence-based home visiting curriculum, “Parents as Teachers.”

#### Part 1: Regional Outreach Activities

| Year 1, Activity 1: Hire a Regional Outreach Specialist to develop and coordinate Public Awareness, “Child Find”, and Public Health Education | Oct 09 - Feb 10 | • Regional Outreach Specialist employed; first shared employee across programs | Dave Hunter, Athens County HMG Director in coordination with other HMG directors |
| Year 1,2,3,4,5 Activity 2: Regional Outreach Specialist (ROS) will work with communication team to develop a shared vision of child wellness. Team will produce HMG communication tools to be used with referrals sources and with the community. | Jan 10 – Sept 14 | • HMG Packets for Medical Practices  
• HMG brochures for community referral sources  
• HMG tools developed to increase public awareness | TBA Regional Outreach Specialist |
| Year 2, Activity 3: ROS will contact pediatric and OB/ GYNs in the 4- County region, new criteria | Oct 10 – Jan 11 | • Referral Process and HMG packets  
• 90% of Medical Practices given promo | TBA Regional Outreach Specialist |
| Year 2, Activity 3: ROS reduces barriers, increases communication between doc and HMG programs. | Jan 11 – Sept 14 | • 85% of practices referring to HMG  
• 20% increase in med practices referrals | TBA Regional Outreach Specialist |
| Year 2, Activity 4: ROS attends a minimum of 2 Community Events for each county | Oct 10 – Sept 14 (Repeats yearly) | • 50% increase in HMG parent-initiated referrals | TBA Regional Outreach Specialist |

#### Part 2: Parents as Teachers

| Year 1, Activity 1: HMG train on “Parents As Teachers” (PAT), an EBP parent education program. | Oct 09 – Sept 10 | • 100% HMG staff are PAT-certified parent educators | State HMG office, HMG directors, HMG staff |
**Year 2, Activity 2:** HMG staff will begin implementation of PAT with enrolled HMG families

<table>
<thead>
<tr>
<th>Date</th>
<th>Expected Outcome</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 10 – Jan 11</td>
<td>100% of Family Plans or IFSP include Family Strengthening goal</td>
<td>HMG directors, HMG staff</td>
</tr>
</tbody>
</table>

**Year 2,3,4,5 Activity 3:** Through state consultation, HMG staff will increase competence on PAT model.

<table>
<thead>
<tr>
<th>Date</th>
<th>Expected Outcome</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 10 – Aug 14</td>
<td>Data collected and Pre-Post PAT measures are evaluated</td>
<td>HMG staff; Evaluator</td>
</tr>
</tbody>
</table>

**Objective D: Early Childhood Mental Health Consultation (ECMH-CL) in Early Education Settings.** ECMH-CL is a “problem-solving and capacity-building intervention” that occurs between a qualified consultant and children, teachers, and other staff in a preschool or childcare setting. It aims to improve the ability of staff, programs and families to prevent, identify and address mental health problems. Child/Family Consultation may also result in individual assessment and treatment for children and families either on-site or in appropriate mental health settings. The second level of ECMH-CL service, Programmatic Consultation, aims to develop the capacity of early childhood providers to manage social, emotional, and behavioral issues (Green, Everhart, Gordon & Gettman, 2006). Improves child self-control, teacher perceptions of classroom quality, teacher confidences and teacher self-efficacy (Alkon, Ramler and MacLennan, 2003; Gilliam, 2007; Geller & Lynch, 1999). Estimated Vinton County Preschools contacts: 65 children, 6 staff; HMG referrals for ECMH services are estimated at 50.

**Part One: ECMH Consultation Services.** Increase the number of early childhood program receiving early childhood mental health consultation (ECMH) by expanding to Vinton County (3 preschools, HMG) EBP Tools DECA, IY, Depression tools, Georgetown. **Part Two: ECMH Training.** Workforce development initiative to increase number of professionals trained on Ohio’s ECMH Core Competencies, preparing individuals to work in early childhood professions.

**Objective D, Part One:** Expand ECMH-CL to serve Vinton Healthy People 2010: 1-6; 11-6; 16-14,23; 18-6,9,17

<table>
<thead>
<tr>
<th>Activities</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1, Activity 1: Hire 2 Early Childhood Mental Health consultants for Vinton and Washington Counties.</td>
<td>Oct 09 – Nov 09&lt;br&gt;ECMH consultants hired</td>
</tr>
<tr>
<td>Year 1, Activity 3: Meet regional early childhood professions (teachers, HMG, Childcare staff) and when indicated, design agency specific implementation plan.</td>
<td>Nov 09 – Dec 09&lt;br&gt;100% early childhood agency staff attending orientation meeting&lt;br&gt;100% staff complete interest surveys</td>
</tr>
<tr>
<td>Year 1, Activity 2: ECMH consultants trained on classroom-based ECMH including Incredible Years Program and the Georgetown ECMH model</td>
<td>Nov 09 – Sept 10&lt;br&gt;ECMH consultants, self-asses; pre, post&lt;br&gt;Providers gain capacity to administer structured ECMH consultation</td>
</tr>
<tr>
<td>Year 1 - 5, Activity 4: ECMH-CL attend ODMH peer supervision group which is a case based-learning support group to build ECMH consultant’s competence</td>
<td>Jan 10 – Sept 14&lt;br&gt;ECMH attends monthly case-based peer consultation training program (85%)&lt;br&gt;ECMH do formal case presentation</td>
</tr>
</tbody>
</table>

**Activities in Preschools or Center-based programs include activity 5 and 6**

<table>
<thead>
<tr>
<th>Year 1,2,3,4,5 Activity 6: Establish classroom-specific consultation plans based on Devereux Reflective Checklists for Teachers.</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb 10 – May 14 (Reviewed and updated annually)</td>
<td>2-4 goals identified, Jointly authored Center and Schools complete Devereux Reflective Checklists, pre/post</td>
</tr>
</tbody>
</table>
### Year 1,2,3,4,5 Activity 7: ECMH consultant and preschool teachers facilitate implementation of service

**Dates:** Feb 10 – May 14

- Increased familiarity with, between EMCH provider, teacher, parents,

**Partner Responsible:** S. Shamblin, PPC-S, ECMH teachers

Targeted Intervention services include activity 8 and 9, appropriate for any setting serving young kids.

### Year 1,2,3,4,5 Activity 8: Targeted consultation provided to children nominated by teachers or HMG staff; parent consent obtained and program implemented. Refer and coordinate with other staff and resources as needed.

**Dates:** Feb 10 – May 14

- DECA resiliency score increases for 75% and/or problems scores decrease for 75% for children receiving at least four months of individualized treatment

**Partner Responsible:** S Shamblin, PPC-S Program Director, Preschool Coordinators, Consulta nt Preschool teachers

Optional Intensive Intervention services include activity 10,11, 12, appropriate for any setting serving young kids.

### Year 1,2,3,4,5 Activity 8: Parent consent to individualized intervention / HIPAA compliant procedures apply. Depression screen offered to parents

**Dates:** Feb 10 – May 14

- 50% of children elect rec MH services
- % parents completing Dep. screen
- pre –post DECA scores

**Partner Responsible:** S. Shamblin, PPC-S Program Director TBA, ECMH Consultants

### Year 1,2,3,4,5 Activity 14: Plan and implement a summer group using Incredible Years program

**Dates:** All summers

- With six enrolled families, 85%
- Incredible Years Parent Scale pre/post

**Partner Responsible:** S. Shamblin, PPC-S TBA, ECMH consultants

### Objective D, Part Two: Implement a workforce initiative to increase capacity of the professionals and paraprofessionals working with young children to support optimal development. Includes annual didactic trainings, a certificate program and a university course using Ohio’s ECMH Core Competency Document.

**Activities** | **Dates** | **Expected Outcome** | **Partner Responsible**
---|---|---|---
**Year 1, Activity 1:** EMCH Director will offer DECA’s “Face the Challenge: Challenging Behavior

Oct 09 – Aug 10

- % of participants who report a increase in knowledge; Number of people trained

S. Shamblin, PPC-S ECMH Program Director

**Year 2, Activity 2:** IPAC will sponsor an ECMH for regional Early Childhood Professionals. Topic identified through ECMH experience in the 4-county area.

Oct 10 – Aug 11

- % of participants who report a increase in knowledge
- Number of people trained

S. Shamblin, PPC-S ECMH Program Director

**Year 3, Activity 3:** IPAC and Ohio University will co-sponsor an ECMH training series for regional Early Childhood Professionals based on Ohio’s Early Childhood Mental Health Core Competency Document.

Oct 11 – Aug 12

- % participants attending 2 or more sessions
- Number of people trained
- Number who earn certificate

S. Shamblin, PPC-S ECMH Program Director and Tom Davis, Ph.D., OU Counseling Department

**Year 4, Activity 4:** OU summer seminar open to enrolled students and professionals based on Ohio’s ECMH Core Competency Document

Oct 12 – Aug 13

- Number of students enrolled
- % passing with B or better

S. Shamblin, PCC-S & Tom Davis, Ph.D.

**Year 4, 5, Activity 5:** Ohio University’s Counseling Department will offer an elective course ECMH Core Competency Document.

Oct 11 – June 14

- Course offered 2013-2014
- Number of students enrolled
- % passing with B or better

Tom Davis, Ph.D. OU And Shamblin, PCC-S, TCMH
**Objective E: Family Strengthening and Parent Skills.** Family and community-focused interventions include (1) the expansion of our Family Navigator Program to reduce barriers and enable coordinated and efficient access to health care systems, (2) the expansion of the Family Support Program by supporting a school based social worker in an elementary school, (3) the enhancement of WIC nutritional intervention by implementing the ODH evidence-based Ounce of Prevention program in the 4 county region, (4) funding for an arts “Artists in Schools” in 21 elementary schools and (5) supporting youth recreation.

<table>
<thead>
<tr>
<th>Objective E: Part One: Family Navigator Program will expand to reduce barriers and enable coordinated and efficient access to health care systems.</th>
<th>Evaluation: Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of consumers satisfied at either a 4 or 5 on a Likert Scale</td>
<td></td>
</tr>
<tr>
<td>Referral Profile: number of referrals, by referrals source.</td>
<td></td>
</tr>
<tr>
<td>% increase in funding</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Navigator (FN) Program</th>
<th>Dates</th>
<th>Expected Outcome</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1, Activity 1:</strong> FN participates in environmental scan and Young Child Wellness Council planning</td>
<td>Sept 09 – Feb 09</td>
<td>• Strategic plan includes expansion of FCN Program</td>
<td>Manager, Family Navigator Program and K. Trace</td>
</tr>
<tr>
<td><strong>Year 1 – 5, Activity 2:</strong> Manager develops regional network of key community leaders and agency directors and staff in order to understand community assets</td>
<td></td>
<td>• Director attends FCFC or other county child serving consortium to determine community assets and needs</td>
<td>Manager, Family Navigator Program</td>
</tr>
<tr>
<td><strong>Year 1 - 5, Activity 3:</strong> FN services to families re: diagnostics, recommendations, access desired services.</td>
<td>Sept 09 – Aug 14</td>
<td>• Families will participate in health care decisions</td>
<td>Manager, Family Navigator Program</td>
</tr>
<tr>
<td><strong>Year 2, Activity 4:</strong> Administer consumer satisfaction survey; Repeat every two years.</td>
<td>June 11 – Aug 11</td>
<td>• Summarize data and implement programmatic improvements</td>
<td>Manager, Family Navigator Program</td>
</tr>
<tr>
<td><strong>Years 1 -5, Activity 5:</strong> Manager attends Council identify where navigation services are needed; to provide Council feedback from consumer perspective where barriers exist.</td>
<td>Sept 09 –Aug 14</td>
<td>• Programs designed as needed</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Funding opportunities identified, applications submitted</td>
<td>Manager, Family Navigator Program</td>
</tr>
<tr>
<td><strong>Year 34,5, Activity 6:</strong> Design and implement navigator programs in communities providing support for healthier lifestyles, increasing health literacy, program outreach</td>
<td>Sept 11 – Aug 14</td>
<td>• Navigator program expansion addresses family risk factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fiscal model, sustainability</td>
<td>Manager, Family Navigator Program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Support Program: School Social Worker</th>
<th>Dates</th>
<th>Expected Outcome</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1, Activity 1:</strong> Hire full time social worker to serve Athens City School district elementary building, expanding the program from 3 to 4 positions.</td>
<td>Oct 09 – Feb 09</td>
<td>• Social worker hired</td>
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<td></td>
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<td>• Placement decision jointly made by Athens City school and ACCS</td>
<td>Andrea Reik, ACCS Sue Johanson, Athens City Schools</td>
</tr>
<tr>
<td><strong>Year 1 – 5, Activity 2:</strong> SW integrates in school culture, offering services through individual, group and family</td>
<td>On hire – Aug 14</td>
<td>• Girl Power increases self-esteem</td>
<td></td>
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<td></td>
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<td>• Family support services provided</td>
<td>Andrea Reik, ACCS</td>
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<thead>
<tr>
<th>Ounce of Prevention</th>
<th>Dates</th>
<th>Expected Outcome</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1,2,3,4,5 Activity 1:</strong> Information is provided to families whose children are at risk for overweight, based</td>
<td>Oct 09 – Aug 14</td>
<td>• #At risk kids identified</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Families enrolled in program</td>
<td>Jody Shriver, WIC Director Athens</td>
</tr>
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</table>
### Artists in Schools

**Evaluation:** Annually
- % increase in arts programming for children in the region developed through new partnerships
- # of participants for whom this is first visit to Dairy Barn Arts Center (museum)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Dates</th>
<th>Expected Outcome</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Years 12,3,4,5:</strong> Andrea Lewis or Ginger Schmalenberg</td>
<td>Oct 09 – Aug 14</td>
<td>- Adds arts dimension to Council</td>
<td>Hamel-Lambert</td>
</tr>
<tr>
<td><strong>Year 1, Activity 1:</strong> Dairy Barn will contact elementary schools in Athens, Meigs, Vinton, and Hocking Counties</td>
<td>Oct 09 – Aug 10</td>
<td>Schedule and materials established</td>
<td>Ginger Schmalenberg</td>
</tr>
<tr>
<td><strong>Year 1, Activity 2:</strong> Dairy Barn staff will develop school specific plans based on programmatic assessment.</td>
<td>Dec 09 – Jan 10</td>
<td>- School specific program plans developed</td>
<td>Ginger Schmalenberg</td>
</tr>
<tr>
<td><strong>Year 1, Activity 3:</strong> Dairy Barn will recruit and select artists</td>
<td>Jan 10 – July 10</td>
<td>- Written commitment of selected artists - Artists assigned.</td>
<td>Lewis/Schmalenberg</td>
</tr>
<tr>
<td><strong>Year 2,3,4,5 Activity 4:</strong> Artists do one-week “Artist in the Schools Program” 21 elementary schools K – 2nd</td>
<td>Aug 10 – May 14</td>
<td>- 525 children participate in afterschool each year</td>
<td>Lewis/Schmalenberg</td>
</tr>
<tr>
<td><strong>Year 2,3,4,5; Activity 4:</strong> Dairy Barn will conduct field trips to the Dairy Barn for Pre K-2nd grade student.</td>
<td>Aug 10 – May 14</td>
<td>- 1,260 children participate in the arts tour each year</td>
<td>Lewis/ Schmalenberg</td>
</tr>
</tbody>
</table>

### Recreation Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Dates</th>
<th>Expected Outcome</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Years 2,3,4,5 Activity 1:</strong> Greater Athens Soccer Leagues (GASA) will hold soccer promotion activities; purchase soccer cleats/shin guards if kids inability to pay.</td>
<td>Oct 10 – Sept 14</td>
<td>- One outreach event at each element - Increase number of low income kids in recreation league soccer</td>
<td>Hamel-Lambert, Elaine Goetz (GASA), Jim Petrik (GASA)</td>
</tr>
</tbody>
</table>

### Goal 2: Integrating Professionals for Appalachian Children’s Local Child Wellness Council will strengthen its infrastructure and develop its capacity to function as a self-sustaining network advancing the vision for strengthening local child wellness in southeast Ohio.

Working collaboratively with the State Council, participating in the environmental scan and jointly developing strategic plans that align local efforts with the state agenda, will increase the capacity of IPAC to improve young child wellness. Collectively design a Young Child Wellness Report Card, with community-defined metrics and goals provides an overarching template to guide our efforts. Efforts increase capacity include board development, leadership and management trainings.

### Objective E, Part Two: To strengthen IPAC’s Local Child Wellness Council capacity to function as a network committed to improving child wellness as defined by our emergent Young Child Wellness Report Card.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Dates</th>
<th>Expected Outcome</th>
<th>Partner Responsible</th>
<th>Evaluation:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1, Activity 1:</strong> FCFCs, parent partner, FN, Council conduct scan</td>
<td>Oct 09 – Feb 09</td>
<td>Identified institutional and grassroots programs for young child wellness</td>
<td>FQCH Council Coordinator + parent rep teams work</td>
<td>- Environmental scan completed</td>
</tr>
<tr>
<td><strong>Year 1, Activity 2:</strong> Strategic planning, coordinating with state Council</td>
<td>Oct 09 – Feb 09</td>
<td>Modifications made to draft work plan, align with state agenda</td>
<td>Local Council Coordinator, State expert, council</td>
<td>- Strategic Plan is developed to - Child Wellness Report Card</td>
</tr>
<tr>
<td><strong>All Years Activity 3:</strong> Cross representation between state and local child wellness councils,</td>
<td>Oct 09 – Aug 14</td>
<td>Sustained effective communication</td>
<td>State Expert, Council Coordinator</td>
<td>- Minutes and notes document regular communication</td>
</tr>
<tr>
<td><strong>Year 2,3,4,5 Activity 4:</strong> Develop a communication campaign to build awareness</td>
<td>Oct 09 – Aug 14</td>
<td>Focus groups assess understanding Public service announcement designed</td>
<td>Communication consultant, photographer, videographer,</td>
<td>- Multi-media campaign executed.</td>
</tr>
<tr>
<td>Activity Number</td>
<td>Activity Description</td>
<td>Start Date</td>
<td>End Date</td>
<td>Key Results and Measurement</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Every Year, Activity 5:</td>
<td>Maintain IPAC website on OUCOM server, Report Card framework posted.</td>
<td>Oct 09 – Aug 14</td>
<td></td>
<td>Web site content links partners to trainings and progress updates; IPAC President/Council Coordinator • % partners submitted information for web site</td>
</tr>
<tr>
<td>Every year, Activity 6:</td>
<td>Board development shift from working board to a governing board.</td>
<td>Oct 09 – Aug 12</td>
<td></td>
<td>Quarterly board development trainings attended by 80% directors; Local Council, Board Millesen, board chair • % Board Members in attendance • Minutes evidence shift</td>
</tr>
<tr>
<td>Year 3 Activity 7:</td>
<td>Diversify the composition of the board of directors</td>
<td>Oct 09 – Aug 14</td>
<td></td>
<td>Create Arts/Rec sector on the board of directors, add regional directors; Council Coordinator/IPAC Pres. • % increase regional partners • Modify bylaws; include arts/rec</td>
</tr>
<tr>
<td>Year 1, Activity 8:</td>
<td>Community Readiness Assessment refine items.</td>
<td>June 10 – Nov 11</td>
<td></td>
<td>Community Readiness Assessment completed; Board, Evaluators • Degree of readiness; change from 2006 evaluation</td>
</tr>
<tr>
<td>Year 2, Activity 9:</td>
<td>Board training and development to ensure sustainability</td>
<td>May 10 – Apr 11</td>
<td></td>
<td>Sustainability committee attend ROI training; Sustainability committee members • % change finances; diversify revenue streams, able to compute ROI for programs</td>
</tr>
<tr>
<td>Year 3,4,5 Activity 10:</td>
<td>Policies revised and amended as needed.</td>
<td>Sept 11 – Aug 2014</td>
<td></td>
<td>Policies are written on employees if needed; Policies and Procedures committee • 1+ new or amended policies or bylaws written annually</td>
</tr>
<tr>
<td>Year 5, Activity 11:</td>
<td>Modify the comprehensive business plan + strategic plan = sustainability plan.</td>
<td>Sept 13 – Aug 14</td>
<td></td>
<td>Sustainability Plan revised, blended funding resources; Board Chair, President • Sustainability plan adopted • Sustain employees</td>
</tr>
<tr>
<td>Year 5, Activity 12:</td>
<td>Community Readiness Assessment measures integrated change efforts.</td>
<td>June 2010 – Nov 2011</td>
<td></td>
<td>Representatives for multiple sectors participate in the Community Readiness Assessment; Voinovich Team conducts interviews, professionals and consumers • Degree readiness, shift since 2010</td>
</tr>
</tbody>
</table>
Potential barriers to the success of this project

The local program in Ohio’s Project LAUNCH has proposed to employ two early childhood specialist/counselors, two social workers, a Manager for the Family Navigator Program and a regional Help Me Grow outreach specialist. Having worked together for many years, IPAC is confident that our partner agencies have the demand for the services it desires to expand, but also that recruitment will be successful. Creating jobs in our community is valuable at any time, but in the current economic climate, it is a tremendous opportunity that in and of itself supports our local families.

As discussed previously, the Appalachian region has a sensitivity based in historical injustices about power and privilege. As in many university rural towns, this tension is often referred to as “town-gown” politics. Inviting local residents to participate in research efforts sponsored by the university requires sensitivity to the local culture and an appreciation of the fact that attitudes surrounding research are well grounded in real history. During the proposal development process, our university-based evaluation team attended two group planning sessions with the IPAC board and they also met individually with agencies to ensure a shared understanding of the evaluation process. We anticipate that our collaborative history, the artfulness of front line providers to engage families, and our genuine interest in evaluating the effectiveness of services in our rural community will support data collection efforts across the project.

Because the proposed project expands local efforts among partners who have been working together locally for a while, we are fully confident that those who have committed will remain committed. Early growing pains involving integration efforts are behind
and the challenges we now face relate to building sustainable integrated delivery systems given current policy and regulations. To support the sustainability of our expansion, we have budgeted for personnel support for providers who are delivering reimbursable services to be reduced during the later years of the project. This design slowly shifts the financial accounting to the agency and begins to leverage internal policies regarding productivity to anchor sustainability.

Care coordination activities, like those delivered by the Family Navigator Program and the curbside consults critical to solidifying the integration of behavioral health in primary care are not billing activities. Neither are the system consultation elements of the early childhood consultation models. Sustainability models to support these services in our current financial environment require sufficient productivity to cover the unreimbursed costs. National efforts within the medical home create hope that care coordination will be supported through health care reform, and it is our hope that Project LAUNCH will inform that debate at the local, state and national levels.

Section D: Staff and Organizational Experience

Ohio has extensive experience in planning and implementing collaborative, innovative programs that foster young children’s wellness. Figure 1 on page 6 of this proposal provides a summary of our state’s current cross-system coordination and department-based initiatives. Recent examples include the Early Childhood Comprehensive Systems grant, of which Ohio is a recipient. This grant is overseen by the Early Childhood Cabinet, which is comprised of the Directors of six state agencies. The state level of project LAUNCH will be led by the Early Childhood Cabinet as described in the Statement of Need. Key project staff at the state level will include Wendy Grove, Ohio Department of Health as state Child Wellness Expert until the vacant position can be filled; Kay Reitz, Assistant Deputy Director for Children’s Services at the Ohio Department of Mental Health; Maureen Corcoran, Assistant Deputy Director of Policy and Programs at Ohio Health Plans; and Alicia Leatherman, Director of the Early Childhood Cabinet. The biographical sketches and job descriptions for staff at the state level are included in Appendix 1.

The success of Project LAUNCH is predicated on the active participation and integration of the State and Local Councils. IPAC has demonstrated a five year history of successful collaboration. The joint development of this proposal by state and local participants bodes well for Ohio. The fiscal agent for the project is Ohio University, which has repeatedly demonstrated its ability to successfully implement large multidisciplinary programs. Ohio University’s College of Osteopathic Medicine (OUCOM) was created by an act of the Ohio General Assembly in 1975, with a mandate to train primary care physicians to practice in the medically underserved areas of the State of Ohio. Currently, over 56% of all OUCOM graduates are in primary care in Ohio and 15% are in communities of less than 10,000 people.

At the local level, key project staff of Project LAUNCH are those listed on pages 7-9. Their link to the target population is described in the table. As the biographical sketches will show, all of the local staff have extensive experience within the counties they work, which has provided them with experience in serving the Appalachian people and
knowledge of their culture. The biographical sketches and job descriptions for staff at the local level are included in Appendix 1.

The Local Council Coordinator and the State Expert will participate on each other’s councils to ensure that communication is effective, timely, and consistent. In addition, email, phone, and videoconference will be used to facilitate the collaborative strategic planning efforts at the state and local levels. The collaboration has already begun through the process of developing this proposal, with no less than six meetings occurring in person or by video teleconference. Numerous phone calls and email exchanges have also furthered the discussion between state and local partners regarding planning for this proposed program. The local staff was intimately involved in the preparation of the proposal and you can see their level of involvement in all proposed activities.

The existing ADA-compliant facilities of the local organizations listed in Appendix 1 are available for the proposed project. Moreover, many of the screening and consultation services described in the implementation plan take place in existing early childhood settings. The project’s comprehensive planning process will address the need for additional transportation resources to overcome the barrier of rural isolation in the proposed locality of Athens, Hancock, Vinton, and Meigs counties.

Section E: Performance Assessment and Data

Upon funding of Project LAUNCH, the Ohio Department of Health will contract with the Voinovich School of Leadership and Public Affairs at Ohio University. They will conduct the following evaluations of the program:

State Level Evaluation of Infrastructure Development and Local-State Collaboration

Key to this initiative is the alignment of local efforts with the State agenda as it relates to the development of an integrated system of care. The expectation is that the State and Local partners will engage in a process of infrastructure reform intended to improve the coordination and collaboration among systems at both levels which service the needs of young children and their families. The evaluation will examine the collaboration among members of the Council at the State level, the coordination between the State and Local Council, lessons learned from the local efforts and actions taken on a policy level at the State to support the work at the local level. The evaluators will observe State level Council meetings, review documents, including meeting minutes and interview member of the State Council, including the Young Child Wellness Expert and the Local Child Wellness Coordinator. Further, Council members will be asked to complete The Wilder Collaboration Factors Inventory. Evaluators will look for evidence of collaboration, networking, resource leveraging, policy changes. Evaluators will also monitor the completion of the state-level Environmental Scan and Strategic Plan as well as the adherence to the timeline and the Project LAUNCH work plan.

Local Level: Process Evaluation

At the local level, the process evaluation will look at: (1) Collaboration to create a seamless system of care; (2) Implementation of Programs and Services (Strategic Plan);
and (3) Required GPRA and Cross-site measures. A mixed methodology is proposed for the process evaluation.

_Evaluation of the Collaboration_

The process evaluation will examine how well the collaborating organizations work together to provide a seamless system of care. The level of collaboration between child-serving systems will be examined as part of the process evaluation. As recommended by the literature on evaluating collaborative groups, the following components will be assessed: (1) Environment and membership characteristics; (2) Vision and goals; (3) Process and structure; (4) Communication; and (5) Change, resources and sustainability.

The Wilder Collaboration Factors Inventory, a five-point Likert scale assessment instrument that addresses the above components, will be completed by members of the local and state coordinating organizations at the start and end of the first project year. The assessment will then be completed at the end of each subsequent year as a comparison analysis. In addition, a document review, observation of coalition meetings, and structured interviews will be conducted with collaborative members each year to gain in-depth information about: (1) group formation, participation, and recruitment; (2) factors determining partnership success and creative methods to overcome barriers, (3) the practices and processes used to increase the level of collaboration between child-serving systems; and (4) how decisions made by the collaboration are implemented within individual agencies. Meeting attendance subcommittee participation and adherence to the strategic plan work plan will be evaluated. Analysis of this information will be discussed with collaborative members throughout the year to promote continuous improvement.

_Evaluation Tools_ include interviews with providers, Wilder Collaboration Factors Inventory, meeting observations, document review.

_Implementation of the Strategic Plan-Programs and Services_

The selection of evidence based practices and the implementation of these practices with fidelity will be examined. The process evaluation at the local level will address the following questions regarding implementation of programs and services: (1) How closely did the implementation match the strategic plan?  (2) When changes were made, how and why were they made? (3) What impact did the changes have on participants? Providers? (4) Who provides what services to which group of participants?

Evaluation Tools will include interviews with providers, program reports documenting implementation, evaluation tools, such as pre/post tests provided by the evidence-based practice materials, documentation of program outputs, such as participation rates, demographic and assessment information on participants, number of referrals, number of services provided. The _Early Childhood Mental Health Consultation: An Evaluation Tool Kit_ (Hepburn, Kaufmann, Perry, Allen, Brennan & Green, 2007) will provide guidance for the evaluation of early childhood mental health consultation services. The University of Idaho: _Survey of Parenting Practice Tool Kit_ (Hepburn, et al., 2007) will be used to evaluate Parents as Teachers. The other evidence-based practices also provide evaluation tools that have already been validated and these will be utilized to measure participant outcomes and fidelity. The data collection tools identified thus far are found in Appendix 2.

_Required GPRA and Cross-site Measures_
In addition to the evaluation of the collaboration and infrastructure development, participating programs will track the appropriate GPRA measures and the measures specified by the cross-site evaluators. The GPRA measures include: Evidence of increased collaboration, Increase in the number of providers using evidence-based practices, Increase in the number of providers with knowledge of child development, Increase in the number of children receiving developmental screening, Increase in the number of children referred for services, Increase in the number of families receiving home visiting services.

The evaluators will cooperate with the National cross-site evaluation team in collecting the measures they request which may include: Measures of infrastructure development, collaboration and coordination; Surveys of change in knowledge, attitudes and behavior among parents, educators, physicians and early childhood caregivers as a result of training, education and/or consultation efforts; Measures of child development, including individual assessments of program participants; Measures of community awareness of young children’s wellness.

**Outcome Evaluation**

Outcomes will include program level participant outcomes as measured by the tools provided by the evidence-based practices. Additionally, programs will track participant characteristics, response to participation and make follow up contact 3-6 months upon the completion or termination of services. The evaluators will work with all participating organizations to design data collection procedures and tools. Further, the evaluators will track the long term GPRA measure: Increase the percentage of young children who are healthy and ready to learn. Data for this indicator can include health status, physical and cognitive development, school readiness and social/emotional/behavioral information from a variety of sources. One of the objectives of the initiative is for the State and Local partners to work with the evaluators to develop a Young Child Wellness Community Report Card. This will provide population level data that will provide needed information about the impact of the initiative.

**System Evaluation**

One of the primary goals of Project LAUNCH is to institute a child and family-friendly system of care. Given current limited capacity of the local and state organizations to track participants across systems, this can not be easily evaluated at the program level or at the level of the interagency organizations. The evaluators will utilize two procedures to evaluate the overall impact and results of this initiative.

First, the evaluation will conduct a Community Readiness assessment using the Community Readiness Model developed by Colorado State University’s Tri-Ethnic Center for Prevention Research. A Community Readiness Assessment was conducted in Athens County in 2005 among service providers, health care providers and other leaders in the professional early childhood community. A Community Readiness Assessment will be conducted in the other three counties in the first year of the grant and will inform the Strategic Plan. The Athens Community Readiness Assessment will be updated in the second year of the grant. In the final year of the initiative, all four counties will
participate in a Community Readiness Assessment. This will provide valuable information about infrastructure change and development as well as collaboration.

The second evaluation strategy will employ a longitudinal family study. The success or limits of systemic change can best be evaluated from the perspective of the families and children that the system is designed to serve. A random sample of families, whose children, ages birth to five, have identified as being at risk by the developmental assessment screens will be recruited to participate in the evaluation study over the duration of the initiative.

Developmental assessments will be conducted at various points in the system, including primary care and pediatric practices, Help Me Grow, Head Start and preschool sites. Using a random numbers procedure to select dates within a month, families, whose child completes a developmental assessment and is determined to be at-risk will be recruited to participate in the Family Life Study. A different sampling procedure will be used at the Preschool sites, as the screening assessment is typically completed for the entire class upon entry. In this case, a set of randomly generated numbers will inform the selection. In order to be invited to participate in the study, the child must have at least one score on the screening instrument used that indicates some developmental risk in at least one domain. Families will be selected from each of the four counties.

These families will consent to participate in study activities for the duration of the initiative and will receive incentives for their participation Participating families will be asked to complete a survey and participate in interviews, both by phone and face-to-face every six months. The survey and interview will explore parenting practices, child health, child care arrangements, use of services including health, behavioral, social and educational as well as the parents’ perception and satisfaction with the services used. Further, a developmental screening will be conducted annually on the identified child. Interviews will be conducted at community sites or in family homes. Assistance will be available for parents with reading difficulties to complete surveys and assessment tools. Incentives may include money, children’s toys, books, baby diapers and other items valued by families with young children. By selecting a sample of at-risk children from a variety of providers, the study will be able to follow the family’s experience from different points of entry and through various referrals and services. It is anticipated that 25–40 families will be recruited in each of the first three years of the initiative and followed until the identified child enters kindergarten or the initiative ends.

A longitudinal data-base will be developed as part of this study. In the final two years of the study, the evaluators will work with the local council to determine how the data-base might be utilized to better integrate the system of care.

**Data Collection, Confidentiality and Security**

The evaluators will work with local service providers to ensure that participants are informed and have consented to be involved in the services provided by the initiative and the evaluation activities. All local service providers will be expected to comply with all state and federal laws regarding confidentiality of health and educational information.
The evaluators will work with local providers to develop secure systems and procedures for tracking needed participant data. Quarterly reports about services and participants will be provided to the evaluators. All data provided will be de-identified at the service provider level before being delivered electronically to the evaluators. When appropriate and possible, numerical identifiers will be assigned at the provider level to allow participant activity and outcomes to be tracked across time. In most cases, the information gathered will be without participant identifiers and will provide an aggregate snapshot of services, activities and results. Ohio University’s Institutional Review Board will review and examine all procedures related to the services and evaluation.

Participants in the Family Study will participate voluntarily and will receive incentives, both cash and gifts for their participation. Informed consent for participation and consent for releases of information from service providers will be requested and required. Since these participants will be tracked over time, they will be assigned a subject code which will be used to examine activity longitudinally. Subject codes matched with identifying information will be kept in hard copy in a locked file cabinet and in a secure electronic document on a separate server from the data base.

The evaluators will maintain data on a secure server that is encrypted and requires security clearance to access. Only individuals on the evaluation team will be allowed access to the data. All data received from local providers will be de-identified before receipt. If any data is received that contains identifying information, this information will be deleted and replaced with a numerical subject code.

Section F: Literature Citations


Felitti, V.J. (2002). The relation between adverse childhood experiences and adult health:


### Appendix H: PIM Report

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>*1. Number of Direct Unduplicated Encounters</td>
<td>$133 + 24 (FN – 2 served by ECMH) + 2 (PSWC) = 159</td>
</tr>
<tr>
<td>*2. Number of Indirect Unduplicated Encounters</td>
<td>$70 + 37 (FN) = 107</td>
</tr>
<tr>
<td>*3. Total Number of Non-Duplicated Encounters</td>
<td>$203 + 63 = 266</td>
</tr>
<tr>
<td>*4. Number of Duplicated Encounters</td>
<td>$631 + 115 + 9 = 755</td>
</tr>
<tr>
<td>*5. Number of people in the target population/new or expanded services</td>
<td>133</td>
</tr>
<tr>
<td>*6. Number of people in target population</td>
<td>215</td>
</tr>
<tr>
<td>*7. Number of new/expanded services</td>
<td>1</td>
</tr>
<tr>
<td>*8. Types of New/Expanded services</td>
<td>ECMH consultation service to a new classroom at Coolville; Consultation program services expanded from previous two years to include greater intensity of services to fewer schools</td>
</tr>
<tr>
<td>9. Ethnicity:</td>
<td></td>
</tr>
<tr>
<td>a. Hispanic/Latino:</td>
<td>0</td>
</tr>
<tr>
<td>b. Not Hispanic/Latino:</td>
<td>$131 + 26 = 159</td>
</tr>
<tr>
<td>10. Race:</td>
<td></td>
</tr>
<tr>
<td>a. White:</td>
<td>131 + 26</td>
</tr>
<tr>
<td>b. Other races:</td>
<td></td>
</tr>
<tr>
<td>Pacific Islander:</td>
<td></td>
</tr>
<tr>
<td>11. Age Group:</td>
<td></td>
</tr>
<tr>
<td>a. Children 0-12:</td>
<td>70 + 10</td>
</tr>
<tr>
<td>b. Adults 18-64:</td>
<td>63 + 16</td>
</tr>
<tr>
<td>c. Elderly:</td>
<td>0</td>
</tr>
<tr>
<td>d. Total:</td>
<td>$133 + 26 = 159</td>
</tr>
<tr>
<td>*12. Underinsured/Uninsured</td>
<td></td>
</tr>
<tr>
<td>a. SCHIP:</td>
<td>$15 + 10 – 2 = 23</td>
</tr>
<tr>
<td>*13. Workforce Recruitment</td>
<td></td>
</tr>
<tr>
<td>a. ECMH Consultant:</td>
<td>1</td>
</tr>
<tr>
<td>14. Partners in Outreach</td>
<td></td>
</tr>
<tr>
<td>a. School Districts:</td>
<td>3 (fed hock, trimb, Athens city)</td>
</tr>
<tr>
<td>b. Social Service Agency:</td>
<td>1</td>
</tr>
<tr>
<td>c. University:</td>
<td>1</td>
</tr>
<tr>
<td>*15. Sustainability</td>
<td></td>
</tr>
<tr>
<td>a. Annual revenue from project: No</td>
<td></td>
</tr>
<tr>
<td>b. Additional funding to assist: Yes; $1000 from schools</td>
<td></td>
</tr>
<tr>
<td>c. Cost savings: ??</td>
<td></td>
</tr>
<tr>
<td>d. Sustainability plan:</td>
<td>Yes</td>
</tr>
<tr>
<td>e. Check all that apply (at least one required):</td>
<td>(Other)</td>
</tr>
<tr>
<td>X Program Revenue</td>
<td></td>
</tr>
<tr>
<td>X In-Kind Contributions</td>
<td></td>
</tr>
<tr>
<td>X Member Fees</td>
<td></td>
</tr>
<tr>
<td>X Donated Resources</td>
<td></td>
</tr>
<tr>
<td>*16. Number of adults screened for depression</td>
<td></td>
</tr>
<tr>
<td>a. Numerator:</td>
<td>10</td>
</tr>
<tr>
<td>b. Denominator:</td>
<td>10</td>
</tr>
<tr>
<td>c. % Screened:</td>
<td>100</td>
</tr>
<tr>
<td>*17. Number of people receiving MH in target area</td>
<td></td>
</tr>
<tr>
<td>a. $90 + 11 (FN) = 101</td>
<td></td>
</tr>
</tbody>
</table>

19 This is an unpublished program report belonging to the “Partnerships for Early Childhood Mental Health Program” It is reprinted for the purposes of this study with permission from Tri-County Mental Health and Counseling Services, Inc.
NOTES:
1. This number includes every child in a classroom served, every teacher/ECMH staff person/any other school staff who had consultation, school administrators that we have been working with, and parents/caregivers of targeted children that we worked with. You’d asked for number of kids per class; I’m not sure what else you would want me to break-out “unduplicated encounters”; but here’s how I calculated it:

<table>
<thead>
<tr>
<th>School Personnel</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers/Aides</td>
<td>8</td>
</tr>
<tr>
<td>Other School Personnel (Administrations/School Psych/SLP’s/ Soc. Workers)</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Of Targeted Children</td>
<td>20</td>
</tr>
<tr>
<td>Additional from Parent Trainings/IY groups</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Coolville Class 1</td>
<td>16</td>
</tr>
<tr>
<td>Coolville Class 2</td>
<td>10</td>
</tr>
<tr>
<td>Trimble Class 1</td>
<td>22</td>
</tr>
<tr>
<td>Trimble Class 2</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total Unduplicated Encounters</strong></td>
<td><strong>133</strong></td>
</tr>
</tbody>
</table>

1. All preschoolers in all districts Athens, Fed Hock and Trimble

<table>
<thead>
<tr>
<th>School Personnel</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers/Aides</td>
<td>8 (TCMH)</td>
</tr>
<tr>
<td>Other School Personnel (Administrations/School Psych/SLP’s/ Soc. Workers)</td>
<td>15 (TCMH)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Of Targeted Children</td>
<td>20 (TCMH)</td>
</tr>
<tr>
<td>Additional from Parent Trainings/IY groups</td>
<td>20 (TCMH)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Coolville Class 1</td>
<td>16 (TCMH)</td>
</tr>
<tr>
<td>Coolville Class 2</td>
<td>10 (TCMH)</td>
</tr>
<tr>
<td>Trimble Class 1</td>
<td>22 (TCMH)</td>
</tr>
<tr>
<td>Trimble Class 2</td>
<td>22 (TCMH)</td>
</tr>
<tr>
<td>Amesville</td>
<td>35 (FN)</td>
</tr>
<tr>
<td>Athens City total</td>
<td>47 (FN)</td>
</tr>
<tr>
<td><strong>Total population</strong></td>
<td><strong>215 with parents and school staff</strong></td>
</tr>
</tbody>
</table>

2. We had monthly IY materials that we made copies of and sent home to parents that went with the IY topics for that month. I think this counts for “indirect encounters”; so I counted 70—estimating at least one parent for each enrolled child. If you don’t think this is something that you want counted, then that’s ok.

FN… school talks
3. Add #1 and #2.
4. This includes all of Jamie’s consultation contacts with teachers, with targeted parents/caregivers, with summer IY group parents, with parents who came to
some school programs she offered, with targeted children, meetings with school personnel; my contacts with teachers and school administrators summer, IY summer group parents and children.

FN Counted contacts with school teachers, counselors, ECMH, parents, etc. Includes all collateral contacts.

5. I didn’t know how to think about this one. I decided to subtract out the few teachers, aides, school administrators that we served last year. JHL used Sherry’s numbers for all personnel, parents, and kids in classes given significant change to the program accessible to all of those individuals.

6. No note

7. I didn’t know how to think about this item; in some ways the ECMH consultation service was “expanded”—The amount of service given to a site was increased and we added a new classroom at Coolville that had been a wait-list teacher the previous two years. Yet we reduced the number of sites served, etc. jhl agreed.

8. None
9. None
10. None
11. None

12. I’m really sorry, completely forgot to collect this information this year. I don’t think I’m going to be able to get this from teachers this year. I have e-mailed them and will try to find out. Minimally, the 10 targeted children and 5 intensive children all had medical cards.
FN… all 10 kids SCHIP

13. Since Jamie was new, I included her as a new recruitment.

14. None

15. I’m not sure about this section, I think it means additional funding that helped the project operate this year—not sustainability funding for next year? That’s how I’ve answered it the last two years.
   a. None
   b. Yes; School Support: $1000.00
   c. I couldn’t think of a way to address this in any logical way.
   d. We just answered, “Yes” last year.
   e. Not sure what you want to include here…these are estimates

Donated by Tri-County Mental Health:
$23,670.00 in additional personnel costs
$ 1,000.00 in mileage costs
$ 2,500.00 in administration costs (estimates)
$ 500.00 in additional supplies (estimates)
$ 27,670.00 Total
I don’t have a good way to think about donated space and supplies from the schools. Unless we really need it, I’m leaving out. We haven’t reported this in the past. If you want me to estimate anything for this, let me know; but I’d need to have suggestions from you about what you want.

16. We didn’t screen parents for depression. FN = 10
17. This is the number of children + parents from IY group…this is how we reported for this section last year. Plus FN 11 referrals (4 for kids, 7 for parents)
Appendix I: Outreach Grant Progress Report

Progress to Date:

Building Capacity-Raising Resiliency proposed to ensure healthy young child development by improving early childhood outcomes and increasing the capacity of our early childhood workforce through implementation of a comprehensive early childhood mental health consultation program (ECMH-CP) (Objective One), and Early Childhood Workforce Initiative (Objective Two). HRSA Year Two progress is reported with the first work plan matrix below, addressing activities that have been accomplished, those that are in progress, those that will be initiated during the second half of the program year, with programmatic modifications and adjustments noted. Please note that HRSA Year Two project period (May 1, 2009 – April 30, 2010) spans the end of the first year in the public preschools (May, June), the summer of 2010 and the start of the second year our program was operating in the public preschools which began in Aug, 2010.

<table>
<thead>
<tr>
<th>GOAL: Improve early childhood outcomes and increase the capacity of our early childhood workforce to ensure healthy development through implementation of a comprehensive early childhood mental health consultation program (EMCH-CP) (Objective One), and Early Childhood Workforce Initiative (Objective Two).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective One: The Comprehensive Early Childhood Mental Health Consultation Program (ECMH-CP) will offer three tiers of intervention – universal, targeted, and intensive – accomplished by integrating the interdisciplinary expertise of the classroom early childhood consultant, the FCN, and a pediatric neuropsychologist who collaboratively can integrate data from teacher and environmental consultation, family advocacy and education, and specialized diagnostic assessments to optimize the child’s resiliency (initiative, self-control, and attachment), while decreasing behavioral concerns ensuring readiness to learn (Healthy People 2010: 1-6; 11-6; 16-14, 23; 18-6,9,17).</td>
</tr>
</tbody>
</table>

**Activity 1: Summer Group**

**Year 2, Activity 1:** Plan and implement a summer group using Incredible Years program to serve interested families.

**Responsible Agency/person:** S. Shamblin and V. Wang

**Completion Date:** August 2010

**Progress:** 6 children, from 4 families, participated in a 4 week modified Incredible Years group (goal was six families). 100% completed the program. 100% of parents participating in the group demonstrated an increase in at least one positive parenting practice, as reported by IY Parenting Scale (75% goal). Overall, 100 percent of participants reported being satisfied or very satisfied with the program (85% satisfaction goal).

**Comments:** Group completed as planned.

**Activities 2-4: Program design and coordination activities**

**Year 2, Activity 2:** Collect and analyze YR 1 qualitative interview data and quantitative data.

**Year 2, Activity 3:** Begin Year 2: ECMH consultant and teacher champions introduce consultation model to preschool teachers and staff through staff meetings to facilitate receptivity to program services. Classrooms in Federal Hocking School District and Athens City School District added, as planned.

**Year 2, Activity 4:** Establish district-specific implementation plan for Year 2 for (1) the city school district and (2) the county schools, collaboratively with Preschool teachers, district preschool coordinator, and ECMH consultant

**Responsible Person Activity 2:** S. Shamblin, V. Heh

**Completion Date:** Fall 2010

**Responsible Person Activity 3 & 4:** S. Shamblin & V. Wang

**Completion Date Activity 3:** Sept. 2010

**Completion Date Activity 4:** Oct. 2010

**Progress:** Year 2, Activity 2: A single group interview was conducted with 6 participating teachers and individual interviews

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20 This is an unpublished program report belonging to the “Partnerships for Early Childhood Mental Health Program” It is reprinted for the purposes of this study with permission from Tri-County Mental Health and Counseling Services, Inc.
Year 2, Activity 1: Workforce Development for Project Director and Administrative Staff

Objective Two: The Early Childhood Workforce Initiative advances a range of professional competencies through mixed-matrix design for professional through didactic trainings, collaborative peer group supervision, learning communities, journal readings, and program consultation through site visits and videoconferencing with state and national experts. Healthy People 2010: 1-6; 16-14; 18-17.

Activity 1: Workforce Development for Project Director and Administrative Staff
Year 2, Activity 1: Program model consultation received for the ECMH program from

Activity 2: HIPAA compliant procedures apply (8)

Activity 3: ECMH team attended school staff meetings at the beginning of the year and presenting model and adaptations incorporated using focus group feedback. 100% teachers from YR ONE choose to participate again (Goal was 67%). 50% of the wait-list classrooms from Year 1 choose to participate in the program; 33% choose to participate as “Control Group” classrooms to contribute to the program evaluation efforts, and 17% choose not to participate at all (Goal was 85%). Year 2 Activity 4: Based on focus group feedback, district specific-plans will be replaced by School-specific plans developed by teachers, ECMH program staff, principals, FN and ECMH supervisor. These are 100% completed for all participants. A decision was made to replace the district plans with school plans, given the variability across buildings and the goal of empowering the teacher.

Comments: During the single group interview with teachers, teachers provided critical feedback in order to improve the program. Challenges were identified in communication, role definition/clarification, understanding of school culture by the ECMH team, and creation of a true collaboration between the ECMH team and school staff. Adaptations made in the program to strengthen communication and improve understanding of the program showed YR2 implementation.

Activity 5-6 Universal Consultation Strategies

Year 2, Activity 5: Establish classroom-specific consultation plans delineating range of interventions desired and anticipated outcomes based on Devereux Reflective Checklists for Teachers.
Year 2, Activity 6: ECMH consultant and preschool teachers facilitate implementation of service plan and integration of mental health culture in preschool classrooms.

Comments: During YR ONE, the DECA Reflective Checklists did not demonstrate enough sensitivity to be used as a pre-post measure. It has been replaced by the Preschool Mental Health Climate Scale based on recommendations from consultation with Georgetown University’s Center for Child and Human Development.

Activity 7a – e: Individual Child Services: Targeted and Intensive Consultation

Year 2, Activity 7 - 8: Targeted consultation provided to children nominated by teacher (7); Provide individualized intervention to identified children with parent consent to treat. HIPAA compliant procedures apply (8)
Year 2, Activity 7b-8b. Family Care Navigator services offered to families whose children are recommended for services by teacher, EMCH staff, or by self-referral
Year 2, Activity 8c: Provide Diagnostic Assessment Services to families whose children are recommended for enrollment in assessment services

Comments: Throughout the school year, the ECMH and FN will continue to attempt to build connections with referred families who aren’t receiving services and to accept new referrals from school staff. Depression screening rates were lower than anticipated because families often self-reported a history of depression and current enrollment in services.
Progress: Summer Kinsel’s consultation was not possible due to Kinsel’s retirement. To replace the workforce development agenda, the ECMH Project Director and consultant participated in Georgetown University’s Center for Child and Human Development’s series What Works in Early Childhood Mental Health Consultation. The Project Director also participated in Community-Based Partnership Caucus to learn more about CBPR approaches to adopt for the project. Project Director and Grant PI receive consultation and technical assistance through S. Willocks. (Goal was that 80% of relevant ECMH Consultation team members attend). New evaluation tools were adopted based on these events.

Activity 2-3: Workforce Development for ECMH team

Year 2, Activity 2: ECMH consultant attends an empirically supported, classroom-based training, such as The Incredible Years Program, Georgetown Training Model, or DECA’s Face to Face Challenging Behaviors

Year 2, Activity 3: ECMH Consultant attends Ohio Department of Mental Health coordinated peer supervision group which is a case-based learning support group to build ECMH consultant’s competence.

Progress: Year 2, Activity 2: Both ECMHC’s have attended the Georgetown Training Model; the DECA Face the Challenge, the DECA training program, 1 has completed the Parent IY program, and 1 has completed the Trauma-Focused Cognitive Behavior Training program. ECMHC’s have developed implementation goals which are identified on their Annual Employee Performance Appraisals. Both ECMHC’s and the FN will attend the National 0-3 Training Institute in December. Year 2, Activity 3: meeting as scheduled to start again in Jan 2011.

Comments: The peer supervision group has reduced the number of sessions for the year and is scheduled for January-May this year so staff has not started this item.

Activity 4-5: Workforce development for teachers

Year 2, Activity 4: Teachers provided 4 part workshop, DECA’s Face the Challenge: Challenging Behaviors program

Year 2, Activity 5: Topics in Mental Health- Learning Community.

Progress: The School-based learning community offered during our first year in the schools focused on executive functioning. Five sessions were attended by 22 different staff, with 13 persons attending on average. This year’s DECA Teacher workshop materials, and this year’s learning community materials are ordered and training dates are scheduled starting in January. The school-based learning community will focus on Conscious Discipline.

Comments: Both activities are slated to begin later in the school year based on requests from teachers because the first 90 days of school represents numerous deadlines for teacher-completed screenings/ assessments/ IEP conferences etc.

Activity 6: Regional Workforce Development

Year 2, Activity 6: Early Childhood Workforce Conference scheduled for April 12, 2010. Focus on early childhood trauma.

Progress: Dr. Perry from the Trauma Academy is scheduled; venue reserved and arrangements for the conference registration, continuing education, lodging etc in full swing.

Comments: Conference on track to be completed by April 2011. It is anticipated that 250 persons will attend, generating significant revenue for IPAC, and advancing its sustainability goals.

**Staff Changes:** We report the resignation of Laurie Fox, Ph.D. the addition of Holly Raffle, PhD to our evaluation team, and the hiring of ECMH consultant, Rena Scarberry. Dr. Fox, who provided the diagnostic psychological assessments (May 1, 2009 – April 30, 2010) resigned prior to the start of the 2010-2011 school year when the terms of her employment were being negotiated. Given this occurred between school years, the program was not negatively impacted. Psychological testing services will be provided through the Psychology and Social Work Clinic (PSWC) at Ohio University. Given the depth of information participating staff had to share with our program staff, we elected to contract with an objective evaluator for the completion of group and individual interviews. Dr. Holly Raffle, PhD is an experience evaluator (resume attached). Lastly, because our program expands our services to three additional schools in Athens County in the 2010-2011 school year, a second early childhood mental health consultant was
Resolution of Challenges:

Creating an advisory/ stakeholder group: The original project proposal included creating an advisory group composed of participating school superintendents and the CEO of the mental health clinic. The group was to meet quarterly and address sustainability challenges. During the first year, the group was only able to meet twice due to scheduling issues. While the initial meeting was well attended, the second meeting was not. It became evident that the best way to connect with superintendents was through their already-established county superintendent meeting to provide brief updates and engage in sustainability discussions. It also became evident, that the project would benefit from “internal school advocates” at all levels—teachers, principals, and other school staff—who believed the program had value and could articulate the value to their school superintendents. Additionally, internal advocates can assist ECMH program staff in the best way to create value for schools. During the second year of the project, the advisory group structure was reconfigured to include a mix of school personnel from a variety of schools including two teachers, the county preschool coordinator, the city school psychologist, the Family Navigator supervisor, the ECMH project director, and two building principals. The first meeting was not well attended, but provided some additional suggestions from the school psychologist and the information that her supervisor, the director of special programs, was interested in attending the next meeting. Another meeting is scheduled. It is too soon to know if this new configuration will produce ongoing and meaningful investment from the multiple stakeholders currently targeted. It’s conceivable that the unique needs and interests of each school are so varied that the investment of time and resources to achieve sustainability will be an individualized at the school or district.

Engagement in the Consultation Services: Feedback from all participants (teachers and the ECMH consultant and Family Navigator) confirmed a lack of definition, shared expectations, and clear roles for the universal consultation services. New ECMH staff found it easier to understand how to deliver targeted and individual services to children, but weren’t always clear in what they should be trying to do for consultation to teachers. In return, teachers seemed to conceptually understand consultation to individual children, but didn’t know what to request for consultation for themselves and/or didn’t find value in this service. Some teachers made requests for the consultant to provide group programming to the children in their classes, but the mechanisms for obtaining permission for all children in a class seemed too big of a barrier to overcome.

Although the ECMH staff and the teachers had more shared expectation and understanding of the targeted and intensive consultation services to individual children and families, teachers varied widely in their use of the program for their students. Teachers at Trimble elementary developed a very consistent strategy of referring children who had flagged on their Ages and Stages developmental screenings. They worked with program staff to build connections with parents and negotiated in-person meetings at the
school between parents and the ECMH consultant and the Family Navigator. As a result, they had a high rate of participation in the individual consultation services. Alexander and Chauncey, on the other hand, referred children based on acting out behaviors that children exhibited in the school setting. They gave basic contact information to the ECMH consultant and the Family Navigator, and then disengaged from the process citing lack of time and opportunity to connect with parents themselves. As a result, these schools had far fewer students enrolled in even the individual consultation services.

In order to address this issue several things were done for year two. (1) Additional training was provided to the ECMH consultant and Family Navigator so they have a better understanding of this service delivery. This training included workshop attendance, supervisor coaching and modeling, and as well as funding each to attend the at the National 0-3 Training Institute with carryforward funding. (2) Clearer definitions and processes related to the universal consultation tier were provided to teachers. (3) A more rigorous environmental classroom checklist was implemented that will provide both the teachers and the consultant more information on strengths and areas for growth. (4) The DECA program was fully implemented so that teachers completed behavioral checklists for their whole classroom. The consultant can use results to develop a classroom profile of group strengths and weakness. Taken together, the Teacher Opinion Scale, the Mental Health Climate Scale, and the DECA classroom profile will provide a powerful overview of a class creating many more opportunities for the creation of universal consultation strategies. Additionally, the supervisor reviewed these materials for each classroom with each consultant and highlighted universal consultation strategies they could recommend to teachers as part of their consultation planning. (5) An additional benefit of the full class DECA implementation is that it provides a tool for teachers to identify individual children for targeted consultation services and supports their discussions with parents. Consultants are encouraging teachers to discuss the targeted services with parents of children who score in the “concern” range on one-or more subscale. Fall DECA administrations and results are in process of being discussed with teachers, but so far this process has resulted in 47% of children scoring in the “concern” range being referred by teachers.

Project Evaluation:

Qualitative Data: Six out of nine teachers who had received the program participated in a single session group interview conducted by Dr. Two of the three principals whose schools had received the program, as well as the county preschool coordinator and the city school psychologist, were interviewed individually.

The results indicated that the family navigator and individual intensive consultation services were valued. Concerns were raised about the ambiguity of the universal consultation services and communication challenges. Five key recommendations were emerged: (1) Create a policies and procedures handbook that describes the program, the roles of ECMH-CP staff (2) define and utilize a communication system with two layers that promotes a continuous feedback loop between the school system and the ECMH-CP; (3) Use a child-centered model that those who work in school systems are familiar with, such as the Intervention Assistance Team
(IAT) model to refer and serve children and families in need (3) Continue to provide family navigation services (4) Refine the role of the teacher consultant and what services exist within the universal services component of the ECMH-CP.

**Quantitative Analyses:** Statistical analyses were conducted by Victor Heh, PhD. Results follow. A **paired sample t test** was used to evaluate the differences in Teacher Opinion Scale scores, a measure of teacher confidence to manage the issues children present with, between the fall and spring quarters. The results indicated that the mean opinion in the spring ($M=49.38$, $SD=3.11$) was significantly greater than the mean opinion in the fall ($M=46.75$, $SD=2.96$), $t(7)=2.38$, $p<.05$. The standardized effect size, Cohen’s $d$ was 0.84 indicating a large effect size.

Teacher and parent ratings on the DECA scale were analyzed in two steps using **mixed model analysis of repeated measures.** The covariates in the model include time, teacher satisfaction, change in teacher opinion between fall and spring, and parent satisfaction survey. The result as show that teacher attachment ratings significantly increased between the fall and spring ratings. Also, teacher opinion change score, between the fall and spring quarters, was significantly related to teacher attachment ratings. For teacher ratings, none of the other subscales (Initiative, Self-control, and Behavioral Concerns) differed significantly over time. The same analysis, as above, was carried out on parental rating with parent satisfaction survey as the only covariate in the model. The results showed that children’s self control, attachment, and behavioral concerns as rated by parents, changed significantly over time.

Teacher and parent ratings on the DECA scale were also analyzed using **individual growth curve analysis** in the latent variable framework. Firstly, two growth factors, final status and rate of change were estimated using the three DECA measurements. Then covariates were added to the model to explain the systematic variation in final status and rate of change if applicable. Given that sample size was small and measurements were taken at only three time points, model identification was insured by fixing some parameters. Fit indices for the structural equation analytic technique were used to determine model fit. The maximum likelihood estimation procedure was used to estimate fix and random effects. Linear or non-linear models were fit depending on which functional form fit the data best. Missing Data assumption was missing at random (MAR).

Analysis of the teacher ratings showed that the initiative, self-control, and behavioral concerns scales did not differ significantly over time and neither did they relate significantly to changes in teacher opinion scale and teacher satisfaction scale. However, their ratings of the child on the attachment and TPF scales change significantly over time (see tables 4a &b). Random intercepts and fixed slopes provided the best fit to the data. The result also showed that the systematic variation in the final status of the attachment score (but not TFP score) was significantly accounted for by both changes in teacher opinion between fall and spring and teacher satisfaction survey conducted in spring; the higher the attachment score in the spring season, the higher the change in teacher opinion and satisfaction.

In conclusion, two different analytical procedures were used with largely similar results. The growth curve analysis showed that, for teachers, attachment and Total
Protect Factor score significantly changed over time. Mixed effect model only shows this for attachment. The relationships between attachment and teacher surveys were much more significance in terms of p-values. For parents, both types of analysis came to the same conclusion that attachment and self control changed significantly over time.

**Sustainability Activities:**

**Impact on Program Design:** Efforts were made to address each of the recommendations that emerged from the qualitative report. ECMH staff has started to assemble a policies and procedures handbook based on the IRB protocol and developed a shared goal, objectives, and brief program description which was distributed at the beginning of the year. A meeting structure was incorporated into the program to create continuous communication: the ECMH consultant and the FN meet monthly with teachers at each school to discuss consultation issues and to plan/coordinate services for individual children and families receiving services. Quarterly, the ECMH project director, the FN supervisor, the school principal, and the preschool coordinator will join these meetings to discuss programmatic issues and to troubleshoot any challenges. The ECMH team, with assistance from the city school teachers, worked to develop better alignment between the ECMH program process and the already established school IAT model. This was diagramed and distributed to all participants at the beginning of the school year.

Taken together with consultation from Georgetown University’s Center for Human Development and the statistical analyses, these modifications led to an IRB amendment was approved prior to beginning our second year in the schools allowing (A) teachers to complete the DECA behavioral checklist for all children in the class. This will enhance the universal consultation services by allowing the teacher and consultant to more fully understand the social-emotional developmental profile of their classrooms and create a more informed consultation plan, as well as improving our evaluation of our program.

**Cost Share with School Districts:** The major evaluation findings were shared at the November county-wide superintendent meeting. During that meeting, YR 3 plans were also discussed. As a result of this presentation, superintendents agreed to sign a Memorandum of Agreement committing $4,500.00 to fund the uncovered portion of the universal consultation component, which is available on request. We also presented the districts with a spreadsheet the illustrated the per pupil and per classroom costs for continuing the program beyond the end of the grant period. The current economic and financial realities facing the district lead to a sobering district of that funding the program in is existing format, based on the costs projected, will not be likely. Meeting are scheduled for February and May to continue to discuss the sustainability of services, particularly the universal consultation services and the family navigator services in the school – two services that are currently not reimbursable through billing.

Activity within Project LAUNCH, a SAMHSA program that IPAC in partnership with Ohio Department of Health may help facilitate innovation in funding as well. Project LAUNCH has established a funding committee investigation strategies for delivering
navigating services, and a Workforce committee focused on the developing the ECMH workforce.

The technical assistance provided by Stacy Willocks through the GA Health Policy Center will focus on sustainability during the remainder of Year Two and into Year Three. In February of this year, she joins us for our next conversation with the school superintendents. Discussion topics may include (1) value of services vs. cost to school system in missed days, teacher turnover, classroom disruption, readiness to learn; (2) increasing the frequency of scheduled check ins with key stakeholders; (3) facilitated conversations with the advisory group about strategies for advocating for school-level support for universal services and family navigating services and (4) reflection on our the service model will change without financing.

Major Accomplishments: Workforce Development achievements top the list.

NEW! Project Director Presents Early Childhood Mental Health project parameters at the All Ohio Counseling Conference: In November 2010, the project director presented “Tools for Tots” at the All Ohio Counseling Conference. This presentation discussed the 3-tiered model and tools used in this project, as well as the program parameters. According to past conference schedules, this was the first inclusion of an early childhood mental health topic in this state-wide professional conference for school and mental health counselors. The session was well attended with 140 participants. This was not part of proposed workforce development initiative, yet the interest demonstrated in the audience strongly endorses our goals.

Workforce initiative doubles the Family Navigator workforce and the ECMH consultation workforce: The workforce initiative that is associated with this project has allowed our region to double the Family Navigator services and has increased accessibility to those services by placing a Family Navigator at the schools. Similarly, the workforce initiative has increased the capacity of our community mental health center to meet the needs of young children by providing an additional ECMH consultant and has increased accessibility by placing these services at schools.

Scheduled Trauma Conference brings national speaker, Dr. Bruce Perry, to the area and aides in network’s sustainability efforts: The Early Childhood conference scheduled for April will bring Dr. Bruce Perry to our area. This would be impossible without grant support. It is anticipated that registration fees collected from this conference will contribute to the sustainability of the IPAC network by providing funds for an annual conference.

School districts collectively commit financial resources to the costs of the early childhood consultation program to support the full implementation of the ECMH consultative services during our second years in the schools. Although not a large financial commitment, it does represent an understanding of the importance of health promotion and prevention efforts, tailored for young children, being offered outside of the tradition mode of mental health services delivery which requires diagnosing very young children in order to bill for services. Universal EMCH services and Family Navigator services both underscore the importance of reaching families through a public health framework.
**Upcoming Budget Period Plans (Year 3: May 1, 2011-April 20, 2012).**

**GOAL:** *Improve early childhood outcomes and increase the capacity of our early childhood workforce to ensure healthy young child development through implementation of a comprehensive early childhood mental health consultation program (ECMH-CP) (Objective One), and an Early Childhood Workforce Initiative (Objective Two).*

**Objective One:** The Comprehensive Early Childhood Mental Health Consultation Program (ECMH-CP) will offer three tiers of intervention - universal, targeted and intensive - accomplished by integrating the interdisciplinary expertise of the classroom early childhood consultant, the Family Navigator and consulting psychologists. Collectively, the team will integrate data from teacher and environmental consultation, family advocacy and education, and specialized diagnostic assessments to optimize the child’s resiliency (initiative, self-control and attachment) while decreasing behavioral concerns ensuring readiness to learn. Healthy People 2010: 1-6; 11-6; 16-14,23; 18-6,9,17.

**Evaluate Annually:** # teachers receiving consultation; # children served at each tier of consultation; Teacher Outcomes: pre/post Mental Health Climate Scale; pre/post Teacher Opinion Survey, Gilliam Quality Relationship Scale- teacher scale; Child/Parent Outcomes: pre/post DECA, % parents participating in services, Pre/Post Incredible Years parenting survey, # parents screened for depression, and referred when indicated and Gilliam Quality Relationship Scale- parent scale.

<table>
<thead>
<tr>
<th>Activities Year Three: May 2011–April 2012</th>
<th>Dates</th>
<th>Outcome/Results</th>
<th>Evaluation</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity 1:</strong> Completion of EMCH Programs for the 2010-2011 school year and launch of services in the 2011-2012 school year.</td>
<td>May 2011 – April 2012</td>
<td>As listed above in progress report matrix, by Activity, with new classroom being served in the Athens City School District, Morrison Elementary and The Plains.</td>
<td>As listed above, by activity</td>
<td>Project oversight: S. Shamblin, J. Hamel-Lambert, S. Meeks</td>
</tr>
<tr>
<td><strong>Activity 1:</strong></td>
<td></td>
<td></td>
<td></td>
<td>EMCH –CL: V. Wang and R. Scarberry.</td>
</tr>
<tr>
<td><strong>Activity 1:</strong></td>
<td></td>
<td></td>
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<td>Family Navigator: E. Soroka</td>
</tr>
<tr>
<td><strong>Activity 1:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Psychological Testing: Psychology Social Work Clinic, Ohio University</td>
</tr>
<tr>
<td><strong>Activity 1:</strong></td>
<td></td>
<td></td>
<td></td>
<td>S. Willocks, GA TA</td>
</tr>
<tr>
<td><strong>Activity 2:</strong> Advisory Group meetings governing program implementation; Superintendent Sustainability meetings</td>
<td>May 2011- April 2012</td>
<td>• Final meetings in the 2010-2011 schools year for advisory group and superintendents • New meetings begin for the advisory group and superintendents for fall of 2011</td>
<td>• Advisory group identifies strategies for communicating the value of universal EMCHE-CL and FN program to participating schools. • Plan created for sustaining universal EMCHE-CL and FN program • EMCH CL program handbook developed</td>
<td>S. Shamblin, J Hamel-Lambert, MBA, PhD, S. Meeks</td>
</tr>
<tr>
<td><strong>Activity 2:</strong></td>
<td></td>
<td></td>
<td></td>
<td>S. Willocks, GA TA</td>
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</tbody>
</table>
Activity 3: Qualitative and quantitative program data collected and analyzed. Focus groups held with school employees to evaluate participant perspectives on the program’s value and effectiveness.

<table>
<thead>
<tr>
<th>Dates</th>
<th>Details</th>
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</table>
| Jun 2011 – July 2011 | • Group and individual interview with program participants conducted during summer 2011.  
• Quantitative data includes full classroom DECAs, climate scale, parent and teacher satisfaction survey & teacher confidence rating analyzed.  
• Results inform sustainability discussion. Continuation of the program’s universal ECMH CL services and the Family Navigator Program will require financial commitment from individual school districts. | Victor Heh,  
Statistician, Hamel-Lambert, PhD,  
Program Evaluator and Holly Raffle, PhD independent evaluator, S Shamblin, director |

Activity 4: Sustainability  
CEO of TCMH-CS, School Superintendents from the AMESC and The Athens City School District will negotiate a contractual relationship to ensure EMCH sustainability. Director of Family Navigator Program negotiates the same.

<table>
<thead>
<tr>
<th>Dates</th>
<th>Details</th>
</tr>
</thead>
</table>
| May 2011- April 2012 | • The final of three superintendent meetings held May- June  
• Contracts signed by individual districts for either unified program, or individual programs to serve individual buildings. | S.Shamblin,  
J Hamel-Lambert, MBA, PhD;  
S Meeks  
S. Willocks, GA TA |

Objective Two:  
The Early Childhood Workforce Initiative advances a range of professional competencies through mixed-matrix design for professional development through didactic trainings, collaborative peer group supervision, learning communities, journal readings, and program consultation through site visits and videoconferencing with state and national experts.

Healthy People 2010: 1-6; 16-14; 18-17

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<th>Dates</th>
<th>Expected Outcome</th>
<th>Partner Responsible</th>
<th>Evaluation:</th>
</tr>
</thead>
</table>
| Activity 5: ECMH consultant attends an empirically supported, classroom-based training, such as The Incredible Years Program or Georgetown Model trainings for mental health consultation, or DECA’s Face the Challenge/Challenging Behaviors | July-Aug 2011 | • Competency focused training goals set for ECMH consult, self-assessment, pre, pos  
• ECMH attends one training program  
• Provider gains capacity to administer a structured classroom intervention program in preschools  
• ECMH consultant able to demonstrate understanding of evidenced-based programs through discussion with supervisor, and implementation of strategies learned in the classroom setting.  
• EMCH achieves 85% of competency goals | R. Scarberry and V. Wang |
| Activity 6: ECMH consultant attends Ohio Department of Mental Health coordinated peer supervision group which is a case based-learning support group to build ECMH consultant’s competence | Aug 2011-April 2012 | • ECMH attends monthly case-based peer consultation training program  
• 85% of meetings attended  
Presents two cases for discussion across year. | R. Scarberry and V. Wang |
| Activity 7: Teachers provided a 3 part workshop: Incredible Years Teacher Training Program | Oct 2011-April 2012 | • Educators gain capacity in supporting their students’ development of self-regulation and social problem solving.  
• Knowledge is transferred to classroom teacher refines new skill through classroom consultation | R. Scarberry, V. Wang, S Shamblin |
| Activity 8: Policy and Advocacy training provided to CEOs, school administrator and superintendents, and other agency professionals interested in advancing understanding of how to disseminate evidence to effect policy. | Fall 2012 | • Program Director and PI, along with interested leaders from school district and mental health center attend training focused on impacting policy and effective advocacy  
• Dissemination of programs findings to impact policy decisions | GSU TA Hamel-Lambert |
Anticipated Challenge Year 3 is Sustainability

The primary challenge on the horizon is sustainability, thus our decision to focus our technical assistance in this area. As discussed above the Family Navigator program and the EMCH consultation services, at the universal level, are services that fall outside traditional delivery systems, and thus they are not reimbursable. To continue the provision of either program within the schools will require financial commitment from the school districts. While the two programs are conceptualize within this grant as two parts of the same program, they are services delivered through two different agencies, and those service are provided based on different views about how to effectively serve families. We are concerned that schools will be in the predicament of choosing to fund one or the other, which sets up an internal competition between programs that ideally exist to support and compliment the skills and abilities of the other. Moreover, the school superintendent who has championed IPACs relationship with the schools is retiring this winter. Our success in sustaining both components will lie in thoughtful planning, good fortune regarding alternate funding opportunities for one or both services through policy changes or foundation support, and clarity of roles and responsibilities between the program directors.
Appendix J: RURAL HEALTH CARE SERVICES OUTREACH GRANT PROGRAM

FINAL CLOSEOUT REPORT

Reporting Period: May 01, 2009 to April 30, 2012

I. Project Identification

1. Project Title: Building Capacity-Raising Resiliency

II. Overview of the Project

A. Describe the need for the project and the specific problems it was designed to address.

Building Capacity – Raising Resiliency was designed to improve early childhood outcomes for preschoolers and to increase the capacity of early childhood workforce to ensure healthy child development. This was accomplished through two objectives: First, we implemented an Early Childhood Mental Health Consultation Program (ECMH-CP), serving preschool-aged children annually in Athens County, OH. The ECMH Consultation Program offered three tiers of intervention - universal, targeted and intensive - provided by an interdisciplinary team of professionals including the ECMH consultant, the Family Care Navigator, and a pediatric neuropsychologist. Next, we implemented an Early Childhood Workforce Initiative designed to advance a range of professional competencies through didactic trainings, collaborative peer group supervision, learning communities, journal readings, and program consultation through site visits and videoconferencing with state and national experts.

B. Describe the service area (scope) of the project. Athens County, OH

Of the 88 counties in Ohio, 29 are Appalachian, including Athens County, which is classified as an eligible rural community by its zip code (45701). Additionally, Athens County faces significant workforce shortages. It is classified as a Mental Health Professional Shortage Area (MHPSA), a dental health professional shortage area and a...
C. Describe the organizations involved in the consortium. Explain each member’s respective contributions and responsibilities for the project and the extent of their involvement in achieving the goals of the project.

<table>
<thead>
<tr>
<th>Partner Organization</th>
<th>Location</th>
<th>Organizational Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>TriCounty Mental Health and Counseling Services, Inc.</td>
<td>Athens, OH Athens County</td>
<td>community mental health center</td>
</tr>
<tr>
<td>Family Navigator Program, Community Health Programs, Heritage College of Osteopathic Medicine, Ohio University</td>
<td>Athens, OH Athens County</td>
<td>university-based community health program</td>
</tr>
<tr>
<td>Multiple School Districts: Athens City, Alexander Schools, Federal Hocking Local Schools, Trimble Local Schools</td>
<td>Athens, OH Athens County</td>
<td>public preschools</td>
</tr>
<tr>
<td>Psychology &amp; Social Work Clinic, Ohio University</td>
<td>Athens, OH Athens County</td>
<td>university-based psychology &amp; social work training clinic</td>
</tr>
<tr>
<td>Integrating Professionals for Appalachian Children (IPAC) (<a href="http://www.ipacohio.org">www.ipacohio.org</a>)</td>
<td>Athens, OH Athens County</td>
<td>regional rural health network</td>
</tr>
</tbody>
</table>

The grant program participants, three of whom are longstanding members our regional rural health network IPAC, worked together to deliver an interagency, interprofessional service to public preschools. Each consortium partner played an active role in the program:

- TriCounty Mental Health and Counseling Services is the regional community mental health center that provided the Early Childhood Mental Health Consultation program director and consultant staff. This staff delivered universal, targeted and intensive consultation services, as well as workforce development trainings to school personnel. The Workforce Initiative was organized by the Director of Early Childhood Mental Health at TCMH who also designed the evaluation strategy in partnership with a statistician and an independent evaluator.
- The Family Navigator Program at Ohio University’s Heritage College of Osteopathic Medicine provided a nurse family navigator who provided education and navigating services to families needing assistance knowing what to do for young children with developmental and behavioral concerns. The Director of the Family Navigator Program worked with the independent evaluator to design an evaluation survey administered at the end of the grant.
- The Psychology & Social Work Clinic at Ohio University’s Department of Psychology provided in-depth evaluations for children.
- Public Preschools: School district personnel consented to have services in district classrooms; principals oversaw implementation at the building level; teachers participated in workforce trainings and worked individually with the consultant to build individual competency to work with children presenting with challenging
behavior or development delays. School staff participated in data collection and evaluation interviews.

D. Describe the services provided through the grant and the population who received those services.

The ECMH consultation program was offered to public preschools across Athens County. The program offered three tiers of intervention - universal, targeted and intensive - provided by an interdisciplinary team of professionals including the ECMH consultant, the Family Care Navigator, and a psychologist. ECMH services facilitated the development of self-control, attachment and initiative skills in young children, while reducing problematic behaviors. It also built the capacity of teachers and school personnel to foster healthy child development. The Family Navigator Program provided families with resources to facilitate their understanding and participation in health care decisions affecting their families. The Family Navigator addressed parent concerns regarding a child’s health and behavior and encouraged parent participation in their child’s treatment by providing anticipatory guidance and support during the service period and by acting as a communication bridge to physicians, school personnel and the ECMH consultant for the purpose of developing, implementing and evaluating a comprehensive service plan. Psychological assessments were used to inform intervention services for children who were already struggling to demonstrate age appropriate developmental milestones and achievement.

It is recognized that as many as 7-20% of preschool and early school aged-children exhibit behavioral problems that meet criteria for a mental health disorder (Ohio Department of Mental Health [ODMH], reported in Sites, Collopy, Velilla, Cayard & Graft, 2008). Despite these prevalence rates of mental health problems in childhood, national estimates indicate that 70% of children with diagnosable disorders do NOT receive mental health treatment (U.S. Public Health Service, 2000). Integrating ECMH services into the classroom setting is one strategy to improve access to services for those in need.

The development of our workforce was integral to our programmatic efforts. The Early Childhood Workforce Initiative advanced a range of professional competencies through didactic trainings, collaborative peer group supervision, learning communities, journal readings, and program consultation through site visits and videoconferencing with state and national experts. Teachers, classroom aides, family navigators and the ECMH consultants were the recipients of a variety of training opportunities.

III. Implementation of the Project

A. Discuss the most significant problems encountered in the project implementation and the efforts made to overcome the problems.
Two significant challenges were encountered. The first involved the capacity of the ECMH to effectively serve the 19 classrooms originally proposed. The second involved the development of the interdisciplinary team. The inclusion of the multiple professionals on the team was designed to provide complementary services to children being served the ECMH consultant at the targeted or intensive tiers of the model. Whereas the capacity challenge was overcome by reducing the number of classrooms served in the third year, hiring new staff, and offering a more intensive service; the second challenge was managed by allowing school personnel to directly refer to the Family Navigator Program so that children and families could be served regardless of their relationship with the ECMH consultant. Both the ECMH program and the Family Navigator Program referred children for psychological services when indicated.

The difficulties in developing our interprofessional team were anchored in role differentiation and interagency dynamics. Team members included the ECMH consultation staff, the family navigator program staff, and the psychologist. By the middle of year two it was evident that difficulty in differentiating roles between the ECMH services and the services offered through the family navigator program and psychologist was negative impacting the ability of the team to work as a unified unit. To improve our delivery of services, we divested from the team approach, such that any single program (i.e., Family Navigator or ECMH) could work with families, rather than having the ECMH consultant as the ‘first responder’ who would engage the others as needed. As anticipated, referrals then came into either the Family Navigator Program or to the ECMH consultation services. In year 3, only 20% of the Family Navigator caseload was jointly served by the ECMH consultant in the classroom, suggesting that the decision to separate the mechanism for referring to the program components effectively reached

B. Describe the management of the consortium and any problems encountered.

In addition to the management challenges that emerged between the members of the team, the relationship between the school districts and the mental health center also required focused attention. At the end of the first year, six out of nine teachers who had received the program participated in a single session group interview conducted by an independent evaluator. Two of the three school principals, whose schools had received the program, as well as the county preschool coordinator and the city school psychologist, were also interviewed individually. The results indicated that the family navigator and individual intensive consultation services were valued. Concerns were raised about the ambiguity of the universal consultation services and communication challenges. Five key recommendations were emerged: (1) Create a policies and procedures handbook that describes the program, the roles of ECMH-CP staff (2) define and utilize a communication system with two layers that promotes a continuous feedback loop between the school system and the ECMH-CP; (3) Use a child-centered model that those who work in school systems are familiar with, such as the school’s existing Intervention Assistance Team (IAT) model to refer and serve children and families in
need (3) Continue to provide family navigation services (4) Refine the role of the teacher consultant and what services exist within the universal services component of the ECMH-CP.

Substantive changes to the design of the program were implemented in Year 3 in response to the program evaluation data. The ECMH CL services were concentrated in two districts, serving four classrooms (rather than 19) which allowed for greater intensity of services, on site supervision, and the opportunity to build a model in partnership with school personnel. EMCH consultation staff changes were part of this transition. The original vision of having a seamless team was modified, recognizing that the components (i.e., the Family Navigators, the EMCH staff and the Assessment team) had not been successfully integrated. As such, the ECMH CL program and the Family Navigator Program operated independently of one another during the second half of the grant.

The end of Year 3 evaluation included a series of stakeholder interviews with teachers (group interview, n = 4), principals, and superintendents to solicit feedback on the structure, strengths, and liabilities of the program with recommendations for improvement. The evaluation of the ECMH program noted marked improvement. Teachers reported satisfaction with the classroom-based consultant highlighted the consultant’s competence and increased clarity surrounding her role with the students and teachers. Teachers described three layers of support provided by the program: teacher support services, classroom support services and specialized support services. The program redesign increased in the amount of time the ECMH consultants were in the classroom, and teachers noted that classroom support services were highly effective in helping children identify feelings, develop emotional competence, build social skills, reduce aggressive behaviors and participate in class. Again, the competence and the consistency of the ECMH consultant was noted as being instrumental in the establishing the EMCH program as valuable. The evaluation report did recommend continued focus on improving communication regarding the program’s design, particularly to the principals and superintendents who desired more structure with regard to interactions with the director and consultant, with an emphasis on providing clear concise communication regarding the anticipated outcomes of the program.

C. Describe innovative methods of service delivery employed by the project.

The ECMH Consultation Program was a school-based intervention that employed an embedded consultant to build teacher skills and to work individually with children.

D. Identify, if any, data collected and/or performance measures used to evaluate the short and long term success of the project.

The evaluation of the ECMH Consultation Program employed a mixed-methods design. Qualitative outcome data were gathered by an independent evaluator through annual
teacher focus groups and individual school administrator interviews. Results were used to assess program satisfaction and inform program design. Quantitative data was collected to measure the effectiveness of program components, which aim to (1) increase capacity of teachers to manage challenging classroom behaviors, and (2) increase the resiliency of children in participating classrooms. To address increased capacity of teachers, we collected the Teacher Opinion Survey (TOS), a teacher completed rating scale. To address increased resiliency of children, the Devereaux Early Childhood Assessment (DECA) was used. The DECA is a standardized, teacher or parent completed resiliency-based behavioral rating scale with subscales for initiative, attachment, and self-control.

The evaluation of the Family Navigator Program employed a survey distributed to personnel in six school districts, one head start, one county board of developmental disabilities, and the regional Education Services Center. Sites were selected based on referrals received during the project period.

IV. Results of the Project

A. Identify how the project was evaluated and the outcomes achieved with the grant funds.

The evaluation methods are described in the preceding two paragraphs.

EMCH Program Effectiveness, selected analyses reported

Please note that because the school year continues pass the end date of the grant (April 30, 2102) analyses are almost exclusively for the first two years of the program.

- Teacher Opinion Scales: A paired sample t test was used to evaluate the differences in teacher scores between the fall and spring administrations (n = 14; 8 participating teachers, 6 wait-list teachers). Year One: The mean score in the spring (M=49.77, SD=3.11) was significantly greater than the mean score in the fall (M=46.75, SD=2.96), t (7) = 2.38, p<.05). The standardized effect size, Cohen’s d, was 0.84 indicating a large effect size. However, comparison of scores between participating teachers and wait-list teachers were inconclusive. Year Two: Results were inconclusive in regards to the change of participating teachers across the year; and in regards to comparison between participants and control group. For Participants, the pre-to-post differences were not statistically significant: fall (M=48.7, SD=3.31); the spring (M=49.8, SD=4.79), t (9) =-.56, p=.6). However, the shift in teacher opinion across the year reflected a medium effect (d=0.27).

- Universal Consultation/ Whole Classroom DECA Scores: For Year Two, DECA questionnaires were collected at the classroom level for all children (n = 133 for 11 classes; 9 participating, 2 wait-list). Comparative analysis indicated wait-list classes
had an over-representation of children whose initial scores were in the “strength” range (T score > 60). In order to control for these differences, a sub-group analysis was conducted which included only wait-list and participating classroom children whose initial scores were in the “typical” or “concern” range (T score <60). Fixed slope, random intercept fit the data so multilevel growth modeling (three level analysis) was conducted to determine the rate of seasonal growth in for each subscale. On the Self-Control Subscale, program children had an average growth rate of 8 points. Again, this rate of growth would move the average child scoring in the “Concern Range” into the “Typical Range.” Children in the control classrooms, on average, only made a gain of 1.6 points. On the Initiative Subscale, program children made an average growth of 10 points. Children in the control classroom, on average, only made gains of 5 points. There were no significant differences in rate of growth for the attachment scale.

- Targeted Consultation: Teacher and parent ratings on the DECA scale were analyzed using the same fixed slope, random intercept linear modeling. Year One Results: Analysis of the teacher ratings for 10 children who entered the study in the fall showed that attachment scores significantly improved over time, however initiative and self-control did not. Parent ratings reflected that children’s self control, attachment, and behavioral concerns as rated by parents, changed significantly over time. Final Results: An individual piecewise growth curve analysis indicated that for teacher ratings, children had a fixed growth rate of 7.465 DECA points between winter and spring. This rate of growth would move the average child who scored in the “Concern Range” into the “Typical Range”. A similar analysis conducted for parents’ ratings showed a non-significant growth rate of 1.745, p=0.678 and 3.111, p=0.090 respectively.

- Mental Health Climate Scales: For Year Two, Bivariate Linear Regression between the DECA subscales and subscales on the MHCS was conducted (DECA’s n = 133 children; MHCS = 11 teachers). Increases in child DECA scores for initiative and attachment were positively related to teacher scores on the following subscales of the MHCS: “Directions and Rules”, “Staff Awareness”, “Staff-Child Interaction”; “Child Interaction.”

**Family Navigator, Program Effective, selected analyses reported**

Teachers, administrators and school personnel from educational settings served were surveyed with a 26 item, Likert Scale instrument to assess their general understanding of the Family Navigator Program (FNP), their satisfaction with the program, and their reasons for referring to the program. 84 respondents completed the survey, 80% of whom had over 6 years of work experience. 40.5% had referred families to the Navigator for services (n=34); 56% indicated they had not (n =47).

The results indicate that individuals learn about the about the Family Navigator Program from a wide-range of informants (e.g., school administrator, Family Navigator Program staff, and colleagues to name the top three sources), yet, there is a need to build awareness and understanding for school personnel. When examining data for the entire
sample, it was typical for somewhere between 28% and 62% of respondents to reply that they simply did not know (DN) answers to all questions asking about basic features of the program (e.g., Are families partners in the FNP process, 45.2% DN) as well as those inquiring about more unique aspects of how the program is integrated into school processes (e.g., Our school has adopted a protocol that clearly defines when and how to refer students to the FNP, 47.6% DN; FNP duplicates services that exist in this school district, 50% DN).

Looking specifically at respondents who had referred (n = 34) to the Family Navigator Program offered a distinctly different picture. “Don’t Know” responses dropped below 12%, for all but three survey items. Respondents who are referred to the FNP either strongly agreed or agreed that (1) service are flexible and proactive (82.4%); the staff respond rapidly to referrals (73.5%); services provide families access to wide range of indicated services/activities (88.2%); families are partners (82.4%); they are confident are to refer to the FNP (85.3%); that referrals are made when concerns are about social/emotional growth (82.4%) or if existing school resources are not able to meet the child’s need (70.6%) and that those served experience social/emotional growth (70.6%) as well as academic growth (50%).

Results indicated the need to increased understanding among users of the program about the primacy of efforts to protect confidentiality, which may prevent information from being shared with the school, as well as to what the process involves are more or less the same whether services are delivered at the school or outside of the school setting. Understanding how the services do or do not duplicate existing school resources and how the program is evaluated are all areas that could benefit from structure communications and educational efforts.

Historically, no formal advertising has been pursued, given that the current flow or referrals was sufficient given the capacity of the program personnel to serve families. Knowledge about the Family Navigator Program has, as documented here, grown one family at a time. As the program plans for deliberate growth and if increased referrals from schools are desired, a marketing plan is recommended.

1The community supports the Family Navigator Program (20.6% DN); Is a student needs to be referred outside of the school system, the intake process is comprehensive while minimizing barriers to service for students and families (29.4%); There is a procedure in place to evaluate the effectiveness of the Family Navigator Program (32.4%).

**Workforce Development**

- 20 education professionals attended Jim Gill, Child Development Specialist singer/songwriter symposium on the use of music play to inspire young children and support health development.
23 educators participated in the Learning Community on Executive Functioning Deficits at Athens City School.

22 school personnel trained on DECA Face the Challenge (n=10), Becky Bailey’s “Conscious Discipline” (n=8), DECA’s “Building Your Bounce” (n=4)

250 professionals attended Bruce Perry, MD, PhD presentation on April 2011. It was an interprofessional audience including physicians, mental health professionals, developmental disabilities specialists, educators, legal professionals, parent and health professional graduate students. Presentation was on the effect of trauma and neglect from a developmental perspective, on identifying signs and symptoms of trauma.

School staff participated in workforce development activities by attending the Georgetown Training Model; the DECA Face the Challenge; the DECA training program, 1 has completed the Parent IY program, and 1 has completed the Trauma-Focused Cognitive Behavior Training program. Additionally, the early childhood mental health consultants and the family navigator attended the National 0-3 Training Institute in December, 2011.

4 members of a regional interprofessional assessment team, the Southeastern Ohio Interdisciplinary Assessment Team trained on the Autism Diagnostic Observation Scale

The ECMH program director gained expertise in: General management skills from the Appalachian Leadership Academy; ECMH program management from Jane Sites, Director of the Therapeutic Interagency Preschool at Cincinnati Children’s Hospital; ECMH program development through consultation from Georgetown University’s Center for Child and Human Development; CBPR approaches for community public health through the Community-Based Partnership Caucus of the American Public Health Association; Program Evaluation through Robert Wood Johnson’s Retooling Professionals Evaluation Fellowship program; Advocacy skills through the Corporation for Ohio Appalachian Development (COAD), and the National Rural Health Association. The director presented a workshop at the All Ohio Counseling Conference which provided 140 participants training on best practices for young children.

School personnel, state legislators and program staff participated in the advocacy session aimed to educate the Ohio’s Children’s Caucus about mental health–school partnerships and the importance of socio-emotional development as it establishes its legislative agenda.

B. Describe if the consortium was able to function as initially planned and whether the existence of a consortium made a difference in the outcome of the project.

Communication among the consortium members was a challenge. The original project proposal included creating an advisory group composed of participating school superintendents and the CEO of the mental health clinic. The group was to meet quarterly and address sustainability challenges. During the first year, the group was only able to
meet twice due to scheduling issues. While the initial meeting was well attended, the second meeting was not. It became evident that the best way to connect with superintendents was through their already-established county superintendent meeting to provide brief updates and engage in sustainability discussions. It also became evident, that the project would benefit from “internal school advocates” at all levels – teachers, principals, and other school staff—who believed the program had value and could articulate the value to their school superintendents.

The original model utilized an interprofessional team that layered supplemented services from the Family Navigator Program and the psychologist within the ECMH model such that those services were provided to children being served the EMCH consultant. This model was disbanded by the middle of year two due to confusion regarding roles and leadership.

By year three the number of schools being served was consolidated down from 5 districts to 2 districts, which involved serving 4 classrooms rather than 19, as originally proposed. The consolidation improved communication between the school-based consultant and the teachers, but there continued to be challenges in establishing an effective communication with the administrators, and the superintendents. The end of Year 3 evaluation noted markedly improved satisfaction with the classroom-based consultant in regard to her skills and the clarity surrounding her role with the students and teachers. However, the evaluation report recommended continued focus on improving communication regarding the value-added, with an emphasis on providing clear concise communication regarding the anticipated outcomes of the program.

The vision that the director of single program within this interagency consortium would be able to represent the interests of the partnering program and lead the team was flawed. The implementation of the ECMH services was in early stages, the importance of successful school-mental health initiative was the priority of the EMCH director and the other members of the consortium felt that she failed to represent them effectively in communications about all of the programs funded to participate and serve the school districts.

Ultimately, I would say the presence of our rural health network, Integrating Professionals for Appalachian Children was critically important in our efforts to secure the grant, and in our ability to work through the challenges that arose during the implementation of the grant. Had we not had years of working together under our belt, the challenges that we encountered in this project would have prevented an emerging consortium from consolidating and sustaining. We are pleased to report that our rural health network, IPAC, continues to thrive and that IPAC has just employed our first executive director. The position is partially supported by the funds raised through the conference funded through this grant.

C. Describe any problems or barriers that were not successfully resolved in the
implementation of the project.

None.

D. Describe any successful recognition or acknowledgement received, either local, state or national (e.g. tv, radio, newspaper article, community recognition).

Press release: “Federal grant brings mental health consultations to public preschools Department of Health and Human Services gives $375,000 to local children’s mental health network” ran in local newspaper and internal communication at Ohio University

Public television interview in 2009; WOUB featuring Sherry Shamblin.

2010, Integrating Professional for Appalachian Children was recognized by the Athens County Red Cross as a “Hometown Hero – Group”. One nominator noted the award recognized “community group, neighborhood organization, or local company that consistently demonstrates a commitment to making a difference in the community.” .. and continued “I can think of no organization more worthy of recognition than IPAC. IPAC is a rural health network composed of university, community, and consumer partnerships aimed at strengthening southeastern Ohio’s health care delivery system to meet the health and mental health care needs of children and their families in not only Athens county but also Meigs, Hocking, and Vinton counties. IPAC is worthy of recognition because through its efforts affiliates have enlarged the scope of health and mental health care resources in our community and access to such resources.”

Sherry Shamblin, Director of Early Childhood at TriCounty Mental Health and Counseling Services Inc. was selected for the Robert Wood Johnson Retooling Professionals Evaluation Fellowship Program, 2012-13.

IPAC also maintains a website, www.ipacohio.org

V. Application to Other Rural Areas or Communities

A. Provide your opinion on whether similar projects to yours could be successful in other rural settings.

EMCH Model
The Early Childhood Mental Health Consultation Model developed in this project differs from the model adopted by our state through Ohio Department of Mental Health and the most recognized national model developed at Georgetown University. In the ODMH and Georgetown ECMHC models, the EMCH consultant serves a number of centers and is called in to only address specific classroom issues or child problems. Moreover,
traditional mental health assessment and treatment are not considered part of the service delivery in these consultation models. In both models, when child needs more intensive assessment and intervention that child is no longer served by the consultation program; he or she would be transferred to a mental health clinician located at the community mental health center or elsewhere in a community.

Due to ECMH specialty workforce shortages in our region, our ECMH program needed to use the same provider for both consultation and assessment/treatment services. However, various factors affected our ability to provide both levels of services. Most notably, the geographic distances between schools limited the consultant’s time in the classroom. With travel time eroding classroom time, the ECMH consultant prioritized the intensive/treatment services at the expense of the targeted and universal consultation services. Not surprisingly, reduced time in the classroom was a barrier to building relationships with school personnel and families.

Additionally, in our rural community, early childhood professionals (ie teacher, school personnel) often share stereotypic views of mental health that we know are held by the public. Locally, the teacher-consultant-parent relationships were under-developed and teachers and parents only connected with the consultant when a specific child was having very extreme problems warranting intensive services. Subsequently, the promotion/prevention services offered within the universal and targeted tiers of the program were not embraced.

Both these challenges were addressed by the redesign of our program in Year 3. In Year 3, TCMH moved to a model that utilized an embedded consultant. This meant we could only serve only two schools, but it led to strong teacher-consultant relationships, high utilization of the universal consultation services by parents and teachers, and decreased use of individual-child intensive mental health services.

To the degree that other rural settings are challenged by large geographic distances between sites, the cultural views of stereotypical mental health services, and relationship driven engagement in services, than this ECMHC model is likely to be transportable, adopted, and successful.

**Family Navigator Program**
The Family Navigator Program’s key feature is the use of *local nurses* to empower consumers to participate in health decisions. The cultural congruence achieving by employing staff with local knowledge is essential to connecting with local residents and understanding the nuances of regional communication patterns. The employment of nurses is also key given the region’s poor utilization of health care and address unmet health education needs that could be addressed in a medical home, if the consumer was more connected with the health delivery system. Overall, the program is a model that could be adopted to other rural communities.
B. Based on your experience, discuss the main issues and problems that other communities might face in using your project as a model for service delivery, health education, or health promotion programs.

The recruitment of workforce that understands the program model, the local culture, and the importance of innovation strategies to address community need are challenges faced by both the Family Navigator Program and the ECMH Consultation model. When services are delivered through innovative programs, communicating the uniqueness of the program and how it is different from tradition service modalities is critical to having a workforce that embraces the work opportunity. Over the course of the grant, the ECMH program experienced workforce attrition, and the expansion of the nurse navigator program has required the director to differentiate this role for licensed nurses, given navigators are often by lay consumers. Both a new role for nurses and for mental health professionals, these programs have worked to clearly communicate the services they offer consumers, and equally important, what they do not offer. Our understanding of this dynamic emerged across the development over the three years.

VI. Sustainability

A. Will all, some or none of the elements of the program be sustainable once Outreach grant funding has ended? Please check the appropriate selection.

____ All elements of the program will be sustained
_x_ Some parts of the program will be sustained
____ None of the elements of the program will be sustained (i.e. the program will completely end after the grant period)

B. Please elaborate on your response to the previous question here.

Early Childhood Mental Health Services

Teachers, principals and superintendents felt that sustainability was a serious concern regarding the continuation of the EMCH Program. Recognizing that the program must be fiscally sustaining, those interviews reflected on shrinking school funding in Ohio, particularly preschool funding. The possibility of losing the program was distressing to those interviewed, as the EMCH Program was deemed beneficial to teachers, children, and families.
TriCounty Mental Health and Counseling Services, Inc is willing to continue to commit resources to sustain these school-based services as long as referrals continue to be robust. In addition, TCMH will continue to negotiate financial support from both the school districts served and the local 317 ADMAHS board; both provided support during the grant. The final source of revenue to sustain the program is reimbursement for services that can be billed to third party payers. Currently, Ohio does not reimburse providers for consultation services; however, assessment and therapeutic services can be reimbursed. The program director will continue advocacy efforts to address policy and legislative actions that would sustain universal consultation regionally, as well as across Ohio. Specifically, it is anticipated that the programmatic tiers will be implemented as described: intensive consultation services will continue and will be funded by third party reimbursement; targeted consultation services be limited to 3-5 contacts at which time a decision will be made by the ECMH consultant, teacher, and parent about enrolling the child into intensive services; universal consultation services will be delivered in the same fashion.

Family Navigator Program

The Family Navigator Program will continue to offer services in the region supported by the SAMHSA Project LAUNCH grant to Ohio and a newly developing care coordination effort to implement AHRQ’s Community HUB/Pathway model. The Community HUB/Pathway model, if successful, will establish a funding mechanism for the Family Navigator Program, such that some of the services it provides will be supported through contracts with the managed care plans and an emerging pediatric accountable care organization. This effort is being funded with $350,000 from Ohio’s Governor’s Office of Health Transformation, awarded in February 2012; implementation is anticipated in August 2012.

The Community HUB/Pathway model holds promise for providing the Family Navigator Program a revenue stream to support it operations, yet it also demands the program stretch the services provided to families and doing so will require the Family Navigator Program to diversify is staff to include lay navigators in addition to nurse navigators. Substantiating a return on investment is also critical for long term sustainable. Project LAUCNH also continues its investment in health care economist, Dr. William Custer from Georgia State University to compute Return on Investment for the Family Navigator Program, a multi-year effort that has required refining the data collection and evaluation efforts to generate a picture of how the Family Navigator Program sparks change in those receiving services, and to compute the value of that change.

C. If all or some of the elements of your program will sustain, what methods were developed and implemented to continue the program once the Outreach grant funding has ended?
D. If no, will the program be closing out? What challenges were faced in developing and implementing a sustainability plan?

Sustainability planning never ends. Both programs are actively involved in diversifying revenue streams to not only maintain current level of services, but to expand the programs. Multiple factors influence sustainability planning, including the funding options, evidence of the program’s effectiveness, and evaluation of the program’s return on investment.

E. Do you consider your program a best practices model? Please explain.

**ECMH Program**
First described in 2000 by Cohen and Kaufman, Early Childhood Mental Health Consultation is an evolving prevention, promotion, and intervention service delivery system. Nationally, ECMH programs vary widely in their component parts and in the outcomes they are able to deliver. Within this landscape, we believe that our ECMH program model can be provisionally identified as a best practice model. Not only are we beginning to generate quantitative and qualitative data that are suggestive of success (outlined earlier in this report), we compare favorably with two respected resources from the ECMH literature. See below:

The earliest document reviewing ECMH programs across the United States in an effort to identify best practices “Promising Practices in Early Childhood Mental Health” by Simpson, Jivanjee, Koroloff, Doerfler, and Garcia (2001) and published by SAMHSA. This document identified ten common criteria of the five promising practices/programs that they reviewed. The table below identifies these and the directors offer a snapshot of how our ECMH program compares:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>TCMH ECMH Program Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive</td>
<td>Our program model offers 3 tiers of service so that children’s needs within their classroom setting are met. Universal (prevention) for typical children in a class, targeted (promotion) for children who have specific classroom behavior challenges but do not need mental health services, and intensive (assessment and intervention) for children who have developmental and mental health delays/disorders.</td>
</tr>
<tr>
<td>Community-Based</td>
<td>Services occur within schools and family homes, not at the mental health clinic.</td>
</tr>
<tr>
<td>Service array uniquely configured for the specific community of service</td>
<td>The program model was developed through the three years of this Outreach grant with input from school partners at all levels and ECMH staff.</td>
</tr>
<tr>
<td>Coordinated with other services</td>
<td>ECMH consultants are part of the school environment and coordinate with teachers, school social workers, school psychologist, Speech/language and Physical therapists, and teachers.</td>
</tr>
<tr>
<td>Culturally competent</td>
<td>Program model, services, and staff are well-suited for rural Appalachian schools and families.</td>
</tr>
<tr>
<td>Builds on strengths/resilience</td>
<td>Universal services are based on identifying teacher strengths and</td>
</tr>
</tbody>
</table>
interests then building on them. Targeted and Intensive services are centered around the Devereux Early Childhood Assessment system which is well-rounded in the resiliency research and literature.

<table>
<thead>
<tr>
<th>Focused on developmental needs</th>
<th>Particular attention has been paid in developing services and using tools, such as the DECA and Incredible Years programs, which are specifically designed to meet the developmental needs of the preschool population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family participation</td>
<td>Families are invited to participate in parenting programs through the summer and the school year; parents and caregivers are involved with designing targeted and intensive strategies.</td>
</tr>
</tbody>
</table>

A second document used by the ECMH field to measure effectiveness of a model is Georgetown University’s national scan of 35 states/29 ECMH programs produced in 2009, titled “What Works? A Study of Effective Early Childhood Mental Health Programs.” This document identified ten core components; the directors comments on our programs features for each component:

<table>
<thead>
<tr>
<th>Core component</th>
<th>TCMH EMCH Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong leadership</td>
<td>ECMH program director has been local and state leader in the development of the ECMH field</td>
</tr>
<tr>
<td>Clear Model Design</td>
<td>Model has well articulated levels with targeted goals, service delivery activities, and evaluation components.</td>
</tr>
<tr>
<td>Process for hiring and training staff</td>
<td>ECMH Consultant core competencies aligned with the model are developed, which employs cognitive apprenticeship methodology for the first year of employment.</td>
</tr>
<tr>
<td>Supervision and support mechanisms for consultants</td>
<td>The ECMH consultant’s attainment of the core competencies is aligned with accompanying supervision activities throughout the cognitive apprenticeship year. Following this year, a peer mentorship program has been developed.</td>
</tr>
<tr>
<td>Strategic Partnerships</td>
<td>The program has strong partnerships with schools and early childhood professionals; the parent network, Integrating Professionals for Appalachian Children (IPAC); the local mental health community; and state departments of mental health (ODMH) and health (ODH) through SAMHSA’s Project LAUNCH</td>
</tr>
<tr>
<td>Community engagement</td>
<td>School partners (even those not directly receiving the services) have been engaged partners in developing the model and in supporting program activities. IPAC sponsors information on their website and e-newsletter.</td>
</tr>
<tr>
<td>Clear communication</td>
<td>Recent qualitative data and surveys report good communication between consultants and school personnel.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Employs mixed methodology to evaluate each tier of service, as well as overall impact.</td>
</tr>
<tr>
<td>Financing</td>
<td>Has been well supported by the home agency (Tri-County Mental Health) and the local mental health board which has agreed to sustain the program after the grant ends.</td>
</tr>
</tbody>
</table>

Additional outcomes for this model are being studied through the Program Director’s Evaluation Fellowship through Robert Wood Johnson, and through her doctoral dissertation process which will employ a mixed method, CIPP model for summative program evaluation.
Family Navigator Program
The Director of the Family Navigator Program notes her staff uses nursing best practices – specifically tailoring interviews and subsequent education to address the whole child, including the home and other impacting environments. By reviewing health, social-emotional, and environmental factors, the needs of the family as a whole are identified and addressed when looking at child service needs. Through education about services and family choice about what services were desirable to them, parents actively participated in guiding what services their child would receive and in a sequence that best fit their needs.

IV. Financial & Sustainability Information

A. List the sources and amounts of cash revenue or in-kind resources received for the Outreach Grant related services or activities (exclude all "reimbursement for services" revenue):

The conference featuring Bruce Perry generated $25,000, which will continue to support the network. Schools in Year 3 contributed $1000.00. And TCMH donated resources to successfully implement the program.

B. Indicate the sources and amounts of “reimbursement for services” revenue for grant-related services:

There were services provided that were reimbursed by third parties. Revenue: $0.00

V. Program Support

A. ORHP Support: Was the support provided by ORHP (i.e. your project officer) helpful to you? If so, please list and explain aspects of ORHP support that were beneficial to you (i.e. accessibility, responsiveness, met your needs etc.)

This project encountered substantial challenges in Year Two. Leticia Manning was a tremendous resource in helping me navigate the problematic communications and arrive at a solution that allowed us to continue to deliver services in Year Three. Ms. Manning’s professionalism, responsiveness were exemplary; and she cared that a solution was found and the grant was a success. Leticia was instrumental in setting appropriate boundaries on the personnel involved.
B. Grants Management Support: Was the support provided by your Grants Management Specialist helpful to you? If so, what aspects of grants management were beneficial to you?

Carryforward requests were managed efficiently and accurately. Any questions emailed were promptly responded to and the directions/answers were clear and concise.

C. Technical Assistance: Did the technical assistance provided by your Georgia Health Policy Center technical assistance consultant help you in successfully implementing your project? If so, what aspects of technical assistance were beneficial to you?

Stacey Willocks was the TA consultant from GSU who worked with us on the OUTREACH grant. She had also provided technical assistance during our network development grant, so she had a deep working knowledge of our partners and our goals. This core understanding proved highly valuable when the challenges arose in this project. She provided a tremendous amount of support and guidance to me. She helped me keep perspective throughout, working alongside Leticia to ensure me that a solution could be found. During this period, we had weekly contact so I could formulate my reasoning and build effective communications with my partners about the management decisions I made. She reviewed proposal plans regarding the redesign of the service program, and she maintained communications with ORHP staff throughout. Again, like Ms. Manning’s, her professionalism and responsiveness were exemplary. Without the two of them, I have a question whether we would have been able to deliver the services in the third year as we did.
Appendix K: 2009 - 2012 Rural Health Care Services Outreach Grant Program
Source Book entry for Building Capacity – Raising Resiliency

Part I: Organizational Information

A. Grantee Organization

<table>
<thead>
<tr>
<th>Project Period (beginning year to end year)</th>
<th>2009 – 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding level for each budget period</td>
<td></td>
</tr>
<tr>
<td>May 2009 to April 2010:</td>
<td>150,000</td>
</tr>
<tr>
<td>May 2010 to April 2011:</td>
<td>125,000</td>
</tr>
<tr>
<td>May 2011 to April 2012:</td>
<td>100,000</td>
</tr>
</tbody>
</table>

B. Consortium Partners

<table>
<thead>
<tr>
<th>Partner Organization</th>
<th>Location</th>
<th>Organizational Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>TriCounty Mental Health and Counseling Services, Inc.</td>
<td>Athens, OH</td>
<td>community mental health center</td>
</tr>
<tr>
<td>Family Navigator Program, Community Health Programs,</td>
<td>Athens, OH</td>
<td>university-based community health program</td>
</tr>
<tr>
<td>Heritage College of Osteopathic Medicine, Ohio University</td>
<td>Athens County</td>
<td></td>
</tr>
<tr>
<td>Multiple School Districts:</td>
<td>Athens, OH</td>
<td>public preschools</td>
</tr>
<tr>
<td>Athens City, Alexander Schools, Federal Hocking Local</td>
<td>Athens County</td>
<td></td>
</tr>
<tr>
<td>Schools, Trimble Local Schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychology &amp; Social Work Clinic, Ohio University</td>
<td>Athens, OH</td>
<td>university-based psychology &amp; social work training clinic</td>
</tr>
<tr>
<td>(<a href="http://www.ipacohio.org">www.ipacohio.org</a>)</td>
<td>Athens County</td>
<td></td>
</tr>
<tr>
<td>Integrating Professionals for Appalachian Children (IPAC)</td>
<td>Athens, OH</td>
<td>regional rural health network</td>
</tr>
<tr>
<td>(<a href="http://www.ipacohio.org">www.ipacohio.org</a>)</td>
<td>Athens County</td>
<td></td>
</tr>
</tbody>
</table>

Part II: Community Characteristics

A. Area: List the communities/counties that the Outreach project served.

Athens County, OH

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22 This is an unpublished program report belonging to the “Partnerships for Early Childhood Mental Health Program” It is reprinted for the purposes of this study with permission from Tri-County Mental Health and Counseling Services, Inc.
B. Community description: *Describe in one paragraph the primary factors that influence life in your community (such as population make up, disease rates, gaps in services, economic and social conditions that impact health).*

Rural America, long known for its picturesque landscapes, often conjures images of quiet tranquility. Yet rural America is home to a vast array of stressors. Poverty is pervasive, especially among more vulnerable populations such as the elderly and children. Relative to urban residents, rural Americans have fewer opportunities for employment; many who do work earn lower wages than their urban counterparts. Educational attainment is lower for rural residents as well; only 15% of rural Americans are college graduates as compared to 28% of urban adults (Office of Rural Health Policy, 2006). For those seeking mental health services, critical resources in rural areas are often unavailable, inaccessible or inadequate (New Freedom Commission on Mental Health, 2004), threatening the education and healthy development of our children.

<table>
<thead>
<tr>
<th>Quick Facts</th>
<th>NATION</th>
<th>OHIO</th>
<th>Athens County</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of all ages in poverty (2005)</td>
<td>13.0</td>
<td>13.3</td>
<td>31.5</td>
</tr>
<tr>
<td>% families, with child &lt;5 yr. old, below poverty (2006)</td>
<td>15.9%</td>
<td>15.9%</td>
<td>29.3% Congressional District 6, including Athens Co.</td>
</tr>
<tr>
<td>% of persons 25 years or older with high school degree (2000)</td>
<td>80.4%</td>
<td>83.0%</td>
<td>82.9%</td>
</tr>
<tr>
<td>Unemployment (2007)</td>
<td>6.1</td>
<td>7.1</td>
<td>8.2</td>
</tr>
<tr>
<td>ARC Economic Designation (2008)</td>
<td>N/A</td>
<td>N/A</td>
<td>At-Risk</td>
</tr>
</tbody>
</table>


In rural America, significant rural mental health workforce shortages are the rule rather than the exception; estimates indicate that 85% of mental health provider shortage areas are rural (Bird, Dempsey, & Hartley, 2001). Lacking human resources, rural mental health providers must manage higher caseloads across wider geographic areas than urban providers. Providers operating in shortage areas tend to focus on acute and emergent presentations, leaving preventive care to fall to the wayside (Office of Rural Health Policy, 2006). Mental health provider shortages also affect the general rural healthcare workforce, as primary care physicians, educators, nurses and other professionals struggle to treat consumers whose needs are complicated by socioemotional, developmental and mental health concerns.

Of the 88 counties in Ohio, 29 are Appalachian, including Athens County, which is classified as an eligible rural community by its zip code (45701). Additionally, Athens County faces significant workforce shortages. It is classified as a Mental Health
Professional Shortage Area (MHPSA), a dental health professional shortage area and a Medically Underserved Area (MUA). (http://bhpr.hrsa.gov/shortage; http://muafind.hrsa.gov/index.aspx). Additionally, the Appalachian Regional Commission classifies Athens as “At-Risk,” the second most severe economic classification (www.arc.gov, retrieved 9/18/08). At its best, the workforce that serves our region’s rural Appalachian children is heavily burdened. At worst, it is chronically beleaguered. Our local educators, human services professionals, pediatricians and childhood mental health professionals operate within a socio-economic landscape rich in risk but poor in resources, particularly human resources.

C. Need: Provide a brief description of the need that your Outreach program was designed to address.

The focus of the grant program was to provide public preschool classrooms in Athens County on-site early childhood mental health consultation services, complemented by comprehensive psychological assessments and family navigating services to promote early childhood socio-emotional development. This involved a partnership between the university, a local community mental health center, and multiple public school districts in Athens County, OH, a rural county in southeastern Ohio that falls within the Appalachian corridor. The second objective is to implement a workforce development initiative to strengthen and advance the competencies of our early childhood workforce.

“Mental health partnerships with schools are …an effective method of helping children succeed. By providing information and support to teachers about children’s mental health issues, mental health professionals in [schools] alleviate behavioral difficulties in both academic and home settings.” (Ohio Department of Mental Health, 2002)
For children, healthy development involves not only the absence of disease but also the ability to form healthy attachments, to cope with day-to-day challenges and to learn. Our nation is home to approximately 25 million children between the ages of birth and five years ([http://childstats.gov](http://childstats.gov), retrieved September 18, 2008) whom popular culture often depicts as infinitely resilient and well-equipped to survive adversity and stress. However, as many as 7-20% of preschool and early school aged-children exhibit behavioral problems that meet criteria for a mental health disorder (Ohio Department of Mental Health [ODMH], reported in Sites, Collopy, Velilla, Cayard & Graft, 2008). Despite these prevalence rates of mental health problems in childhood, national estimates indicate that 70% of children with diagnosable disorders do NOT receive mental health treatment (U.S. Public Health Service, 2000). Although many would protest the application of the term “mental health” to the population under age six, such a rebuttal fails to recognize the importance of early developmental experiences in establishing a solid foundation for relating to others and regulating one’s affect and behavior and for learning (Shonkoff & Phillips, 2000).

Data collected through the Well-Child/Well Family community health program at Ohio University’s Heritage College of Osteopathic Medicine further demonstrates that a significant proportion of parents accessing care for their children’s behavioral health concerns report personal histories of mental health problems and trauma, substantiating the need for a comprehensive approach to meeting the needs of all family members to ensure health child development.

### Well-Child/Well Family Data Summary, 2003 – 2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Child Referrals</th>
<th>% Child History of abuse</th>
<th>% Parent History of abuse</th>
<th>% Parent have Mental Health Diagnosis</th>
<th>% Family History of Domestic Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003-04</td>
<td>60</td>
<td>No data</td>
<td>37%</td>
<td>45%</td>
<td>45%</td>
</tr>
<tr>
<td>2004-05</td>
<td>56</td>
<td>11%</td>
<td>39%</td>
<td>45%</td>
<td>41%</td>
</tr>
<tr>
<td>2005-06</td>
<td>33</td>
<td>No data</td>
<td>27%</td>
<td>45%</td>
<td>33%</td>
</tr>
<tr>
<td>2006-07</td>
<td>37</td>
<td>11%</td>
<td>51%</td>
<td>73%</td>
<td>30%</td>
</tr>
<tr>
<td>2007-08</td>
<td>32</td>
<td>16%</td>
<td>34%</td>
<td>47%</td>
<td>28%</td>
</tr>
</tbody>
</table>

### Part III: Program Services

#### A. Focus Area: Check the primary focus areas of your Outreach program:

<table>
<thead>
<tr>
<th>Focus Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access: Primary Care</td>
</tr>
<tr>
<td>Access: Specialty Care</td>
</tr>
<tr>
<td>Aging</td>
</tr>
<tr>
<td>Behavioral/Mental Health</td>
</tr>
<tr>
<td>Children’s Health</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
</tr>
</tbody>
</table>


Cardiovascular
Chronic Disease Management: Diabetes
Chronic Disease Management: Other:
Community Health Workers/Promotoras
Coordination of Care Services X
Emergency Medical Services
Health Education and Promotion
Health Information Technology
Health Professions Recruitment and Retention/Workforce Development
Integrated Systems of Care X
Maternal/Women’s Health
Migrant/Farm Worker Health
Oral Health
Pharmacy Assistance
Physical Fitness and Nutrition
School Health
Other: Nurse Family Navigators X
Other: Psychological Assessment Services X

B. Target Population: Check the populations that received the services provided through your Outreach grant program.

<table>
<thead>
<tr>
<th>Population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-school children</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>School aged children - elementary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School aged children - teens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasians</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>African Americans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latinos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native Americans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska Natives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Underinsured</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Other: families of preschoolers</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Other: please describe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
C. Description: Describe the services provided and activities conducted through your Outreach grant program.

Building Capacity- Raising Resiliency provided three services to young children: the Early Childhood Mental Health Consultation services, Family Navigator Services and psychological assessment services. The ECMH program provided universal, targeted and intensive services through classroom-based consultation program. ECMH services facilitated the development of self-control, attachment and initiative skills in young children, while reducing problematic behaviors. The Family Navigator Program provided families with resources to facilitate their understanding and participation in health care decisions affecting their families. The Family Navigator addressed parent concerns regarding a child’s health and behavior and encouraged parent participation in their child’s treatment by providing anticipatory guidance and support during the service period and by acting as a communication bridge to physicians, school personnel and the ECMH consultant for the purpose of developing, implementing and evaluating a comprehensive service plan. Psychological assessments were used to inform intervention services for children who were already struggling to demonstrate age appropriate developmental milestones and achievement. Building Capacity- Raising Resiliency also provided for workforce development.

D. Role of Consortium Partners: Describe the roles and responsibilities that each consortium partner had in the planning and implementation of the grant-funded program.

The grant program participants, three of whom are longstanding members of Integrating Professionals for Appalachian Children, worked together to deliver an interagency, interprofessional service to public preschools. This three-year program provided an important opportunity for the consortium partners to develop stronger working relationships. Each consortium partner played an active role in the program:

- TriCounty Mental Health and Counseling Services is the regional community mental health center that provided the Early Childhood Mental Health Consultation program director and consultant staff. This staff delivered universal, targeted and intensive consultation services. The Director of Early Childhood Mental Health at TCMH designed the evaluation strategy working with a statistical consultant and an independent evaluator.

- The Family Navigator Program at Ohio University’s Heritage College of Osteopathic Medicine provided a nurse family navigator who provided education and navigating services to families need assistance knowing what to do for young children with developmental and behavioral concerns. The Director of the Family Navigator Program worked with the independent evaluator to design an evaluation survey administered at the end of the grant.

- The Psychology & Social Work Clinic at Ohio University’s Department of Psychology provided in-depth evaluations for children referred by the Family
Navigator or EMCH staff to assess behavioral and developmental concerns, and their relationship with achievement and learning.

- Athens County public preschool classroom are found in multiple school districts. Teachers and administrators from each district were responsible to facilitating integration of the services in the classrooms, participating in workforce development programs, and working collaboratively with the school-based EMCH consultants. Additionally, school personnel could refer children to the Family Navigator Program.

Part IV: Outcomes

*Summarize the outcomes and other evaluation findings resulting from your efforts, such as changes in clinical measures, knowledge, and attitudes, include return on investment data (if known).*

The evaluation of the ECMH Consultation Program employed a mixed-methods design. Qualitative outcome data were gathered by an independent evaluator through annual teacher focus groups and individual school administrator interviews. Results were used to assess program satisfaction and inform program design. Quantitative data was collected to measure the effectiveness of program components, which aim to (1) increase capacity of teachers to manage challenging classroom behaviors, and (2) increase the resiliency of children in participating classrooms. To address increased capacity of teachers, we collected the Teacher Opinion Survey (TOS), a teacher completed rating scale. To address increased resiliency of children, the Devereaux Early Childhood Assessment (DECA) was used. The DECA is a standardized, teacher or parent completed resiliency-based behavioral rating scale with subscales for initiative, attachment, and self-control.

During Year One, the DECA was collected during the fall and spring, by parents and teachers, for children receiving targeted services. In remaining years, DECA’s were completed by teachers for all children in their classrooms for three points during the school year. For children who also received targeted services, parents were also asked to complete DECA’s. Selected evaluation findings are listed below:

**Teacher and Administrator satisfaction, ECMH Program**

At the end of the first year, six out of nine teachers who had received the program participated in a single session group interview conducted by an independent evaluator. Two of the three school principals, whose schools had received the program, as well as the county preschool coordinator and the city school psychologist, were also interview individually. The results indicated that the family navigator and individual intensive consultation services were valued. Concerns were raised about the ambiguity of the universal consultation services and communication challenges. Five key recommendations were emerged: (1)Create a policies and procedures handbook that
describes the program, the roles of ECMH-CP staff (2) define and utilize a communication system with two layers that promotes a continuous feedback loop between the school system and the ECMH-CP; (3) Use a child-centered model that those who work in school systems are familiar with, such as the Intervention Assistance Team (IAT) model to refer and serve children and families in need (3) Continue to provide family navigation services (4) Refine the role of the teacher consultant and what services exist within the universal services component of the ECMH-CP.

Substantive changes to the design of the program were implemented in Year 3. The ECMH CL services were concentrated in two districts which allowed for greater intensity of services, on site supervision, and the opportunity to build a model in partnership with school personnel. EMCH consultation staff changes were part of this transition. The original vision of having a seamless team was modified, recognizing that the components (i.e., the Family Navigators, the EMCH staff and the Assessment team) have not been successfully integrated given unique parameters of each component. As such, the ECMH CL program and the Family Navigator Program operated independently of one another during the second half of the grant.

**EMCH Program Effectiveness, selected analyses reported:**

- **Teacher Opinion Scales:** A *paired sample t test* was used to evaluate the differences in teacher scores between the fall and spring administrations. Year One: The mean score in the spring ($M=49.77$, $SD=3.11$) was significantly greater than the mean score in the fall ($M=46.75$, $SD=2.96$), $t (7) = 2.38$, $p<.05$). The standardized effect size, *Cohen’s d*, was 0.84 indicating a large effect size. However, comparison of scores between participating teachers and wait-list teachers were inconclusive. Year Two: Results were inconclusive in regards to the change of participating teachers across the year; and in regards to comparison between participants and control group. For Participants, the pre-to-post differences were not statistically significant: fall ($M=48.7$, $SD=3.31$); the spring ($M=49.8$, $SD=4.79$), $t (9) =-.56$, $p=.6)$. However, the shift in teacher opinion across the year reflected a medium effect ($d=0.27$).

- **Universal Consultation/ Whole Classroom DECA Scores:** Comparative analysis indicated wait-list classes had an over-representation of children whose initial scores were in the “strength” range (T score > 60). In order to control for these differences, a sub-group analysis was conducted which included only wait-list and participating classroom children whose initial scores were in the “typical” or “concern” range (T score <60). Fixed slope, random intercept fit the data so multilevel growth modeling (three level analysis) was conducted to determine the rate of seasonal growth in for each subscale. On the Self-Control Subscale, program children had an average growth rate of 8 points. Again, this rate of growth would move the average child scoring in the “Concern Range” into the “Typical Range.” Children in the control classrooms,
on average, only made a gain of 1.6 points. On the Initiative Subscale, program children made an average growth of 10 points. Children in the control classroom, on average, only made gains of 5 points. There were no significant differences in rate of growth for the attachment scale.

- Targeted Consultation: Teacher and parent ratings on the DECA scale were analyzed using the same fixed slope, random intercept linear modeling. Year One Results: Analysis of the teacher ratings showed that attachment scores significantly improved over time, however initiative and self-control did not. Parent ratings reflected that children’s self control, attachment, and behavioral concerns as rated by parents, changed significantly over time. Final Results: An individual piecewise growth curve analysis indicated that for teacher ratings, children had a fixed growth rate of 7.465 DECA points between winter and spring. This rate of growth would move the average child who scored in the “Concern Range” into the “Typical Range”. A similar analysis conducted for parents’ ratings showed a non-significant growth rate of 1.745, p=0.678 and 3.111, p=0.090 respectively.

- Mental Health Climate Scales: A Bivariate Linear Regression between the DECA subscales and subscales on the MHCS was conducted. Increases in child DECA scores for initiative and attachment were positively related to teacher scores on the following subscales of the MHCS: “Directions and Rules”, “Staff Awareness”, “Staff-Child Interaction”; “Child Interaction.”

**Workforce Development**

Our project also advanced an Early Childhood Workforce Initiative. As part of this initiative, the competency grid was developed for ECMH program model. The result is an ECMH professional development design that includes a set of core competencies with benchmarks documenting proficiencies at the “introductory level”, “moderate level”, and “mastered level”. Each proficiency level is linked to supervisory tasks and expectations. In order to move to the next level, an ECMH consultant must demonstrate 75% attainment of competencies within a given category. By the end of this project, the current ECMH consultant had moved to the “mastered level.” An additional part of this plan is an ECMH peer coaching/modeling plan. Knowledge gained through this project was used to inform the newly released Ohio Department of Mental Health’s Early Childhood certification process. Additional workforce development activities from the project are as follows:

- 20 education professionals attended Jim Gill, Child Development Specialist singer/songwriter symposium on the use of music play to inspire young children and support health development.
- 23 educators participated in the Learning Community on Executive Functioning Deficits at Athens City School.
• 22 school personnel trained on DECA Face the Challenge (n=10), Becky Bailey’s “Conscious Discipline” (n= 8), DECA’s “Building Your Bounce” (n= 4)

• 250 professionals attended Bruce Perry, MD, PhD presentation on April 2011. It was an interprofessional audience including physicians, mental health professionals, developmental disabilities specialists, educators, legal professionals, parent and health professional graduate students. Presentation was on the effect of trauma and neglect from a developmental perspective, on identifying signs and symptoms of trauma.

• School staff participated in workforce development activities by attending the Georgetown Training Model; the DECA Face the Challenge; the DECA training program, 1 has completed the Parent IY program, and 1 has completed the Trauma-Focused Cognitive Behavior Training program. Additionally, the early childhood mental health consultants and the family navigator attended the National 0-3 Training Institute in December, 2011.

• 4 members of a regional interprofessional assessment team, the Southeastern Ohio Interdisciplinary Assessment Team trained on the Autism Diagnostic Observation Scale

• The ECMH program director gained expertise in: General management skills from the Appalachian Leadership Academy; ECMH program management from Jane Sites, Director of the Therapeutic Interagency Preschool at Cincinnati Children’s Hospital; ECMH program development through consultation from Georgetown University’s Center for Child and Human Development; CBPR approaches for community public health through the Community-Based Partnership Caucus of the American Public Health Association; Program Evaluation through Robert Wood Johnson’s Retooling Professionals Evaluation Fellowship program; Advocacy skills through the Corporation for Ohio Appalachian Development (COAD), and the National Rural Health Association. The director presented a workshop at the All Ohio Counseling Conference which provided 140 participants training on best practices for young children.

• School personnel, state legislators and program staff participated in the advocacy session aimed to educate the Ohio’s Children’s Caucus about mental health – school partnerships and the importance of socio-emotional development as it establishes its legislative agenda.

Part V: Challenges & Innovative Solutions

Identify challenges experienced during your program implementation and describe how these challenges were addressed.

The original project proposal included creating an advisory group composed of participating school superintendents and the CEO of the mental health clinic. The group was to meet quarterly and address sustainability challenges. During the first year, the group was only able to meet twice due to scheduling issues. While the initial meeting was well attended, the second meeting was not. It became evident that the best way to
connect with superintendents was through their already-established county superintendent meeting to provide brief updates and engage in sustainability discussions. It also became evident, that the project would benefit from “internal school advocates” at all levels – teachers, principals, and other school staff—who believed the program had value and could articulate the value to their school superintendents.

Implementation of the ECMH consultation program was originally proposed to serve 19 classrooms with a team. This design was modified entering the third year of the grant such that more concentrated services could be delivered in four classrooms, those who were the most frequently using the program in the first two years. This change reduced the number of children served, but we believe it improved the quality of the programming offered to the schools that were most interested in the ECMH CL services. The Family Navigator Program continued to serve all preschool classrooms.

Part VI: Sustainability

A. On-going Services and Activities

Identify the services and programs that will be sustained beyond the Outreach grant period. Sustainability does not mean that the activities or services necessarily continue in the same form as originally conceived, funded or implemented. You may be continuing some but not your entire grant funded services and activities; you may be expanding your scope of services; you may be serving a smaller/larger geographic area or fewer/more target populations.

Also describe the strategies that you will utilize to sustain your services and activities, such as funding sources, in-kind support, absorption of services by consortium partners, etc.

Early Childhood Mental Health Services

- Cost Share with School Districts: Superintendents signed a Memorandum of Agreement committing $4,500.00 to fund the universal consultation component of the early childhood mental health consultation program. This commitment was secured between the second and third year of the grant. Since the grant ends prior to the end of the school year, it isn't know yet what level of support will be committed in the future, yet we are optimistic that districts interested in services will continue to provide some support.

- Additional funds were committed by the local 317 Board, and the community mental health center is willing to commit resources to continue these school-based services as long as referrals continue to be robust. Tri-County plans to negotiate each year with participating school superintendents to assess the financial and in-kind contributions they can make to continue the program services in their schools. Tri-County plans to obtain any funds for remaining
expenses from the Athens-Hocking-Vinton 317 ADAMHS board. This strategy has already proven successful in sustaining the program’s ECMH consultant working with our local Head Start program. Additionally, the ECMH program director will continue advocacy efforts to address policy and legislative actions that would sustain universal consultation regionally, as well as across Ohio.

- The current economic and financial realities facing the districts led to a sobering discussion that funding the program in its existing format, based on the costs projected, will not be likely. Moving forward the program will likely need to bill for services, requiring children to be diagnosed with mental health concerns, thwarting the health promotion/prevention focus on the initiative.

- Given it is anticipated that reimbursement for services will need to sustain the program, the programmatic tiers will be implemented as described: intensive consultation services will continue and will be funded by third party reimbursement; targeted consultation services be limited to 3-5 contacts at which time a decision will be made by the ECMH consultant, teacher, and parent about enrolling the child into intensive services; universal consultation services will be delivered in the same fashion.

Family Navigator Program

- The Family Navigator Program will continue to offer services in the region supported by the SAMHSA Project LAUNCH grant to Ohio and a newly developing care coordination effort to implement AHRQ’s Community HUB/Pathway model. The Community HUB/Pathway model, if successful, will establish a funding mechanism for the Family Navigator Program, such that some of the services it provides will be supported through contracts with the managed care plans. This effort is being launched with $350,000 of funding from Ohio’s Governor’s Office of Health Transformation.

B. Sustained Impact

*Discuss the long-term effect on your community as a result of your Outreach grant program. Focusing solely on sustained services and activities may understate the full impact of your program and does not describe the potential for lasting effects in the community. There are multiple ways that an initiative can impact a community long after services have been discontinued. These impacts could include changes in the way that consortium partners work together to serve your community, improved service models, changes in institutional practices, increased capacity, new skills developed by service providers, or policy changes.*

Our community has been impacted in significant ways since this program was funded. The Family Navigator program is anchored in the community, and continuing with
diverse funding streams, ensuring families have access to services that empower them to participate in health care decisions affecting their families. The Outreach funding has helped accomplish this, as it allowed for increased staffing and communication with regional school personnel. The same can be said of the ECMH program; the grant funded allowed the ECMH Consultation Program at our local community mental health center to increase its capacity, hiring new personnel to provide services in the schools. Today, the community mental health center has an administrative unit dedicated to early childhood, complementing its child services. The outreach funds facilitated this institutionalized change. Both programs are strong additional to our regional health care delivery system that serves young children.

The grant funding has also reinforced the importance of interagency partnerships to address access and quality of care in rural communities. Leveraging existing resources, and partnering agencies with services to those with consumers in need, has enabled us to serve children and families that otherwise may not have embraced services delivered through traditional points of access. Successful integration of early childhood mental health consultation services into public preschools has likely reduced stigma regarding mental health services for young children.

**Part VII: Implications for Other Communities**

*Discuss how your experience and program outcomes might benefit other communities that are interested in implementing a similar program.*

The lessons we learned about how to recruit and retain early childhood mental health consultants into our program are important ones that could be applicable in other communities, rural or otherwise. Through this grant we have developed a competency template for consultation skills in working with preschoolers. Additionally, we have developed training modules to advance workforce competency of educators, classroom aides, and health professionals interested in working with young children. Within our school partnerships, we have adopted a highly participatory model for program design, ensuring that services delivered are valuable to the school districts. To accomplish this we have dedicated much effort to establishing a common language and shared vision for the program.
Appendix L: Context Coding Directions, Worksheet, and Independent Review

1. Review documents in Packet 1. For each document, list any needs of preschool children or their caregivers discussed in the document.
2. List each item in Column 1 of the worksheet.
3. Use Column 2 to list documents from Packet 1 that contained this item.
4. Read Documents from Packet 2. After reading each document, use Column 3 to rate each of the program on each item listed in Column 1. Give a score from 0-2; with “0” indicating that documents reviewed made no mention of this need being addressed by the program, “1” indicating that documents mentioned actions by the program that addressed the item, and “2” indicating that documents demonstrated that the documents contained outcomes associated with this item need.
5. Use Column 4 to list evidence you found in a document for the rating that you gave for that item--Abbreviation of document and what you found.
<table>
<thead>
<tr>
<th>Identified Need (Column 1)</th>
<th>(Column 2: Use Documents from File 1 in order to complete. Read documents in File 1. Did document mention any of the items listed in Column 1? If so, put the document’s abbreviated title. If you find an unaddressed need that is not found in Column 1, then write it in one of the extra spaces provided at the end of Column 1) Document (s) Identifying this need *Abbreviations (e.g., PLES) are explained in table notes.</th>
<th>(Column 3: Read Documents from File 2. After reading, rate each of the items in Column 1) Ranking “0” = no evidence that this item was addressed by the program; “1” = the item was mentioned in association with program services; and “2” = documents mention program outcomes associated with this item.</th>
<th>(Column 4: What evidence—if any—did you find in the documents in File 2 documents to support your rating in Column 3?) Supporting Evidence. An “X” denotes the absence of any evidence a need was addressed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>5.</td>
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<td>12.</td>
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<td>13.</td>
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</tbody>
</table>
Directions:

1. Review list of items in Column 1 of chart. They represent a list of “unmet” needs for preschool children and their families.

2. Read documents in File 1. For each document: Did document mention any of the items listed in Column 1? If so, put the document’s abbreviated title in the box next to that item. If you find an unaddressed need that is not found in Column 1, then write it in one of the extra spaces provided at the end of Column 1.

3. Read Documents from File 2. After reading each document, use Column 3 to rate each of the program on each item listed in Column 1.

4. Use Column 4 to list evidence you found in a document for the rating that you gave for that item—Abbreviation of document and what you found.

<p>| Identified Need (Column 1) | (Column 2: Use Documents from File 1 in order to complete Read documents in File 1. Did document mention any of the items listed in Column 1? If so, put the document’s abbreviated title. If you find an unaddressed need that is not found in Column 1, then write it in one of the extra spaces provided at) | Ranking “O” = no evidence that this item was addressed by the program; “1” = the item was mentioned in association with program services; and “2” = documents mention program outcomes associated with this item. | (Column 4: What evidence—if any—did you find in the documents in File 2 documents to support your rating in Column 3?) Supporting Evidence. An “X” denotes the absence of any evidence a need was addressed. |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Easy Access to services for young children</strong></td>
<td><strong>OGFCR, SBCRR, FRN, ECMHYY3F</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>2. Parents overwhelmed with identifying and accessing services</strong></td>
<td><strong>SBCRR, ECMHYY3F</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>3. Lack of coordination across service systems</strong></td>
<td><strong>OGFCR, SBCRR</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>4. Redundancy and amount of paperwork parents have to complete</strong></td>
<td></td>
<td>0</td>
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</tr>
<tr>
<td>5. More professionals available with more tools to provide care for children</td>
<td>OGFCR, SBCRR, PRN, ECMHY3F</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Numerous assessments, levels of expertise, coordination between school special services and community services - OGFCR, SBCRR, PRN, ECMHY3F</td>
<td></td>
</tr>
<tr>
<td>6. Lack of screening</td>
<td>SBCRR</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Many children undiagnosed with social and emotional mental health issues due to lack of services nationwide - SBCRR</td>
<td></td>
</tr>
<tr>
<td>7. Lack of family transportation</td>
<td>OGFCR</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Geographic issues in rural areas - OGFCR</td>
<td></td>
</tr>
<tr>
<td>8. Mental Health challenges of adult caregivers</td>
<td>SBCRR, PRN</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Depression and abuse screening of adult caregivers - SBCRR, PRN</td>
<td></td>
</tr>
<tr>
<td>9. Programs/Professionals that are sensitive to Appalachian culture</td>
<td>OGFCR, SBCRR</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Attention paid to the challenges of being located in rural Appalachian Ohio - OGFCR, SBCRR</td>
<td></td>
</tr>
<tr>
<td>10. More mental health services for younger children</td>
<td>OGFCR, ECMHB, SBCRR, PRN, ECMHY3F</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>A plethora of choices for mental health needs ranging from general to severe (universal, targeted, intensive) - OGFCR, ECMHB, SBCRR, PRN, ECMHY3F</td>
<td></td>
</tr>
<tr>
<td>11. Affordable services that all children can participate in</td>
<td>OGFCR</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>TCMH agency funding as well as 3rd party billing for intensive services - OGFCR</td>
<td></td>
</tr>
<tr>
<td>12. Mental Health services offered in “neutral” locations like schools, homes, etc.</td>
<td>OGFCR, ECMHB, SBCRR, PRN, ECMHY3F</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Consultant available in schools or in homes based on the needs of the client and their family - OGFCR, ECMHB, SBCRR, PRN, ECMHY3F</td>
<td></td>
</tr>
<tr>
<td>13. Lack of access to medical home</td>
<td>OGFCR</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Family Navigator Program</td>
<td></td>
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<tr>
<td></td>
<td>14. Trauma-related services</td>
<td>SBCRR</td>
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<tr>
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<tr>
<td></td>
<td>15. Increased capacity for</td>
<td>OGFCK, SBCRR, PRN, OUTOSD</td>
</tr>
<tr>
<td></td>
<td>mental health issues of young</td>
<td></td>
</tr>
<tr>
<td></td>
<td>children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>16. Decrease challenging</td>
<td>OGFCK, ECMHB, SBCRR</td>
</tr>
<tr>
<td></td>
<td>behaviors in preschool</td>
<td></td>
</tr>
<tr>
<td></td>
<td>classrooms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>17. Teachers increase feelings and</td>
<td>ECMHB, EHYY3F</td>
</tr>
<tr>
<td></td>
<td>problem solving</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18. Reduce child obesity</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>19. Increase immunization rate</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>20. Reduce childhood lead poisoning</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>21. Reduce rate of infant mortality</td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix M: ECMHC Evaluation Service Log Universal Consultation to Teachers-Specific Classroom Site Visit Contacts

<table>
<thead>
<tr>
<th>Consultant Name:</th>
<th>Teacher Name:</th>
</tr>
</thead>
</table>

| Date: | | | | |
|-------| | | | |

**Total Minutes of on-site Consultation:**

**Summary of Support Provided:** Fill in the bubble to all that apply

<table>
<thead>
<tr>
<th></th>
<th>Visit 1</th>
<th>Visit 2</th>
<th>Visit 3</th>
<th>Visit 4</th>
<th>Visit 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal Meeting with Teacher/School Personnel</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Use of screenings/Assessments</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Developmental Milestones</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Referral options for children with concerns</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Observation</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<tr>
<td>Consultation on a specific Management Technique</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Model classroom behavior management techniques</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Train in formal workshop</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Consultation to coordinate services</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Conduct Incredible Years Activities</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Other (Describe)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

**Off-Site Consultation Time**

**Total Minutes of Off-Site Consultation (Includes phone calls)**

Source: Adapted from Louisiana Service Log

Revised 8-10-1

*PLEASE MAKE NARRATIVE COMMENTS ON THE BACK*

---

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Appendix N: Teacher satisfaction survey results

| ID | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 | Q9 | Q10 | Q11 | Q12 | Q13 | Q14 | Q15 | Q16 | Q17 | Q18 | Q19 | Q20 | Q21 | Q22 | Q23 | Q24 | Q25 | Q26 | Q27 | Q28 | Q29 | Q30 |
|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| A  | 2  | 2  | 2  | 2  | 2  | 3  | 3  | 2  | 1  | 2   | 1   | 2   | 1   | 1   | 1   | 2   | 3   | 3   | 2   | 2   | 1   | 2   | 3   | 3   | 1   | 2   | 2   | 2   | 2   | 2   | 2   |
| B  | 4  | 2  | 1  | 1  | 2  | 2  | 1  | 1  | 2  | 5   | 2   | 2   | 1   | 1   | 1   | 1   | 2   | 2   | 0   | 1   | 1   | 1   | 1   | 2   | 2   | 1   | 2   | 1   | 4   |
| C  | 4  | 1  | 1  | 1  | 1  | 1  | 4  | 3  | 1  | 1   | 4   | 2   | 4   | 1   | 1   | 1   | 2   | 4   | 2   | 0   | 1   | 1   | 1   | 2   | 2   | 2   | 2   | 2   | 2   |
| D  | 2  | 2  | 1  | 1  | 1  | 4  | 2  | 4  | 1  | 4   | 5   | 1   | 1   | 1   | 1   | 1   | 1   | 2   | 2   | 2   | 0   | 1   | 1   | 1   | 2   | 1   | 1   | 1   | 1   | 1   | 1   | 3   |
| E  | 5  | 5  | 2  | 2  | 2  | 4  | 5  | 5  | 1  | 2   | 5   | 3   | 4   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 0   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   |
| F  | 2  | 2  | 4  | 4  | 5  | 5  | 2  | 5  | 5  | 5   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 0   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   |
| G  | 2  | 2  | 1  | 0  | 1  | 0  | 4  | 1  | 1  | 4   | 5   | 3   | 5  | 3   | 5   | 1   | 1   | 1   | 2   | 2   | 1   | 2   | 1   | 1   | 1   | 1   | 2   | 1   | 1   | 2   | 1   | 4   |
| H  | 4  | 4  | 3  | 4  | 4  | 5  | 4  | 4  | 4  | 3   | 5   | 4   | 5   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 2   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   |
| Avg| 3.2| 2.5| 1.9| 1.9| 2.0| 2.9| 3.8| 3.1| 1.5| 2.9  | 4.4  | 2.8  | 3.8  | 1.0  | 1.0  | 1.1  | 1.5  | 2.0  | 1.5  | 0.75 | 1.0  | 1.1  | 1.4  | 1.5  | 1.4  | 1.5  | 1.5  | 2.0  | 2.8  |
| Max| 5  | 5  | 4  | 4  | 4  | 5  | 5  | 5  | 4  | 5   | 5   | 5   | 5   | 1   | 1   | 1   | 2   | 3   | 4   | 2   | 2   | 1   | 2   | 3   | 3   | 2   | 2   | 2   | 2   | 2   | 2   |
| Min| 2  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1  | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 0   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   |

Comments on Open-Ended Questions

What does Consultant do that is most helpful
- Her personality and caring was helpful to build relationships with children. All children in the room enjoyed her presence. She offered me good advice. Parents she was able to contact reported back with positive comments.
- She is very helpful with ALL children in the classroom! She is very caring to ALL of the children! I enjoyed having her in my classroom very much.
- Works within classroom with certain children at center time; DINA program; targeted children and 1 on 1 with families.
- She does Dina school and introduces a lot of feelings awareness for kids. This has created a relationship with each student and the students look to her for guidance and support as much as the regular teachers.
- Easy access to mental health services for children and family support--families as they work through challenges raising young children.
- She is wonderful member of our classroom. She does so much that its impossible to pick just one.
- Consistently tries to reach parents to inform them of services available to help with their children.

Suggestions for improvement
- Work more with our parents.
- Start DINA program sooner in the school year.
- I hope we get her back next year.
- Figure out how to start right when the school year starts.
- More conversations about what parents are being taught.
- She came to our school with lots of experience with counseling and working in schools. She was a great match. The program is strong when there is an experienced consultant. The program is as good as the consultant. If the consultant is not experienced or not comfortable working with low SES families the program is at risk of failure.
- This is a wonderful program this year. Many changes were made last year that made the program a success today.
## Appendix O: Consultation Time 2010-2011

### 2010-2011 Consultation Time (In hours)

<table>
<thead>
<tr>
<th>Teacher ID Number</th>
<th>Total Consultation Time</th>
<th>Universal Consultation Time (rounded to nearest half hour)</th>
<th>Total Targeted Consultation Time Spent on Children in this Class</th>
<th>Percentage Time spent in universal activities</th>
<th>Percentage Time spent in targeted consultation</th>
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<tr>
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<td>B04AP10</td>
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<td>19.5 hours</td>
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<td>100%</td>
<td>0%</td>
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<tr>
<td>B06AL10</td>
<td>80</td>
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<td>65%</td>
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<tr>
<td>B05AJ10</td>
<td>13</td>
<td>13 hours</td>
<td>0</td>
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<td>0%</td>
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<tr>
<td>B03A010</td>
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<td>54.5</td>
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<td>63%</td>
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<td>B03AD10</td>
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<td>116.5</td>
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<td>81%</td>
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<td>B02AC10</td>
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<td>Total</td>
<td>535</td>
<td>237.5</td>
<td>297.5</td>
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<tr>
<td>Average</td>
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### Program Year

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<th>Total Consultants</th>
<th>Consultant-Teacher Ratio</th>
<th>Total consultation time (hours)</th>
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<th>Average hours of consultation per consultant</th>
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<td>53.5</td>
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<td>2011-2012</td>
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<td>1 to 3.5</td>
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<td>217</td>
<td>796</td>
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### Appendix P: 2011-2012 Universal Consultation Time Activities

Consultation Data from Logs

#### 2011-2012 Consultation Break-Down

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<tr>
<td>Conduct Observations</td>
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<tr>
<td>Consultation with individual parents (Not targeted children)</td>
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<tr>
<td>Consultation to teacher on individual teacher requested topic</td>
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<tr>
<td>Model classroom behavior management techniques</td>
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<tr>
<td>Train through formal workshop</td>
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<tr>
<td>Consultation with a referral source/collateral school personnel</td>
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<tr>
<td>Other types of consultation activities with teacher</td>
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<tr>
<td>Conduct DINA/Incredible Years activities</td>
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### Appendix Q: Teacher TOS

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<th>Kurtosis</th>
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<td>Statistic</td>
<td>Statistic</td>
<td>Statistic</td>
<td>Std. Error</td>
<td>Statistic</td>
<td>Statistic</td>
<td>Std. Error</td>
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<td>37.00</td>
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### Paired Samples Statistics

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### Paired Samples Correlations

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<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
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Appendix R: Mental Health Climate Scales

PMHCS outcome measures

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<th>Spring Total Positive Attributes</th>
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<th>Fall Total Negative Attributes</th>
<th>Spring Total Negative Attributes</th>
<th>Change</th>
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### Positive Attributes

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<th>Variance</th>
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#### Paired Samples Statistics

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#### Paired Samples Correlations

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### Negative Attributes

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### Paired Samples Statistics

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### Paired Samples Test

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<th></th>
<th>Paired Differences</th>
<th>95% Confidence Interval of the Difference</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Deviation</td>
</tr>
<tr>
<td>Pair 1</td>
<td></td>
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</tr>
<tr>
<td>pmhc negative fall - pmhc negative spring</td>
<td>-2.2909</td>
<td>.20511</td>
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</table>
Supplemental Material

Documents in this section are unpublished materials used by the Partnerships for Early Childhood Mental Health Program. They are not original works produced for this current dissertation study. They have been included to provide more complete knowledge about the “Partnerships” program. They have been reprinted with the permission of the “Partnerships” home agency, Tri-County Mental Health and Counseling Services, Inc.
Partnerships for Early Childhood Mental Health Staff Manual

24 This is an unpublished program report belonging to the “Partnerships for Early Childhood Mental Health Program” It is reprinted for the purposes of this study with permission from Tri-County Mental Health and Counseling Services, Inc.
PROGRAM OVERVIEW
Partnerships for Early Childhood Mental Health
Sherry Shamblin, PCC-S Director of Early Childhood Programs
592-3091 ext. 4631
sshamblin@tcmhcs.org

Vision
Building partnerships between parents, teachers, other early childhood professionals, and early childhood mental health to promote the social-emotional wellness and school readiness of children in their care.

Our Program
A problem-solving, capacity-building intervention implemented within a collaborative relationship between the professional early childhood mental health consultant and other early childhood professionals who provide services to a child and family.

Three Tiers of Service

Universal Consultation
Services to support the healthy social emotional development of all children in a class. The consultant can help teachers create a profile of the social-emotional strengths and challenges of the children in their classroom then identify strategies to increase protective factors and decrease behavioral concerns.

Targeted Consultation
Behavioral supports for individual children with challenging behaviors. The consultant can help a teacher or parent with strategies to address a specific behavioral challenge or answer a specific mental health question.

Intensive Services:
Mental health assessment and treatment for individual children with identified special needs.

## 2012-2013 Program Demographics

<table>
<thead>
<tr>
<th>Early Childhood Education (ECE) Program</th>
<th>FTE Dedicated Consultant Time</th>
<th>County</th>
<th>ECE Staff Represented</th>
<th>Number of Children Served by EC Program</th>
<th>Funding Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Preschools</td>
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<tr>
<td>Federal Hocking</td>
<td>.6 FTE</td>
<td>Athens County</td>
<td>7</td>
<td>60</td>
<td>Local Agency</td>
</tr>
<tr>
<td>Nelsonville York</td>
<td>.4 FTE</td>
<td>Athens County</td>
<td>3</td>
<td>55</td>
<td>Project LAUNCH</td>
</tr>
<tr>
<td>Trimble Local South</td>
<td>.6 FTE</td>
<td>Athens County</td>
<td>5</td>
<td>40</td>
<td>School/317 Board</td>
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<tr>
<td>Elementary</td>
<td>.4 FTE</td>
<td>Vinton County</td>
<td>4</td>
<td>60</td>
<td>Project LAUNCH</td>
</tr>
<tr>
<td>Central Elementary</td>
<td>.4 FTE</td>
<td>Vinton County</td>
<td>4</td>
<td>40</td>
<td>Project LAUNCH</td>
</tr>
<tr>
<td>Little Hocking</td>
<td>.4 FTE</td>
<td>Washington County</td>
<td>2</td>
<td>17</td>
<td>Project LAUNCH</td>
</tr>
<tr>
<td>Help Me Grows</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Athens County HMG</td>
<td>.2 FTE</td>
<td>Athens County</td>
<td>3</td>
<td>80</td>
<td>ODH/HMG Part C</td>
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<tr>
<td>Early Head Start</td>
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<td></td>
</tr>
<tr>
<td>HAPCAP</td>
<td>.5 FTE</td>
<td>Athens County</td>
<td>5</td>
<td>60</td>
<td>HAPCAP Head Start</td>
</tr>
<tr>
<td>Head Start</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAPCAP</td>
<td>1.0 FTE</td>
<td>Athens County</td>
<td>21</td>
<td>422</td>
<td>HAPCAP Head Start</td>
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<tr>
<td>Clinic-Based</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>TCMHC Athens Hocking</td>
<td>1.0 FTE</td>
<td>Athens County</td>
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<td>20-30</td>
<td>Medicaid/Insurance</td>
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<tr>
<td>TCMHC Hocking</td>
<td>.4 FTE</td>
<td>Hocking County</td>
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<td>12</td>
<td>Medicaid/Insurance</td>
</tr>
<tr>
<td>TCMHC Vinton</td>
<td>.2 FTE</td>
<td>Vinton County</td>
<td>0</td>
<td>6</td>
<td>Medicaid/Insurance</td>
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</table>
**Service Model**

Our program is based on a comprehensive early childhood mental health consultation model which offers three tiers of service—universal, targeted, and intensive. Universal consultation is focused on strategies that teachers can use to support the healthy social-emotional development of all the children in a classroom. Targeted consultation provides strategies that teachers can use for individual children who present with challenging classroom behaviors. Finally, intensive services address mental health treatment needs for individual children on-site.

Early childhood mental health consultation, in general, has been shown to improve child self-control, teacher perceptions of classroom quality, teacher confidence and teacher self-efficacy (Alkon, Ramler and MacLennan, 2003; Gilliam, 2007). There is growing experience and research evidence, from a public health perspective, that early childhood mental health consultation promotes emotional development and circumvents or reduces the impact of mental health problems in young children (Gilliam, 2007). There is some evidence that consultation improved parent-staff communication, created greater access to mental health services, and led to more positive child-parent interactions. Gilliam (2007) concluded that early childhood mental health consultation may be an effective means for decreasing the likelihood that children with challenging classroom behaviors will be expelled or suspended.
Our program model has been developed over time from ongoing feedback from participating school personnel, ECMH consultation staff, and technical assistance from Georgetown University and the Ohio Department of Mental Health. The model was also informed by materials from the Center for Social-Emotional Foundations in Learning and publications from Georgetown University's Center for Child and Human Development. Both are nationally recognized leaders in early childhood mental health consultation.

Key features:

(1) Advances our team vision to facilitate partnerships between parents, teachers, and early childhood professionals to promote the social-emotional wellness and school readiness of children in their care.

(2) Focuses on problem-solving, capacity-building interventions that are implemented within collaborative relationships between the professional early childhood mental health consultant and other early childhood professionals who provide services to a child and family.

(3) Promotes a comprehensive approach: Universal Consultation focused on supporting the healthy social-emotional development of all children in a class, with the consultant helping teachers create a profile of the social-emotional strengths and challenges of the children in their classrooms then identifying strategies to increase protective factors and decrease behavioral concerns; Targeted Consultation focused on behavioral supports for individual children with challenging behaviors, with the consultant helping teachers and parents with strategies to address a specific behavioral challenge or answer a specific mental health question; and Intensive services focused on mental health assessment and treatment for individual children with identified special needs.

(4) Involves of parents in helping reduce the challenging behaviors of targeted and intensive children.

(1) Assists school personnel in understanding and meeting the mental health needs of children from stressed care situations.

Each tier of service has a similar progression: an assessment phase, a planning phase, an intervention phase, and an evaluation phase. The purposes for doing this is to provide a "picture" or understanding of how the
consultation process evolves throughout a school year and to provide a common language for discussions between consultants and early childhood staff.

Each tier has specific goals to be addressed. For universal consultation, the consultant and teacher will focus on two goals: (1) Implementation of a social-emotional curriculum in order to increase resiliency factors and reduce behavioral challenges for all children in the class, and (2) Supporting the professional development of teachers through a teacher training menu, a teacher consultation request process, a teacher lending library, and a teacher e-newsletter. In targeted consultation services, teachers and consultants will work together to accomplish two goals: (1) Decreasing challenging behaviors for children who have not responded to typical classroom interventions by identifying the function of the challenging behavior and creating a pointed intervention to extinguish it, and (2) Initiating a home-school communication strategies to facilitate home-school partnerships for children who are exhibiting behavioral challenges. In intensive services, the consultant, teacher, and parents are working together to assess and treat the specialized behavioral health needs of children who are manifesting possible mental health and/or developmental disorders.

The following two tables outline the details of each tier. Because intensive services involve mental health diagnostic assessment and clinical treatment services, ECMH staff will use the same agency approved protocols used by other clinical staff. Please consult the TCMHC staff manual for these procedures that have been approved by Ohio Department of Mental Health and the Commission of Accreditation of Rehabilitation Facilities.
## Partnerships for Early Childhood Mental Health Consultation Model

<table>
<thead>
<tr>
<th>Tier</th>
<th>Assessment Stage</th>
<th>Planning Stage</th>
<th>Intervention Stage</th>
<th>Evaluation of Service</th>
</tr>
</thead>
</table>
| **Universal Consultation** | • Teacher completes: Teacher Opinion Survey (TOS), Classroom DECA’s, Interest Survey  
• ECMHC completes Preschool Mental Health Climate Scale (PMHCS), DECA Profile, Consultation Report  
• Process Repeated in early spring | • Consultant and teacher meet to review consultation report and write annual consultation plan  
• Plans made for consultant’s implementation of social skills curriculum  
• Plan reviewed/updated in January  
• Teacher self-identifies consultation requests as needed; plan updated as needed | • Weekly: Consultant conducts social skills curriculum and provides follow-up materials for teacher  
• Monthly: Conduct teacher training/skill building on teacher-selected topics  
• Quarterly: E-Newsletter  
• Ongoing: Teacher lending library; respond to teacher self-identified requests | • Fall/Winter/Spring: Change in DECA’s  
• Fall/Spring: TOS, PMHCS, Teacher-Consultant Collaboration Survey  
• Spring: Teacher Satisfaction Survey, Teacher Demographic Questionnaire |
| **Targeted Consultation**     | • Child identified by score on classroom DECA, teacher concerns, or parent concerns  
• DECA completed by caregiver  
• Consultant completes classroom behavior assessment | • Parent, teacher, and consultant meet to review classroom behavior assessment and write targeted consultation plan.  
• Plan is reviewed/updated mid-year or as needed based on child’s progress on identified goals | • Social skills training/ coaching by consultant  
• Special classroom materials for teacher (i.e. Social Stories, Schedule cards, etc.)  
• Home-School communication system  
• Behavioral supports for parents to use at home to provide consistency of behavioral strategies  
• Monthly progress report for teacher/parent completed by consultant | • Fall/Winter/Spring: Change in parent and teacher DECA’s  
• Spring: Parent Satisfaction Survey  
• Ongoing: Completion of goals on plan |
| **Intensive Services**       | • Consultant and parent complete the TCMHC Diagnostic Assessment  
• ASQ (if needed)  
• DECA-C  
• Additional assessments as needed  
• Review other relevant assessments from school and other providers | • Consultant and parent, with teacher input, complete TCMHC Individual Service plan. | • Individual/Family/Group treatment services, as appropriate. These may include Parent-Child Interaction Therapy, Trauma-Focused CBT, parent-child psychotherapy, developmental individual differences-relationship floor time, applied behavior strategies, and Incredible Years. Services will be offered in most appropriate settings (school, home, or clinic). | • Completion of goals on treatment plan |
<table>
<thead>
<tr>
<th>TYPE OF CONSULTATION SERVICE</th>
<th>FUNDING</th>
<th>DOCUMENTATION</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher Consultation (Universal Consultation): Any contact with a teacher focused on improving the overall quality of the classroom to address a specific issue that affects more than one child. This includes participating in the classroom to assess and assist with suggestions. Can occur in the classroom or formal meetings.</td>
<td>Non-billable activity</td>
<td>Consultation Log</td>
<td>Teacher file in locked drawer with monthly copies to Program Director.</td>
</tr>
<tr>
<td>Targeted Consultation (Individual Child Consultation): Consultation focused on one-child; requires permission from the parent; addresses classroom issues and results in classroom activities. Child is not a TCMHC enrolled client when receiving this service. May occur at school, home, clinic, or phone.</td>
<td>Non-billable</td>
<td>Non-billable Targeted Consultation Note</td>
<td>Non-client: Child file in locked drawer.</td>
</tr>
<tr>
<td>Treatment: Individual child/ family one-on-one services; child enrolled as client of TCMHC; using therapeutic interventions including formal child mental health diagnostic services, play therapy, and case management. Counseling may occur at school, home, or clinic. Case Management may occur in classroom, school, home, clinic, other community setting, or on the phone.</td>
<td>Billable</td>
<td>Counseling: Progress Note</td>
<td>TCMHC Chart located in records department</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Case Management: CPST form</td>
<td></td>
</tr>
</tbody>
</table>
## Overview of ECMH Activities through the Year

<table>
<thead>
<tr>
<th>Activities:</th>
<th>Dates</th>
<th>Outcome/Results</th>
<th>Evaluation</th>
<th>Partner Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>School meetings conducted to review ECMH Handbook, and to plan program implementation</td>
<td>August 2012</td>
<td>ECMH Consultant and School personnel have shared understanding of program components</td>
<td>100% of school personnel articulate improved understanding of ECMH consultation model • Program implementation plan created</td>
<td>Consultant, School Administrators, Teachers, Aides</td>
</tr>
<tr>
<td>Assessment of each classroom using the TOS, Mental Health Climate Scale, DECA profile, collaboration survey, and teacher interest survey</td>
<td>Sept-Oct 2012</td>
<td>Consultation report</td>
<td>ECMH Consultation plan that captures all of the data from assessment</td>
<td>ECMH Consultant and teachers</td>
</tr>
<tr>
<td>Consultation report reviewed and classroom-specific plans created which address universal consultation services.</td>
<td>Sept-Oct 2012</td>
<td>Classroom-specific implementation plans • Consultation report shared and plans shared with school administration</td>
<td>Consultant, teacher, and principal have shared vision/agreed upon goals for universal consultation during the school year</td>
<td>ECMH consultant and teachers</td>
</tr>
<tr>
<td>ECMH consultant and preschool teachers facilitate implementation universal consultation plans</td>
<td>Oct 2012-May 2013</td>
<td>Increased familiarity with, and comfort established between EMCH provider, teacher, parents, and children • Successful implementation of all universal consultation activities outlined in program model</td>
<td>Degree of teacher satisfaction with ECMH Consultation Program • Changes on Mental Health Climate Scale • Classroom DECA profile demonstrates increased resiliency factors and decreased behavioral concerns at the Spring administration</td>
<td>ECMH Consultant and teachers</td>
</tr>
</tbody>
</table>
| Targeted consultation provided to children nominated by teacher or parent | Oct 2012 - May 2013 | • Parents consent to targeted consultation to individual child  
• Parents and Teacher complete DECA  
• Classroom Behavior Assessment Completed  
• Classroom Behavior Plan completed | • Increased competency demonstrated on TOS  
• Increased collaboration documented on teacher-consultant questionnaire  
• DECA resiliency score increase and problem scores decrease for participating children  
• Goals on Behavior Plan completed  
• Parent Satisfaction with program | ECMH consultant, teachers, parents |
| --- | --- | --- | --- | --- |
| Intensive services begin for children identified by parent, teacher, and ECMH Consultant. Parent consent to individualized intervention / HIPAA compliant procedures apply. | Dec 2012 - May 2013 | • Parents consent to assessment/treatment delivered either in the classroom, or at the community mental health center. | • 50% of children nominated for intensive services enroll accept the referral for ongoing mental health services.  
• Clinical improvement, evidenced by pre-post DECA scores on resiliency factors and behavioral concerns. | ECMH consultant, teachers, and parents |
| Analyze program data collected during the year. Program report given to school personnel. Program changes made in response to recommendations. | June-August 2013 | • Classroom-specific outcome reports are written.  
• Recommendations for program improvements are written based on data collected | • Reports are disseminated  
• 65% of recommended improvements are put in place in classes that will continue to receive services  
• Data-driven program modifications are made where applicable. | ECMH Consultant and Director |
Program Alignment

Because our work is housed in schools and early childhood programs, it is essential to become knowledgeable about the curricula, procedures, and structures of these programs. The following pages demonstrate how our program model aligns with school-based models including the Intervention Assistance Team process and the Search Institute’s 40 Developmental Assets. Additional crosswalks and alignment charts can be developed upon request.
SCHOOL BASED INTERVENTION ASSISTANT TEAM (IAT) AND IT'S CORRELATION TO THE ECMH MODEL

INTENSIVE STRATEGIES:
ECMH: Mental Health Diagnostic Assessment and treatment with parental permission. Alignment with school Evaluation Team Reporting/ Individual Education Plan process.

TARGETED STRATEGIES:
ECMH: DECA and Classroom Behavior Plan with parental permission results in the development of a classroom behavior plan and home/school communication program.

UNIVERSAL STRATEGIES:
ECMH: Creation of classroom DECA profile and assistance with classroom strategies to help teacher address the social, emotional, and behavioral concerns of children in their care.

STEP 1: Best Practices in Instruction and Behavior Management, call to parents/caregivers for suggestions and ideas, etc.

STEP 2: Informal consultation with peers and face-to-face conference with parents

STEP 3: Consultation with school specialists for ideas/feedback

STEP 4: Documentation Classroom Interventions (Action Plan based on consultation with school specialists)

STEP 5: Formal Assessment with School Specialists (Speech, OT, PT, Psychologists, etc.)

Early Childhood Mental Health Consultation Program activities that align with the School Intervention Assessment Team process

(c) 9-16-11 Sherry Shamblin ssamblin@tcmhcs.org
PROGRAM STEPS

A. UNIVERSAL CONSULTATION:

(1) Teacher Signs Consent. The consultant should meet with each teacher for introductions and to review of the consent form. Teachers who volunteer to participate will be individually consented by the ECMH Consultant or ECMH Supervisor. The process will involve reviewing the details outlined in the consent form. Once signed, a copy of the consent form should be given to the teacher, a copy to the program director, and the original placed in the teacher's consultation file. Teacher consultation files should be created by the consultant, are maintained by the ECMH consultant, and stored at Tri-County Mental Health and Counseling Services, Inc. in a locked filing cabinet. Teacher consultation files should be accessible to the program director.

(2) Teacher informs parents about the program. At preschool orientation for families held at the school, each consented teacher will distribute information about the ECMH program to parents and inform them about the teacher's participation in the ECMH Program. ECMHC's should attend school open houses/orientations as their schedules allow. This information will also be placed in the Classroom Newsletter. Parent consent for Universal Services to be offered within preschools classroom is not required by school policy.

(3) ECMH Consultant visits classroom. The ECMH Consultant will visit classrooms of consenting teachers, support the establishment of beginning of the year routines/procedures, assist with challenging children, and complete Preschool Mental Health Climate Scale. The ECMH Consultant will store the original of the PMHCS in the Classroom File in a locked file cabinet at TCMH-CS. A copy should be given to the teacher at the consultation planning meeting, and a copy should be given to the Program Director.

(4) Teacher completes the Teacher Opinion Scales. Consented teachers will be asked to complete the Teacher Opinion Scale. Once completed, the form will be returned to the ECMH consultant who will put the original in the
teacher’s consultation file. A copy will be given to the teacher as part of the consultation conference; and a copy given to the program director.

(5) **Teacher completes whole-class DECA’s.** Consented teachers will be asked to complete DECA’s for all of the children in their classes. The program director will assign child codes to DECA’s for each classroom. The ECMHC will deliver the forms along with a DECA CLASSROOM ROSTER. The teacher will assign each child in their class a code and record it on the roster. Teachers will keep the roster for the school year and use it for each DECA administration. The ECMHC will pick up the de-identified DECA’s, score them, and make a classroom profile. Originals will be stored in the teacher consultation file. The ECMHC will make copies of the DECA’s and the profile for the teacher’s consultation conference. Copies of the DECA’s will be given to the program director.

(6)**Teacher completes Interest Survey.** The ECMHC will review the survey and include the information in the consultation report/consultation conference. The survey is filed in the consultation file.

(7) **Teacher and Consultant complete the Teacher-Consultant Collaboration Survey.** Originals of both are given to the program director.

(8) **ECMH Consultant scores all tools and creates a Consultation Report.**

(9) **The ECMH Consultant will hold a consultation conference with each teacher.** At the conference, the ECMHC will review the results of TOS, the PMHCS, the interest survey, and the DECA profile. The consultation report will be discussed. The consultant and teacher will complete the Classroom Consultation Plan. The ECMH Consultant will give a copy of the classroom plan to each teacher and the original will be kept by the ECMH Consultant in the teacher consultation file.
(10) **Classroom Consultation Plan will be implemented.** Services are documented on the “consultation log” which is stored in the teacher consultation file with monthly copies to the program director.

(11) **Mid-Year:** Whole Classroom DECA’s will be completed again in the same process described above. The Classroom Consultation Plan will be amended as needed.

(12) **Quarterly,** the consultant completes the Classroom Consultation Summary, the Program Activities Summary, and the Developmental Screening Log. These should be given to the program director.

(13) **Spring:** The TOS, PMHCS, and Classroom DECA’s will be repeated using the process described above. Teachers will complete the Satisfaction Survey, and the Demographic Questionnaire. Teachers and Consultants will complete the teacher-consultant collaboration survey.
Teacher Training

We are able to offer a variety of teacher trainings. It is our goal that these trainings will be a part of the continuing education credit that each teacher must complete through their professional development committee. We are willing to make adaptations to the materials and style format to accommodate the requirements of your teachers. Below is a list of trainings already developed. Each year we will add additional topics, so please make suggestions and add make your training materials to other consultants.

Training Menu:
1. Impact of Trauma on Preschool Children developed by Dr. Heidi Llewellyn, PCC.
2. Children Who Have Experienced Sexually Abused developed by Jenny Byers, PCC-S.
3. “Building Your Bounce: Simple Strategies for a Resilient You” developed by Mary Mackrain and Nefertiti Bruce from the Devereux Organization. This program is designed to help teachers build their own resilience so that they can manage the stressful job of teaching young children.
4. CARE training. Many of our consultants are trained in Parent-Child Interaction Therapy. The CARE training, translates these principals into strategies that teachers and other caregivers can implement.
5. DECA’s Face the Challenge: Working with Children who Have Challenging Behaviors
**Teacher Lending Library**

Teachers participating in the ECMH program have access to the Teacher Lending Library at Tri-County Mental Health. Teachers can request materials or you might make recommendations as part of your consultation. Sign materials out on the clipboard that is located on the library bookshelf. Although there are no official due dates, please be sensitive to the fact that others may also be interested in a particular item and to return the materials within a month.

**Lending Library**

**Teacher Resources:**

**Books with activities/interventions for students:**

*Great Games for Young Children: Over 100 games to Develop Self-Confidence, Problem-Solving Skills, and Cooperation* by Rae Pica

Games that help enhance children’s cognitive, social/emotional, and physical development.

*The Kindness Curriculum: Introducing Young Children to Loving Values* by Judith Anne Rice

This book gives numerous activities that help foster and enhance kindness and respect.

*Routines & Transitions: A Guide for Early Childhood Professionals* by Nicole Malenfant

Gives general guidelines for transitions as well as some suggestions for common activities.

*Seven Skills for School Success: Activities to develop Social and Emotional Intelligence in Young Children* by Pam Schiller

This book is aimed at helping students become successful learners through information, activities and experience.
Transition Tips and Tricks for Teachers: Attention-Grabbing, Creative Activities that are Sure to Become Classroom Favorites by Jean Feldman

Turning transitions into fun, learning experiences through activities, songs and stories.

Socially Strong, Emotionally Secure: 50 Activities to Promote Resilience in Young Children by Nefertiti Bruce and Karen Cairone

Activities that help children become socially and emotionally secure during daily activities.

Wiggle, Giggle, & Shake: 200 Ways to Move and Learn by Rae Pica

This book has activities and ideas that are designed to help children participate physically in their learning; encouraging ways to problem solve, explore feelings and think critically.

Classroom Strategies and “How To” Books:

The Anti-Bullying and Teasing Book for Preschool Classrooms by Barbara Sprung and Merle Frosch

This book uses activities, the classroom, and family involvement to help children develop empathy and respect.

Designs for Living and Learning: Transforming Early Childhood Environments by Deb Curtis and Margie Carter

Full of great ideas to turn your room into a wonderland for kids.


Ever wanted to put together a newsletter for your parents of your students? This book will guide you through the process.

Transition Magic: Strategies for Guiding Young Children in Early Childhood Programs by Nola Larson, Mary Henthorne, and Barbara Plum

Full of exciting techniques that have been proven to be effective, this book offers a variety of ideas that even the most seasoned teacher would appreciate.
The Inclusive Early Childhood Classroom: Easy Ways to Adapt Learning Centers for All Children by Patti Gould and Joyce Sullivan
  Practical ways to adjust centers and classroom routines for children with special needs.

Specialized Topics:

Beyond Behavioral Management: The Six Life Skills Children Need to Thrive in Today’s World by Jenna Bilmes
  A strengths-based approach to helping children build essential life skills.

Diagnosis and Treatment of Feeding Disorders in Infants, Toddlers, and Young Children by Irene Chatoor
  In-Depth Information on Infantile Anorexia, Sensory Food Aversions, and Posttraumatic Feeding Disorder.

Partnering With Parents; Easy Programs to Involve Parents in the Early Learning Process by Bob Rockwell and Janet Rockwell Kniepkamp
  27 easy to organize family meeting strategies.

Sensory Integration: A Guide for Preschool Teachers by Christy Isabell and Rebecca Isabell
  Helps identify children with sensory processing difficulties and offers practical solutions to support these children’s needs.
FORMS Required for Universal Consultation*:

1. The Teacher Consent Form
2. The Teacher Opinion Scale
3. Teacher Interest Survey
4. DECA
5. The Classroom DECA Roster
6. The DECA Profile
7. Information about the e-deca for teachers using this system
8. The Preschool Mental Health Climate Scale (Sample)
9. Teacher-Consultant Collaboration Survey
10. Consultation Report
11. Consultation Plan
12. Consultation Log
13. Teacher Satisfaction Provider Survey
14. Demographic Questionnaire
15. Classroom Consultation Summary
16. Program Activities Summary
17. Developmental Screening Log

*Copies of these forms can be obtained from the Program Director
B. TARGETED CONSULTATION:

(1) **Teacher identifies children for Targeted Consultation.** Throughout the school year, a consented teacher may identify a child who needs individual consultation. This may be based on results from the whole-class DECA’s, results from the Ages and Stages Questionnaires completed as part of the preschool screening process, parental concerns, or their concerns. When this occurs, the teacher will get the parent’s permission to complete the Targeted Consultation Request form and give it to the consultant. The ECMH consultant should make every effort to respond to this request within two days at this site.

(2) **The ECMH consultant will contact the parent** (via phone, written note, or face-to-face) to schedule a time to meet. At that meeting, the parent/guardian will be provided an overview of the program. The consultant will review the consent form and the Parent Program Overview. If the parent is interested, the ECMH Consultant or the ECMH Supervisor will consent his/her participation (Parent Consent Form). If the parent is not interested in the ECMH Program, then the consultant will provide contact information should the parent be interested in the program at a later time. Additionally, consultants will give the parent other service options.

(3) **The ECMH consultant will make two copies of the Parent Consent Form.** One copy should be given to the parent and one to the program director. The consultant should create an individual child consultation for this child, and file the original consent form in this file. The file should be stored in the ECMH’s office in a locked file cabinet.

(4) **Additional targeted consultation paperwork will be completed with the parent during the initial meeting.** This includes a TCMHCS Release of Information for the School (and any other necessary releases), the TCMHC White Intake Demographic Form, and the LAUNCH Intake Summary. Parents or teachers may have copies of any of these forms if they wish. Originals should be stored in the child’s consultation file.
(5) The ECMH Consultant will complete the Assent Form with the child. This process can be completed in the child’s classroom during individual active learning time when kids are selecting activities. This is a common procedure when children are working with specialists, such as speech pathologists. The Assent form should be filed in the child’s consultation file.

(6) After consent and assent are obtained, the child’s teacher and parent will complete the Devereux Early Childhood Assessment (DECA) which will be scored by the ECMH Consultant. The ECMHC will make a report for the teacher and for the program director. The original should be filed in the child’s consultation file.

(7) ECMHC completes the Classroom Behavior Assessment Packet.

(8) ECMH, parent and teacher meet to review all of the assessment materials. They complete the Classroom Behavior Plan. Services offered may also include referrals for additional assessments from the school assessment team, the local Interdisciplinary Assessment Team, or other independent clinicians in the community. Copies of the assessment and plan will be given to the teacher and the parent, with the original stored in the Targeted Consultation File.

(9) The ECMH Consultant will conduct classroom activities as indicated on the individual intervention plan. Consultation activities should be documented on the “Child Consultation Note.” The Consultant will communicate progress with the teacher and parent using the “Monthly Progress Form.” The original copies of this form will be filed in the child’s consultation file. Based on the child’s progress, an intervention plan may be amended during a meeting between the ECMH Consultant, teacher, and parent. The team may decide that a child would benefit from intensive mental health services, at which point, formal enrollment as a client of the community mental health center would be required.
(10) The school IAT protocol is followed with monthly meetings concerning children receiving targeted and intensive services.

(11) Mid-year: DECA’s will be completed by the child’s teacher and parent. The ECMHC will score them and meet with the teacher and parent. The Classroom Behavior Plan will be updated based on results.

(12) Quarterly: The consultant will complete the LAUNCH Service Summary for each targeted child. A copy should be given to the program director and the original should be stored in the child’s consultation file.

(13) In the spring, the teacher and parent will complete a final set of DECA’s and the Consultation Questionnaire and the Satisfaction Survey.

(14) Participation is voluntary and parents may choose to withdraw their child from the program at any time during the year with no consequences simply by informing the ECMH Consultant, the teacher, or the ECMH Supervisor who will subsequently inform all remaining members of the team. A signature will be obtained from the parent when possible.
FORMS REQUIRED FOR TARGETED CONSULTATION*

1. Program Overview
2. Universal Consultation Checklist
3. Targeted Consultation Referral Form
4. Parent Consent
5. TCMHC Release
6. TCMHC Demographic Intake Forms
7. DECA Form
8. DECA Report Form
9. Child Assent
10. Classroom Behavior Assessment Report Packet (Observation Form, Protective Factors Observation Summary, Behavioral Concerns Observation Summary—all with samples)
11. Classroom Behavior Plan Packet (Individualized Protective Factors Plan, Individualized Positive Guidance Plan—all with samples)
12. Consultation Note
13. Monthly Progress Form
14. LAUNCH Intake Summary
15. LAUNCH Service Summary
16. Satisfaction Survey

*Copies of forms can be obtained from the Program Director
C. INTENSIVE SERVICES

(1) Sometimes, the Parent, School Staff and ECMH will decide that a child needs specialized services beyond the classroom. When that happens, the ECMHC will meet with the parent and complete a diagnostic assessment using the TCMHC paperwork.

(2) ECMH works with child and/or parent individually at school, home, or in-clinic. The TCMHC protocols and procedures for treatment will be followed for these services. These are outlined in the “TCMHC Clinical Manual” located in the main office of each clinic.
ECMH Professional Development

Becoming a competent ECMH Consultation takes time and is a developmental process. It is a unique profession because there are no formal training programs to assist individuals in acquiring the knowledge and skills needed. New consultants bring to their work a vast variety of knowledge and skills gained through their formal master’s degree programs and their previous employment experiences. However, rarely does any new consultant start the job with all of the needed skills. Most consultants have to learn a great deal “on the job.” TCMHC has the expectation that it is our job to help support you through this process in a manner that is developmentally consistent with your initial knowledge and skills. As a result, our ECMH team has developed a progressive professional development process to provide new ECMH consultants the support to:

1. Gain a general understanding of the philosophy and concepts specific to ECMHC.

2. Attain the skills needed for specific job-related tasks associated with delivery of the TCMHC ECMH Consultation Model

3. Progress in the mastery of ECMH ODMH Core Competencies

Initial Orientation

Upon hire, new consultants will completed the following orientation activities prior to beginning work in a classroom:

1. Read the following documents and discuss them with their supervisor:
   - Early Childhood Mental Health Consultation by Cohen and Kaufman;
   - Early Childhood Mental Health Consultation by Donuhue;
   - Ohio’s Core Competencies for Early Childhood Mental Health Professionals; DECA Technical Manual;
   - DECA Classroom Strategies Manual; and
   - TCMHC Early Childhood Mental Health Consultation Program Manual;
(2) **View the "What Works" web-based ECMH training modules and complete the post tests with a 90% average for the series;**

(3) **View the DECA training video;**

(4) **View the Incredible Years video series;**

(5) **Complete all other TCMHC Orientation activities assigned by the HR Department.**

**Gaining Competency on the TCMHC ECMH Consultation Model:**

Your supervisor will use a coaching model to assist you with learning the necessary skills to reach mastery level on the entire core competencies listed on the TCMHC ECMH Core Competency Grid. The timeline on this will vary for each consultant but will likely encompass the first 6-12 months of employment to attain.

The Supervisor/Coaching process contains the following steps:

1. **Complete the TCMHC ECMH Consultant Self-Assessment.**
2. **Meet with supervisor/coach, and using the Self-Assessment, complete the Tri-County Mental Health ECMH Core Competency grid.**
3. **Collaboratively identify a goal that is specific, measureable, relevant, and time-bound (SMART). It should align with the results of your self-assessment and your competency level as matched by the TCMHC ECMH Core Competency grid.**
4. **Identify strategies and specific action steps to meet each goal, with a clear, timeline, and evidence that will show completion of each goal. Use the Goal-Setting Template to record your plan.**
5. **You and your supervisor/coach will work together on the activities listed on your plan.**
6. **Monthly, meet with your supervisor/coach, review your progress on your goal and outline supporting actions taken, and revise your plan as needed. Once your goal has been reached, begin a new goal until you have mastered all of the TCMHC ECMH Core Competencies.**
7. **In correlation with your TCMHC Employee Evaluations, meet with your supervisor/coach quarterly to complete the Self-Assessment and update your TCMHC ECMH Core Competency grid. The following**
materials will be used by you and your supervisor/coach during the program year.

Prior to beginning ECMH Consultation Activities, new staff will complete the following orientation activities: The Georgetown "What Works" web-based training series, "The Center for Excellence ECMH Consultation" modules with a 95% on post-tests; "Incredible Years" training video; and the "DECA" training video and manual with 95% on post-test.

| Knowledge/Skill | Potential—This is a skill that consultant has not yet begun to develop. (Requires supervisor to do direct teaching, modeling, coaching, and give constructive feedback) | Developing—This is a skill that the consultant is actively working to acquire and improve (Requires supervisor to provide monitoring, give constructive feedback, assist with problem-solving, support the development of self-reflective practices. Direct teaching, modeling and coaching as needed) | Mastered—This is a skill that the consultant feels very confident about and could teach a new person how to do. (Requires supervisor support self-reflective practice, and to monitor, and assist with problem-solving as needed) |

**UNIVERSAL CONSULTATION**

- Conducting Dina Circle Time Activities with Children
- Coaching a teacher on classroom implementation of IY activities
- Conducting CESEFL Circle Time Activities with Children
- Coaching a teacher on classroom implementation of CESEFL learning activities
- Completing classroom observations using the Mental Health Climate Scale
- Scoring and interpreting DECA's and Classroom Profiles
- Writing a Consultation Report
- Writing a Consultation Plan
- Conducting a Planning Conference with Teacher
- Conducting Teacher Training
- Conducting Teacher Consultation meetings
Dedicated Program Director Time:

- For an ECMH Consultant who has 70%-80% or more competencies scored in the "Potential" Category, the supervisor will be provide 3-5 hours weekly of direct time in the classroom with the consultant to teach, model, coach, and observer performance.
- For an ECMH Consultant who has 70-80% or more competencies scored in the "Developing" Category, the supervisor will be provide 1-3 hours weekly of direct time in the classroom with the consultant observe, monitor, and problem-solve.
- For an ECMH Consultant who has 70-80% or more competencies scored in the "Mastered" Category, the supervisor will provide 1 hour a week on-site monitoring and problem-solving; direct-time in the classroom as needed.

11-22-11 sshamblin@tcmhcs.org
Tri-County Mental Health and Counseling ECMH Core Competency Self-Assessment

Name_________________________________ Date____________________

On a scale from 0-5 (0 = no knowledge/new concept and 5 = completely comfortable/mastery of the concept) rate yourself on the following items:

_____ Conducting Dina circle time activities
_____ Coaching a teacher on classroom implementation of IY activities
_____ Completing classroom observations using the Mental Health Climate Scale
_____ Scoring and interpreting the DECA's and classroom profiles
_____ Writing a consultation report
_____ Writing a consultation plan
_____ Conducting a planning conference with a teacher
_____ Conducting a teacher training
_____ Conducting a teacher consultation meeting
_____ Completing an individual child observation using the DECA process
_____ Completing a classroom behavior assessment
_____ Conducting a planning conference with a teacher and parent
_____ Completing a classroom behavior plan
_____ Conducting social coaching with a child in the classroom
_____ Writing a social story
_____ Making a visual support
_____ Coaching a teacher and parent on the use of positive guidance techniques
_____ Creating a home-school communication tool
_____ Conducting a teacher-parent team meeting to discuss a child's progress on a classroom behavior plan
Goal-Setting Template for ECMH Coaching

ECMH Consultant_______________________________________

Supervisor/Coach_______________________________________

Teacher(s) Served______________________________________

Date Written_________ Dates Reviewed:________________

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For Reflection:

1. Summarize your progress in the goal area. How did your progress in this area affect the universal consultation process? The targeted consultation process?

2. If you met your goal, what contributed to your success?

3. If you did not meet your goal, what were barriers to your success?

Supervisor/Coaching Observation Guide

Through the use of the Observation and Observation Conference form, coaches will collect objective evidence and engage ECMH Consultants in formatively examining their own practice and setting professional goals. This can occur in both informal and formal observations.

The Supervisor/Coach's Role: ECMH consultants and coaches establish a trusting relationship of mutual understanding and respect for risk-taking and growth to occur through both informal and formal observations. Coaches should make frequent informal observations of consultants to build a level of comfort and rapport and set up a culture of professional support and collaboration. A subsequent formal observation engages consultants in professional dialogue around objective evidence of their consultation practice to help inform their goal setting and consultation practices.

The Process for ECMH Consultants and Coaches: Coaches provide a first objective view into the consultant's practice. Both informal and formal observations should be scheduled in advance. Informal observations need not be documented. Pre-Observation Conference: Following several informal observations, the coach and consultant should meet to discuss the upcoming observation. The coach should discuss with the consultant what the focus of feedback should be in order to tailor the observation.

Conducting the Observation: The observation should be scheduled in advance at a mutually agreed upon time and last for at least 30 minutes or long enough to include the full consultation session. Coaches should focus on both the consultant and the teacher/parent/child to capture evidence of consultant learning and engagement. Do not record opinions or judgments about those receiving the consultation. Use the Observation of ECMH Consultation Template to record notes.

Activities to note during an observation:
Scripting: Involves writing down exactly what the consultant/teacher/parent/child said or did at a particular point. It is impossible to script every statement and action. Therefore carefully select which observations are scripted. Keep the consultant's goals in mind when transcribing to capture items that attend to these goals. It is also helpful to note the time of a statement or event that is transcribed to provide an accurate picture for the ECMH consultant.
Charting: can help consultants identify their own patterns in relation to teachers or children during classroom activities
Tallying student responses to an intervention: serves to assist ECMH consultant in identifying various levels of teacher or child participation
A list of the strategies used by the consultant during the session can be helpful in assessing which strategies work best with a particular child or teacher/ or in a given situation.

Reflecting on the Observation: While the purpose of the formal observation is not evaluative, coaches and consultants should spend some time reflecting on the consultation to prepare a post-observation reflection. Coaches should summarize key observations and plan coaching language and reflective questioning strategies.

Use the Post-Observation Conference template.
Similarly, the consultant should reflect on the consultation and consider bringing additional data to the meeting with the coach. To facilitate this reflection, coaches may provide consultants copies of their observation notes.

Preparing for post-observation meetings: Coaches should schedule a meeting with consultant within two days of the observation to discuss the objective evidence collected during the consultation.

Facilitating post-observation meetings: Coaches should analyze data from the observation to provide consultants specific insights into their consultation practices. Coaches should use an Instructive-Collaborative-Facilitative framework to guide consultants to their own conclusions about the session. Together, they should use the information to write the consultant and mentor's next steps.

Observation Form

Consultant Name_________________   Date________________

Supervisor/Coach_____________________________________

Type of consultation session observed:

Who was present:

What was observed:

Consultation Practices Identified:

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Post-Observation Conference

ECMH Consultant____________________           Date___________
Supervisor/Coach____________________________________________
Teacher_________________ Classroom____________________________

Directions: Coaches should analyze data from the Coaching Observation to provide the ECMH Consultant with specific insights into their consultation practice. Coaches should use the Instructive-Collaborative-Facilitative framework to guide consultants to draw conclusions about the observed consultation process and outcomes, as well as their own strengths and areas for growth. Together, the coach and consultant should use the information generated through this reflective process to write the consultant and the coach's next steps—keeping in mind the goal on the coaching plan and the ECMH Consultant's self-assessment.

1. What was the greatest surprise in the session observed today?

2. What was the focus of the consultation session?

3. What were some of the most effective connections between the consultation purpose and the activities?

4. What were some of the enduring understandings that emerged from this session?

5. How will you build on this consultation session?

6. What do you need to accomplish this?

Developing Competency on the ODMH ECMH Competencies:

Once you have mastered the TCMHC Core Competencies, your supervisor will assign you a peer mentor for the process of progressing through the ODMH Core Competencies. You and your peer mentor will work together for one program year. Following that year, you may choose to continue working together, ask to be paired with a new peer mentor, or discontinue the program.

The Peer Mentoring process contains the following steps:

1. Complete the ODMH ECMH Consultant Self-Assessment. A copy may be obtained from the Program Director.
2. Meet with peer mentor and discuss your self-assessment.
3. Collaboratively identify a goal that is specific, measurable, relevant, and time-bound (SMART). It should align with the results of your self-assessment.
4. Identify strategies and specific action steps to meet each goal, with a clear, timeline, evidence that will show completion of each goal. Use the Goal-Setting Template to record your plan.
5. You and your peer mentor will work together on the activities listed on your plan.
6. Meet quarterly with your peer mentor, review your progress on your goal and outline actions taken which supports it, and revise your plan as needed. Once your goal has been reached, begin a new goal until your year is complete or you have mastered all of the core competencies.
7. The following materials will be used by you and your peer mentor during the program year.
Goal-Setting Template for ECMH Peer Mentorship

ECMH Consultant__________________________________________
 Peer Mentor _____________________________________________
 Teacher(s) Served________________________________________
 Date Written_________ Dates Reviewed:____________________

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For Reflection:
4. Summarize your progress in the goal area. How did your progress in this area affect the universal consultation process? The targeted consultation process?

5. If you met your goal what contributed to your success?

6. If you did not meet your goal, what were barriers to your success?
EARLY-CHILDHOOD MENTAL HEALTH CONSULTATION
PARTNERSHIP AGREEMENT

Each school has signed a partnership agreement. Consultants should review the signed agreements for each school that they serve. The standard agreement form follows:

EARLY-CHILDHOOD MENTAL HEALTH CONSULTATION
PARTNERSHIP AGREEMENT

Tri-County Mental Health & Counseling, Inc.          School: _______________________
90 Hospital Drive                                     Address: _______________________
Athens, OH 45701                                      Contact Person: _______________
Contact Person: Sherry Shamblin                       Phone: _______________________
592-3091 ext. 4631                                    E-Mail: _______________________
sshamblin@tcmhcs.org

This agreement is made between Tri-County Mental Health and ___________________ for the purposes of implementing an Early Childhood Mental Health Consultation Program.

The ECMH Consultant responsible for consultation services to this site is

______________________________________________________________________.

Teachers participating in the program at this school are:

______________________________________________________________________.

This agreement covers the ____________ school year.

Tri-County Mental Health:

The Program Director, Sherry Shamblin will:

☐ Provide an ECMH Consultant to serve the school 2 days a week
☐ Be on site to monitor and support the professional development of the ECMH Consultant from 1-5 hours a week. Time will be determined by the ECMH Consultant’s acquisition of core competencies
☐ Analyze and manage the data for the project
☐ Provide Administration and teaching staff ongoing progress reports
☐ Meet quarterly with administration to discuss project and modify the program as needed
☐ Assist ECMH Consultant with conducting teacher-identified training
Complete monthly e-newsletter

The ECMH Consultant will:

- Provide universal, targeted, and intensive services to enrolled children and families 2 days a week
- Score classroom DECA’s and complete classroom profiles
- Complete the Mental Health Climate Scale for each participating class
- Complete a Consultation report with recommendations
- Work with Teacher to develop a classroom consultation plan
- Deliver agreed-upon universal and targeted consultation services within participating classrooms for 3-6 hours a week. Time will be determined by consultation goals and the needs of the targeted children in the classroom
- Weekly, conduct circle time activities associated with either the Incredible Years or the CESFL program (30 minutes per classroom; this will be part of the 3-6 hours)
- Weekly, assist teachers with implementation of the IY or CESFL classroom activities, including providing teacher with the materials and copies of the parent newsletter
- Respond to teacher consultation requests within a two-week time period.
- Conduct teacher-identified training and follow-up
- Conduct IY Parent Groups as agreed upon by consultant and teachers
- Meet minimally ______ times a month on Wednesdays with participating teachers to consult on implementation of the social-emotional curriculum, implantation of behavior plans for targeted children, and to jointly plan for children receiving intensive treatment
- Complete a Functional Behavioral Assessment on children whose parents have consented to targeted consultation services
- For targeted consultation children, work with the teacher and parent to complete a behavior plan based on the FBA
- Provide class-room based intervention for targeted children.
- Assist in the creation of home-school communication system for targeted and intensive children
- For targeted children, assist parents with home implementation of functional behavior plan
- Participate in school IAT process for targeted and intensive children
- With parent consent and participation, provide intensive treatment services on-site, in-home, or at TCMHC clinic
- Coordinate and implement summer Incredible Years program
Schools:

The Superintendent will:

☐ ______________ Work with Project Director to sustain universal consultation portion of the program in future years
☐ ______________ Support implementation of program components with participating teachers and staff
☐ ______________ Meet quarterly with Program Director to discuss project, modify the program as needed, and develop sustainability plan
☐ ______________ Complete administrative satisfaction survey
☐ ______________ Provide space for the consultant to see individual children/families as needed
☐ ______________ Provide access to school equipment to make teacher materials for the social-emotional curriculum and targeted classroom strategies

The Principal will:

☐ ______________ Support implementation of program components with participating teachers and staff
☐ ______________ Participate in the school IAT process for identified targeted and intensive children.
☐ ______________ Meet quarterly with Program Director to discuss project and to modify the program as needed
☐ ______________ Complete administrative satisfaction survey
☐ ______________ Provide space for the consultant to see individual children/families as needed
☐ ______________ Provide access to school equipment to make teacher materials for the social-emotional curriculum and targeted classroom strategies

School Social Worker will:

☐ ______________ Assist ECMH Consultant with connecting with parents of children referred for targeted and intensive services
Assist with planning, coordinating, and implementing the summer IY group

Participating Preschool Teachers will:
- Complete Universal Consultation Tools:
  - Teacher Opinion Scale (Fall and Spring)
  - Classroom DECA’s (Fall, Winter, Spring)
  - Interest Survey (Fall)
  - IY or CESEFL Curriculum Questionnaire (Fall, Spring)
  - Satisfaction Survey (Spring)
  - Demographic Survey (Spring)
  - Pre/Post tests for Teacher Trainings
- Allow ECMH Consultant to complete the Mental Health Climate Scale
- Work with ECMH Consultant to develop consultation plan
- Participate in weekly IY or CESEFL classroom activities
- Distribute parent newsletter information from IY or CESEFL
- Meet minimally ______ times a month on Wednesdays with ECMH consultant to discuss implementation of the social-emotional curriculum, implementation of the behavior plans for targeted children, and to jointly plan for children receiving intensive treatment.
- Complete “Consultation Request Form” to request specific information
- Select and participate in 2 annual trainings from ECMH training list
- For targeted children, assist ECMH Consultant with information for the Functional Behavior Assessment
- For targeted children, assist ECMH Consultant and parent in development of a Functional Behavior Plan and complete agreed upon interventions
- For targeted children, complete the Provider Relationship Scale (Fall, Spring)

This agreement may be terminated or renegotiated in its entirety at any time by sending written notification thirty (30) days in advance to the other party.

TCMHC ECMH Program Director

School Superintendent

Date

Date
ADDITIONAL ECMH RESOURCES


What Works? Study located at http://gucchd.georgetown.edu/78358.html


Center for Effective Mental Health Consultation located at http://www.ecmhc.org
IRB Protocol Documents for Partnerships for Early Childhood Mental Health Program. The Title of the IRB Proposal was “Building Capacity-Raising Resiliency” based on the HRSA Outreach Grant which initiated the program. Dr. Jane Hamel-Lambert (grant PI) and Sherry Shamblin were co-investigators. In 2011, the research portion of the project was separated from the HRSA Outreach Grant and Jane Hamel-Lambert stepped off the project. Sherry Shamblin continued as Primary Investigator. Later in 2011, the IRB Protocol was re-named “Partnerships for Early Childhood Mental Health” to match the Tri-County Mental Health Program name and to further differentiate the IRB protocol (under Sherry Shamblin) from the HRSA Outreach Grant “Building Capacity-Raising Resiliency” (under Jane Hamel-Lambert).

OHIO UNIVERSITY
INSTITUTIONAL REVIEW BOARD (IRB)
PROJECT OUTLINE FORM
Title of Research Proposal: Building Capacity – Raising Resiliency

Investigator(s) Information
Primary Investigator
Name: Jane Hamel-Lambert, PhD
Department: OUCOM, Dept Fam Med

Address: 347 Grosvenor Hall, Athens, OH 45701
(If off-campus, include city, state and zip code)

Training Module Completed? X Yes □ No

Co-investigators
Name: Sherry Shamblin, PCC-S
Department: TriCounty Mental Health & Counseling Center

Address: 90 Hospital Drive, Athens, OH 45701
(If off-campus, include city, state and zip code)

Email sshamblin@tcmhcs.org Phone 740-594-5000

Training Module Completed? X Yes □ No

Advisor Information (if applicable)

25 This is an unpublished program report belonging to the “Partnerships for Early Childhood Mental Health Program” It is reprinted for the purposes of this study with permission from Tri-County Mental Health and Counseling Services, Inc.
Name ___________________________ n/a ___________________________ Department ____
Research Assistants

Name ___________________________ Valerie Wang, M.Ed ___________________________ Department: Tri-County Mental Health and Counseling Center
Training Module Completed? X Yes ☐ No

Anticipated Starting Date _______________ Aug 25, 2009 ______________ Duration _______________
___ mos ____________3 yrs ________________
(Work, including recruitment, cannot begin prior to IRB approval. This date should never precede the submission date)

Funding Status
Is the researcher receiving or applying for external funding? X Yes ☐ No
If yes, list source: HRSA/ Office of Rural Health Policy
If yes, describe any consulting or other relationships with this sponsor.
The same sponsor funds a second OU grant, which ends in April 2010.

Is there a payment of any kind connected with enrollment of participants on this study that will be paid to persons other than the research participants? ☐ Yes ______________ X No (If yes, describe.)

Review Level
Based on the definition in the guidelines, do you believe your research qualifies for:
___ Exempt Review ______________ Category ______________
___ Expedited Review ______________ Category ______________
X___ Full Committee Review

Recruitment/Selection of Subjects
Maximum Number of Human Participants ___________________________
Characteristics of subjects (check as many boxes as appropriate).
___ x__ Minors _____ Physically or Mentally Disabled ___ x__ Elementary School Students,
Specifically preschool students ___ x__ Adults _____ Legal Incompetency ______ Secondary School Students
___ Prisoners ___ Pregnant Females ___ University Students
___ Others (Specify) ___________________________

Briefly describe the criteria for selection of subjects (inclusion/exclusion). Include such information as age range, health status, etc. Attach additional pages if necessary.
Exclusion criteria: None

Inclusion criteria: The teacher must be assigned to a preschool classroom in the catchment area. A child must be a pupil in the preschool classroom being served by the early childhood mental health consultation program/consultant, or in a classroom serving as a control group.

How will you identify and recruit prospective participants?

Preschool classroom teachers and school district staff who staff the classrooms proposed in this grant-funded project have collectively informed the development of the project plan. The catchment area for the program is Athens County; the classrooms fall under the management of either the Athens-Meigs Educational Services Center (AMESC) or the Athens City School District, often referenced as the county and city schools. Teachers will be recruited based on their employment. All children and staff in consented classroom with the ECMH program will receive universal services. Students recommended for individualized services (e.g., targeted or intensive) will be nominated by the classroom teacher because of challenging behaviors in the classroom. Children nominated to receive targeted or intensive early childhood mental health services will only be served if parents consent to the program, and child assent is obtained, enabling individualized interventions to be tailored to a specific child.

Recruitment of Preschool Teachers:

At the beginning of the school year, we will introduce the consultation model to preschool teachers and staff through their initial and monthly staff meetings to facilitate adoption of program services. The consultant will attend meetings for two schools districts within Athens County that are cooperatively served through the Athens-Meigs Educational Service Center (Alexander and Trimble) and the Athens City School district (Year One). The consultant will provide an overview of the consultation model and answer questions. Teacher will volunteer to participate in the program and they will be consented to participate by the early childhood mental health consultant or the ECMH supervisor. Two groups will be established. Teachers in Alexander, Trimble, and the Chauncy preschool classrooms will be eligible for active program services. Teachers in Amesville and Coolville and those in Athens City classrooms in The Plains and West Elementary will be recruited to consent to the Wait List Control group.

Recruitment of Family/Child Participants:

The ECMH program provides three tiers of service: universal, targeted, and intensive. Universal services are provided through consultation with the preschool teacher and benefit all children enrolled in the teacher’s classroom. There is no recruitment for participation at this level for children in a classroom for universal services per school policy (see letter of commitment from school superintendents). Parents will be provided
the Parent Program Overview flyer explaining Building Capacity –Raising Resiliency Program at the start of the school year. (see Parent Program Overview, recruitment materials)

Children will be recruited for targeted and intensive services through a teacher nomination process. Students will be nominated by the classroom teacher to receive targeted or intensive consultation services if challenging behaviors in the school environment continue to concern the preschool teacher despite the implementation of universal strategies. Nominated children will be considered for either targeted or intensive services tailored to the meets the needs of the particular child. When a teacher identifies a child who she/he is nominating to receive individualized services, the teacher will discuss his or her concern with the child’s parent and ask for permission to provide contact information to the consultant. If interested, the teacher will provide the parent/guardian’s contact information to the ECMH consultant. The ECMH consultant will then contact the parent (via phone, written note, or face-to-face) to schedule a time to meet. At that meeting, program as outlined in the consent form and Parent Program Overview flyer. If the parent is interested in enrolling, the early childhood classroom consultant will consent his/her participation. Once parental consent is obtained, child assent will be sought by the early childhood mental health consultant.

Following consent and assent, tailored interventions will be designed for implementation in the classroom for the child (ie targeted services). Evaluation and response to intervention delivered in the classroom may lead to a recommendation that the family received intensive mental health services, at which point formal enrollment as a client of the community mental health center would be required. Intensive services typically will include a school component, however it may also involve adding a range of services available through the community mental health system which could include individual or family therapy, case management, psychiatric consultation. Such services are delivered to the child as a client of the mental health system, and those services will be governed by the policies and procedures of the community mental health center.

Please describe your relationship to the potential participants, i.e. instructor of class, co-worker, etc. If no relationship, state no relationship.

Neither investigator or the research assistant has a formal know relationship with the anticipated participants, teachers or students. However, it is possible that a teacher or child/family participant have received or are currently receiving mental health services through Tri-County Mental Health and Counseling Services, Inc. Investigator knowledge of this prior relationship or current relationship between a participant and her employer/or agency staff would be held in confidence.

Attach copies of all recruitment tools (advertisements, posters, etc.).

See Parent Program Overview for distribution at the beginning of the school year by teachers to families.
Performance Sites

List all collaborating and performance sites, and provide copy of IRB approval from that site and/or letters of cooperation or support.

Project Description

Please provide a brief summary of this project, using non-technical terms that would be understood by a non-scientific reader. Please limit this description to no more than one typewritten page, and provide details in the methodology section.

Building Capacity – Raising Resiliency is aimed at improving early childhood outcomes and increasing the capacity of early childhood educators to address mental health issues in the classroom. This will be accomplished through the implementation of an Early Childhood Mental Health consultation program (ECMH-CP) in public preschools. Consultation services will provide universal (delivered by the teacher for all the children in the class), targeted (delivered by the teacher to meet the needs of a specific child) or intensive (delivered by a specialized professional to meet the needs of a specific child enrolled as a client the local community mental health center, which may include a classroom component) interventions. Parents and families of young children offered targeted or intensive services will be provided health education through the Family Navigator Program to build awareness, increase understanding of his/her child’s behavioral problems and facilitate participation in recommended services. Additional evaluation services may also be offered to children receiving intensive services through a local psychologist, who will work cooperative with the classroom teacher and school psychologist (as authorized by the family) to ensure the child’s educational needs are being fully accommodated.

The ECMH-CP will serve approximately 299 preschool-aged children between the ages of 3 and 5 each year. These students will be enrolled in the Athens City and Athens County public preschools. In year one, our ECMH-CP will be implemented in the Alexander School District, Trimble School district and in the Chauncey Elementary preschool classrooms, which is part of the Athens City District. Services will reach 11 classrooms in year one. In year two, the Federal Hocking School District will receive services, reaching an additional four classrooms. Finally, in year three, the remaining preschool classrooms in the Athens City School District will receive ECMH Consultation programming. Classrooms enrolled into the program during the previous years remain eligible for consultation services throughout the grant period. Those classrooms not being served in any given year will be recruited to serve as Wait List Control classrooms.

Please describe the specific scientific objectives (aims) of this research and any previous relevant research.
To increase teacher capacity to establish an optimal classroom environment and to build effective behavioral management skills optimizing the developmental outcomes for preschoolers in the classroom.

To increase childhood resiliency by strengthening individual child protective factors – self-control, attachment, and initiative – and reducing challenges behaviors as measured by the DECA tools reported by both teachers and parents for individual children who in classrooms with early childhood mental health consultation services.

Methodology: Please describe the procedures (sequentially) that will be performed/followed with human participants.

Two groups of human participants will be involved in generating research data: consented teachers and consented/assented children/families. Consented teachers are further subdivided into two groups, those whose classrooms are receiving services, and those whose classrooms are serving as a Wait List control group, who will receive services in years 2 and 3 of the project. The Early Childhood Mental Health Consultant also generates data during the program’s implementation.

The measures to be completed for research purposes are detailed in the chart below; the methods for obtaining that data is subsequently described. There is data collected that measures teacher variables, classroom variables, and child/family variables. Those that measure teacher variables are collected twice a year; measures on child variables are collected three times across the school year. Classroom data informs a consultation plan developed at the beginning of the school year, and the % of goals achieved is documented at the end of the school year for the Classroom Consultation Plan. Participation is voluntary. At any point, human participants can voluntarily withdraw from the program without consequence.

<table>
<thead>
<tr>
<th>Measures</th>
<th>ECMH Consultant</th>
<th>Teachers, Active</th>
<th>Teachers, Control</th>
<th>Parents or Guardians</th>
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<tr>
<td><strong>Initial data collected</strong></td>
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<td></td>
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<td>Fall, upon consent</td>
<td>Fall, upon consent</td>
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<td>n/a</td>
<td>n/a</td>
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<tr>
<td>Classroom Consult Plan</td>
<td>September</td>
<td>September</td>
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</tr>
<tr>
<td>Child DECA* - pre</td>
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<td>Upon</td>
<td>Oct-Dec 2009**</td>
<td>Upon consent/assent</td>
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<td>Feb/Mar, May/ June</td>
<td>Feb/Mar, May- June**</td>
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<td>n/a</td>
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<td>Focus Groups</td>
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<td>June 2010</td>
<td>n/a</td>
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</tr>
</tbody>
</table>
Teachers in Participating Classrooms

(1) The ECMH Consultant and the ECMH Supervisor will attend preschool staff meetings for the Athens-Meigs Educational Service Center and the Athens City Schools in August. The consultant and supervisor will provide an overview of the consultation model, answer questions, and discuss the benefits and consequences of participating in the program. Teachers from Trimble, Alexander, and Chauncey preschools will be specifically targeted for participation in Year 1 of the program. This represents 168 students, 11 teachers.

Teachers who volunteer to participate will be individually consented by the ECMH Consultant or ECMH Supervisor. The process will involve reviewing the details delineated in the consent form. The Teacher Consent Forms will be collected and given to the Evaluator. The evaluator will de-identify the forms by assigning a six digit Teacher ID numbers. The following procedure will be used to assign the mixed alpha-numeric code:

   Bxx (building code; B01,B02, B03 etc)
   YY (alpha teacher code: aa, ab, ac, ad, ae, af, etc)
   ZZ (year services implemented, 09 indicating services started in the fall of 2009; 10, indicating services began in the fall of 10; 00 indicates classroom is a control group)

The identified teacher consent forms will be retained by the Evaluator and stored at Ohio University. The Teacher Identification list, matching teacher names to teacher IDs will be separately stored on the evaluator’s computer in password protected file. The hard copies of the de-identified forms will be collectively stored in a locked file cabinet, following entry of the de-identified data (organized by teacher id) into a password protected database. Back up files for both the data and the IDs will be stored a separate flash drives, in a locked file cabinet. Copies of the identified Teacher Consent Forms will be returned to the consultant for inclusion in the Classroom File, maintained by the ECMH consultant, and stored at Tri-County Mental Health and Counseling Services, Inc in a locked filing cabinet.

(2) Consented teachers will be asked to complete the Teacher Opinion Scale (see Instruments, Appendix C). The ECMH consultant will provide the teacher the
form, coded by the teacher id, but also labeled with the teacher’s name on a Post-It Note to ensure the correct teacher completes the measure. Once completed, the form will be returned to the ECMH consultant, who will remove the Post-it Note and return the de-identified form to Evaluator. The hard copies will be stored in a locked file cabinet in files organized by teacher ID number, as file which will contain all de-identified teacher generated data collected across the year. Also, the data will be electronically entered in a password protected database on the evaluator’s computer.

(3) The ECMH Consultant will visit classrooms of consenting teachers and complete the DECA Reflective Checklists (see Instruments, Appendix C). The ECMH Consultant will code Reflective Checklists within the first month of school and label the form with corresponding Teacher ID Number. The ECMH Consultant will store Reflective Checklists in the Classroom File in a locked file cabinet at TCMH-CS. A de-identified copy will be given to the Evaluator, who will enter the data into a password protected database organized by teacher id number. The hard copy will be stored in a locked filing cabinet in a file identified by the teacher ID in the Evaluator’s office.

(4) The ECMH Consultant will meet with each teacher to review the Reflective Checklist results, to discuss group dynamics occurring in the class, and any teacher concerns. As a team, the consultant and the teacher will develop the Classroom Consultation Plan. The ECMH Consultant will review the plan with the ECMH Supervisor to get final approval. The ECMH Consultant will give a copy of the classroom plan to each teacher and the original will be kept by the ECMH Consultant at TCMH-CS in a locked file cabinet. The Classroom Plan will be reviewed throughout the year, tracking completion of goals, and documenting the addition of new goals. At the end of the year, a de-identified copy of the Classroom Plan, coded by the teacher ID number, will be provided to the Evaluator, who will enter the data in a password protected database, and store the hardcopy in the teacher file, in the locked filing cabinet in the Evaluator’s office.

(5) The ECMH Consultant and ECMH Supervisor will attend April or May preschool staff meetings to begin collecting the end of the year measures. Consented teachers will complete the Teacher Opinion Survey and the ODMH Teacher Satisfaction Survey, each coded with the teacher’s ID number, and labeled with a Post-It Note with the teacher’s name. The forms will be collected, Post-it Notes removed and the de-identified data will be given to the Project Evaluator, who will enter the de-identified data in the password protected database on the Evaluator’s computer. The hard copies of the forms
will be stored in a locked filing cabinet in the Evaluator’s office, filed under teacher identification numbers.

(6) The project Evaluator will schedule teachers to participate in the focus group. Consent to participate in the focus group is obtained when the classroom teachers consent to participate in the program at the beginning of the year. Participants will be given a stipend of $50 to participate. The focus group session will be recorded and verbatim transcripts will be prepared. Participant’s identity will be anonymous on the transcription. Following transcription the tapes will be destroyed. A transcript interpretation team from the Program’s advisory board will analyze the transcripts. The transcripts themselves will be stored in the locked filing cabinet in the Evaluators office, stored with a folder labeled Year One Focus Group.

(7) The Project Evaluator will give a report summarizing the results of the focus group to the Building Capacity – Raising Resiliency advisory group to inform programmatic improvements.

Teachers in Wait List Control Group

1. The ECMH Supervisor, during the programmatic overview provided at the preschool staff meetings held at the start of the school year, will also address the teachers from classrooms not slated to receive ECMH services in Year One, specifically those staffing preschool classrooms at Amesville and Coolville Elementary Schools in the Federal Hocking District of Athens-Meigs Educational Service Center, and those within the Athens City School Districts not being served in year one (The Plains and West Elementary School). ECMHC Supervisor will recruit teachers from non-targeted schools, those not receiving consultation services in Year One, to participate as a comparison classroom/wait-list control group. Teachers will have been provided an overview of the modified program for control groups during their first staff meeting. Additionally, the ECMH Supervisor will provide an overview of the research role of the comparison classrooms, answer questions and discuss the risks and benefits of consenting to serve as a comparison classroom. Teachers will volunteer and be individually consented to participate by reviewing the specifics delineated in the consent form. Comparison classroom teachers will be given a list of school and community resources available to help them with the behavioral health needs of their students (see School and Community Resource List) at the time of consent.

The identified teacher consent forms will be retained by the Evaluator and stored at Ohio University. Teacher identification numbers will be assigned; IDs will be separately stored on the evaluator’s computer in password protected file. The hard copies of the indentified forms will be collectively stored in a locked file cabinet, following entry of the de-indentified data (organized by teacher id) into a password protected database. Back up files for both the data and the IDs will be stored on...
different flash drives, in a locked file cabinet. De-identified copies of the Teacher Consent Forms will be filed under the teacher’s identification number in a locked filing cabinet in the Evaluator’s office.

2. The program Evaluator will ask consented Wait List Control teachers to complete the Teacher Opinion Scale both at the time of consent and during the last month of the school year. Additionally, the ECMH consultant will complete a DECA Environmental Reflective Checklist in the comparison classroom during the last month of the school. On each occasion, the forms provided the teacher and the consultant will be coded by the teacher ID, and labeled by the Post-It Note ensuring the forms are completed by the correct teacher or about the correct classroom. Once returned to the evaluator, the Post It Note will be removed, the de-identified data entered into the password protected database on the evaluator’s computer, and then hard copies of the forms filed in the folder labeled with the teacher’s ID.

3. The teachers consented as a Wait List Control Group will also be asked to nominate 20% of the class (ie, 3—4 children) presenting with challenging behaviors to serve as a de-identified control group. The evaluator will provide pre, mid-year, and post DECAs to the teacher, (labeled A,B,C,D) coded by the teacher id to indicate child control data. The initial data will be completed between Oct and Dec 2009, again between mid Feb and mid March, and during the last month of school. The identity of the child will only be known to the teacher who has selected the individual children who he/she will report on. A waiver of parental consent to complete these DECAs is requested, because the data serves the purpose of creating a de-identified control group. The de-identified forms will be returned to the Evaluator, hard-copies will be stored in files labeled by the teacher ID (locked filing cabinet) and the de-identified data will be entered into the password protected database on the evaluator’s computer.

4. As noted previously, the Teacher Identification list, matching teacher codes to teacher IDs will be stored on the evaluator’s computer in password protected file, separated from the data. The hard copies of the de-identified forms will be stored in a locked file cabinet, following entry of the data into a password protected database. Back up files for both the data and the IDs will be stored a separate flash drives, in a locked file cabinet.

**Child Participants:**

1. At preschool orientation for families held at the school, each consented teacher will distribute information about the ECMH program to parents and inform them about the teacher’s participation in the ECMH Program (Parent Program Overview, see recruitment materials). Parent consent for Universal Services to be
offered within preschools classroom is not required by school policy (see school district letters of committed).

2. Throughout the school year, a consented teacher may identify a child who she/he would like to be consented for individualized (e.g., targeted or intensive) services. When this occurs, the teacher will get permission from the parent/guardian to provide the parent/guardian’s contact information to the ECMH consultant. The ECMH consultant will contact the parent (via phone, written note, or face-to-face) to schedule a time to meet. At that meeting, the parent/guardian will be provided an overview of the program by reviewing the consent form and the Parent Program Overview information sheet, which will include information about the Family Navigator Program (FN brochure) and availability of specializes assessment services, two clinical aspects of the program that are not part of the research protocol. If the parent is interested, the ECMH Consultant or the ECMH Supervisor will consent his/her participation (Parent Consent Form). If they are not interested in the ECMH Program, we will offer parents contact information for the ECMH consultant should the parent can express interest in the program at a later time. Additionally a list of school and community resources will be provided to families to help them with the behavioral health needs of their children (Resource List), and the Family Navigator Program brochure.

3. The ECMH consultant and/or supervisor will collect the Parent Consent Forms and give them to the Evaluator. The evaluator will de-identify the forms and create Child ID numbers. Copies of the identified consent forms will be returned to the ECMH consultant for storage in the child’s file, maintained by the consultant and stored in a locked filing cabinet at TriCounty Mental Health Center. The Child Identification Key, matching child names to child IDs will be stored on the evaluator’s computer in password protected file, separated from the data. The hard copies of the identified consent forms will be collectively stored in a locked file cabinet by the Evaluator, following entry of the data into a password protected database. Back up files for both the data and the IDs will be stored a separate flash drives, in a locked file cabinet. Data folders will be created for each consented child that will be labeled by the child’s id number and will contain on de-identified data, including a de-identified copy of the parent consent form.

4. The ECMH Consultant will meet with the child whose parents or guardians have consented to participate, for the purpose of obtaining the child’s assent (see Child Assent Form). This process can be completed in the child’s classroom during individual active learning time when kids are selecting activities. This is a common procedure when children are working with specialists, such as speech pathologists.
De-identified copies of the child assent forms will be stored by the Evaluator in a locked filing cabinet in files created under the child’s identification number. The identified assent forms will be collectively stored in a locked filing cabinet file in the Evaluator’s office, separated from the Child Identification Key. After consent and assent are obtained, the child’s teacher and parent will complete the Devereux Early Childhood Assessment (DECA) which will be scored by the ECMH Consultant. (see DECA, Instruments). DECA will be provided by the Evaluator to the ECMH consultant such that the form is coded by the child id, but also labeled with the child’s name on a Post-It Note to ensure that the teacher completes the measure for the correct child. Once completed, the forms will be returned to the ECMH consultant, who will remove the Post-it Note, make a copy for her file stored at TCMH-CS, and return the de-identified form to Evaluator. The original de-identified hard copies will be stored in a locked file cabinet in files organized by student ID number and the de-identified data will be electronically entered in a password protected database on the evaluator’s computer. This process is repeated at the end of Feb and again in May/June of the school year.

5. The ECMH Consultant will review the clinical data obtained from DECAs, combine it with parent and teacher observation to create individually tailored service plan for the child. Clinical services offered may also include referrals for additional assessments from the school assessment team, the local Interdisciplinary Assessment Team, or other independent clinicians in the community. The ECMH Supervisor will review the intervention plan before it is finalized. The ECMH Consultant maintains a clinical file for each child receiving individually tailored interventions which will contain the Consent Form, the Assent Form, DECA’s, and related clinical information. The ECMH Consultant will store files in a locked file cabinet at TCMH-CS. The ECMH Consultant will conduct classroom activities as indicated on the individual intervention plan. The Consultant will communicate progress with the teacher during classroom visits and with the parent via phone, notes, and face-to-face meetings. Based on the child’s progress, an intervention plan may be amended during a meeting between the ECMH Consultant, teacher, and parent. The team may decide that a child would benefit from intensive mental health services, at which point, formal enrollment as a client of the community mental health center would be required.

6. In May, the Evaluator will provide the ECMH consultant an envelope containing the ODMH Parent Satisfaction Survey. The Survey within will be coded by the child’s identification code. The parents name will be on the exterior of the envelop on a Post It Note. The survey will be returned in the sealed envelope to any of the program staff, who will return it to the Evaluator.
The de-identified satisfaction survey will be file in the student file, stored by the Evaluator in a locked filing cabinet. And the de-identified data will be entered into the password protected database on the Evaluator’s computer. In May, the teacher and parent will complete the DECA. The ECMH Consultant will meet with the teacher and parent to review the child’s progress. Based on this review, services may end. If there is a need for continued services then the team will develop a transition plan which may include participation in the Incredible Years summer program.

7. The ECMH Consultant will invite parents who have consented to participate in services during the school to join a summer group called the Incredible Years Program, offering a children’s DINA program and a parenting program. Both programs will convene in summer of 2010. The ECMH supervisor offering the IY program for parents will be provided by the Evaluator the IY Parenting Skills Questionnaire that is coded by the child’s id, but also labeled with the child’s name on a Post-It Note to ensure that data collected is filed under the correct child. Once completed, the forms will be returned to the ECMH consultant, who will remove the Post-it Note, makes a copy for her file stored at TCMH-CS, return the de-identified form to Evaluator. The original de-identified hard copies will be stored in a locked file cabinet in files organized by student ID number and the de-identified data will be electronically entered in a password protected database on the evaluator’s computer. This process is repeated at the end of the six session summer program. In addition, the Evaluator will provide the ECMH consultant leading the children’s group, the DINA School Questionnaire at the last session for parents to complete. The form will be labeled with the student ID, and a Post It Note will provide the child’s name, so it is given to the correct parent for completion. The completed forms will be collected by ECMH consultant, who will remove the Post-it Note, makes a copy for her file stored at TCMH-CS, and returns the de-identified form to Evaluator. The original de-identified hard copies will be stored in a locked file cabinet in files organized by student ID number and the de-identified data will be electronically entered in a password protected database on the evaluator’s computer.

8. Participation in voluntary and parents may choose to withdraw their child from the program at any time during the year with no consequences simply by informing the ECMH Consultant, the teacher, or the ECMH Supervisor who will subsequently inform all remaining members of the team. A signature will be obtained from the parent when possible.
Describe any potential risks or discomforts of participation and the steps that will be taken to minimize them.

Teachers may experience discomfort when receiving direct instruction from a mental health professional in his or her classroom. Mild embarrassment may be experienced. To minimize these risk, the ECMH consultant will work cooperatively with the teacher on goals to improve teacher-identified areas of weakness. Additionally, teaching and feedback strategies will be jointly developed to ensure the teacher is held in the best light in the classroom and in front of the children. One common strategy is to schedule time to discuss challenging moments that fall outside of the time children are in the classroom.

On the whole, targeting behaviors warranting intervention are typically more notable by peers than the interventions established to improve functioning in the classroom. Children who receive targeted or intensive services from the early childhood mental health consultant and/or the teacher, may experience some embarrassment or they may be the target of peer teasing or possible social isolation. To further minimize the potential risks, programs will be developed that positively reinforce desired behaviors and ignore problematic behaviors.

Parents who consent to services may also experience discomfort when enrolling their family for either targeted early childhood mental health consultation services or intensive mental health intervention, as enrollment involves identifying oneself as needing help. Meeting held with families will be held at jointly negotiated times to protect their confidentiality and ensure sufficient privacy for conversation and consultation.

Describe the anticipated benefits to the individual participants. If none, state that. (Note that compensation is not a benefit, but should be listed in the compensation section on the next page.)

Teacher participants are anticipated to gain behavior management skills and increased knowledge about behavior, child development and the effect of the environment and management skills on children’s learning, growth and development.

Child participants are anticipated to gain improved self-management skills, increased attachment, and increased ability to self-initiate activities. This may be evidenced by improved peer relationship, improved relationships with adults and reduced challenging behaviors.

Parents are anticipated to gain increased knowledge about behavior and development, improved skills for managing behaviorally challenging behaviors and strategies for supporting socio-emotional development.

Describe the anticipated benefits to society and/or the scientific community in lay language. There must be some benefit to justify the use of human subjects.
The anticipated benefit to society is to optimize developmental outcomes for children and to strengthen the capacity of the early childhood workforce to foster optimal development. Implementation of ECMH consultation aims to prevent behavioral problems and/or reduce the morbidity associated with behavioral problems.

Please discuss the confidentiality level for the data collected. For example, indicate whether records will be labeled with the subject’s name, or whether they will be labeled with a code number. If code number used, provide detail about the key that links name and code number (where stored/when destroyed, etc.).

Identification codes will be established to ensure the data is de-identified when stored and analyzed by the evaluator. Teacher identification codes will be established for both teachers in classrooms receiving services and for teachers serving as a control group. Buildings will be assigned numbers by the Evaluator. Teacher number will be assigned at the time of consent. The following procedure will be used to assign the mixed alpha-numeric code:

**Bxx** (building code; B01, B02, B03 etc)

**YY** (alpha teacher code: aa, ab, ac, ad, ae, af, etc)

**ZZ** (year services implemented, 09 indicating services started in the fall of 2009; 10, indicating services began in the fall of 10; 00 indicates classroom is a control group)

Ex: building three, fifth teacher consented in 2009 would be: B03ae09

Child identification codes will be created by adding a “one alpha, two digit” child identification to the existing identification code for the teacher resulting in the child identification of: Syy (numeric student code: 01, 02, 03 etc)

Ex: The first child consented is in building three, with the fifth teacher consented in 2009 would be: B03ae09501

The two masters, the Teacher Identification Key and the Student Identification Key, will be stored by the Evaluator, separated from any identified data (ie consent forms). Original consents and assents will be the only forms which contain identification stored by the Evaluator. These will be stored in a locked filing cabinet. De-identified teacher data (Teacher Opinion Scales, DECA Reflective Checklists, Classroom Plan, satisfaction surveys) will be filed under the Teacher IDs. De-identified student data (DECAs, parent satisfaction surveys, Incredible Years data) will be filed under the student ID. Because the codes are linked, the classroom data can be readily merged with the student data for analyses.

Paper forms will be stored in a locked filing cabinet. The Identification Keys and the database will be electronically stored in a password protected file on the Evaluator’s computer.

When clinical measures are distributed by the Evaluator to the ECMH consultant or supervisor, they will be labeled with the teacher or student identification number. The forms will also have a Post It note on the front, ensuring that the appropriate person completes the distributed form. The Post It notes will be removed prior to returning the data to the Evaluator. The identification numbers on the copies of forms maintained by TCMH for clinical purposes will be blacked out, so we do not create a key linking the
code to the teacher or student names. Clinical forms retained by TCMH will be stored in a locked filing cabinet at TCMH, governed by the agencies policies and procedures. The focus group transcript from the summer evaluation session will be fully de-identified, with a hard copy stored in a locked filing cabinet, and the electronic copy saved in a password protected file on the Evaluator’s Computer. Following completion of the Focus Group report, which is disseminated the project’s advisory council, the tapes will be destroyed by the Evaluator.

**With whom will identifiable data be shared outside the immediate research team? For each, explain confidentiality measures.**

Identifiable data that has been generated by teachers, parents, and the ECMH consultant program staff will be exchanged between those individuals for the purposes of implementing the program.

Identifiable data will not be shared with anyone outside the immediate research team.

**Will participants be: Audiotaped?**

- Yes Focus Group evaluation sessions with the teachers will be audiotaped and transcribed; once transcribed the audiotapes will be destroyed.

**Videotaped?**

- Yes
- No

If so, describe how/where the tapes will be stored (i.e. locked file cabinet in investigator office), who will have access to them, and an estimate of the date they will be destroyed.

The focus group audiotape will be stored in a locked filing cabinet in the PI’s office at Ohio University. Transcription will be performed by the OU administrative assistant of the PI.

**Will participants receive any compensation (money, course credit, gifts)? yes**

**If so, please detail amount/session and total compensation possible. Additionally, describe what compensation amount is paid to participants who discontinue participation prior to completion.**

This three-year grant integrates early childhood mental health consultants into public preschool classrooms. Classroom participation is incented; participating classroom will be paid $300 each if services are active and $150 if serving as a wait list control group, paid following consent to participate. This payment is made at the beginning of the year so the money can be spent on classroom resources. It is not paid back if the program is prematurely terminated or if teachers withdraw consent to participate.

Focus groups involving teachers will be moderated by the Evaluator at the end of the 2009 – 2010 school year, and at the end of the 2010 - 2011 school year. Focus group participants are the classroom staff who worked with the early childhood mental health consultant. Focus group participants will be paid $50 each. (goal 10 participants in each
focus group.) Payment follows completion of the program so there is not a scenario requiring repayment, or reduced payment.

The Incredible Years Program – DINA, an evidenced-based group treatment program focused on building social skills and anger management skill will be offered during the Summers of 2010, and 2011. Backpacks with back-to-school supplies will be given to the Incredible Years Program participants who complete the six session curriculum, each valued at approximately $10.00. Payment follows completion of the program so there is not a scenario requiring repayment, or reduced payment.

* If University funds are used to compensate participants, minimally, the name and address of participants will need to be provided to the Finance Office at OU. If participants will be paid $100 or more in a calendar year, participant social security numbers must be provided to Finance. The consent form must reflect this.
Instruments

List all questionnaires, instruments, standardized tests below, with a brief description, and provide copies of each, labeled as APPENDIX C.

1. Teacher Opinion Survey (Completed pre/post by the teacher) is a 12-item survey instrument designed to assess teacher self-perception regarding teacher ability to affect the lives of children in the classroom. Items ask about the teacher's confidence in his/her ability to manage challenging behaviors, to respond effectively, and to influence the child's development. Items are scored on a 1 -5 Likert Scale.

2. Devereux Early Childhood Assessment (DECA) Reflective Checklists for Teachers (Completed pre/post by the ECMH consultant) is a part of the DECA system designed to assess how well the learning environment promotes resiliency. It contains 54 items divided into the following categories: the physical environment, the daily program, the activities/experiences, the teacher’s supportive interactions, and the efforts to partner with families. The tool is designed as a checklist. Unmastered items provide potential opportunities for consultation intervention with the teacher.

3. Classroom Consultation Plan (Completed by the teacher and the consultant) is a tool designed specifically for this project. It measures objectives to be achieved through work with the consultant, strategies for achieving the objectives, and the amount of time the consultant will spend with the teacher toward those objectives. Objectives will be developed from the results of the Reflective Checklists, Consultant Observations, and the teacher’s own professional development requests. The percent of objectives achieved during the school year will be tracked as an indicator of the success of the consultation services with the teacher.

4. ODMH Teacher Satisfaction Survey (Completed by the teacher at the end of the year) is a form designed by the Ohio Department of Mental Health for the Early Childhood Mental Health Initiative to be used to measure satisfaction of the teacher with the consultation services. It contains 11 items that are ranked as “strongly agree, agree, unsure, disagree, strongly disagree, and not applicable”. It also contains an open-ended section for teacher comments.

5. Devereux Early Childhood Assessment (DECA) Questionnaire (Completed by teacher and parent following consent and assent to participate pre/post) is a part of the DECA system designed to assess resiliency factors for individual children. It is a standardized, norm-referenced behavior rating scale with 27 items that evaluate the frequency of positive behaviors and 10 items that measure the presence of challenging behaviors.

6. Incredible Years (IY) Parent Scale (Completed by parents participating in the
IY program, pre/post) is a 13 item Likert scale measuring a parent’s reported use of positive parenting practices which will be addressed during the IY program.

7. Incredible Years (IY) Dina School (Completed by parents of children participating in the IY program) is a 9 item Likert Scale measuring a parent’s report of their child’s progress as a result of participation in the IY Dina School program.

8. ODMH Parent Satisfaction Survey (Completed by parents) is a form designed by the Ohio Department of Mental Health for the Early Childhood Mental Health Initiative to be used to measure satisfaction of the parent with the consultation services. It contains 10 items that are ranked as “strongly agree, agree, unsure, disagree, strongly disagree, and not applicable”. It also contains an open-ended section for teacher comments.

How will the data be analyzed? If applicable, state the hypothesis and describe how the analysis of the data will test that hypothesis.

The objective of this research study is to evaluate whether the implementation of the early childhood mental health consultation program affects child behavior outcomes and teacher confidence to manage challenging behaviors. We hypothesize that students receiving individualized services through the early childhood mental health consultation program will evidence more positive change on the resiliency ratings and greater reduction in the challenging behaviors (both measured by the DECA) than students in the wait-list control group. We also hypothesize that teachers receiving services through the early childhood mental health consultation program will evidence greater gains in self-perceived confidence to manage challenging behaviors in the classroom as measured by the Teacher Opinion Scale than teachers in the wait-list control group.

We will employ a repeated measure design for the student data, collecting parent and teacher behavioral rating for each student receiving individualized services three times across the school year. Teacher ratings will be collected at the beginning and end of the school year. The method of analysis will be Hierarchical Linear Modeling (HLM), which is selected because the design violates the assumptions of independence of observations (data collection points nested within students within classrooms). For the student data, we will employ the Individual Growth Curve Model which will yield estimates (fixed and random) of initial status and rates of change in challenging behaviors. An Alpha of .05 is established as our level of statistical significance. Mixed Effect Modeling in SAS version 9.1 (PROC MIXED) will be used to conduct data analyses.

Informed Consent Process
Are you requesting a waiver or alteration of Informed Consent? x Yes No
Full consent, secured by signatures is proposed for teachers, parents and children (assent) who are located in classrooms which are receiving ECMH services.

Full signature consent is proposed for teachers in classrooms that are serving as control groups. We are requesting permission to waive parent consent for the collection of child de-identified DECAs, completed by the teacher, for 3–4 children in each control classrooms.

(If yes, check one, and answer a - e)

☐ Waiver of signature
☐ Deception (incomplete disclosure)

X Complete Waiver of consent is requested for only one aspect of the full program. We are requesting permission to waive consent by parents for the teachers, who are consented for participation in the classroom not receiving services, to complete the Devereux Early Childhood Assessment (DECA) on 3–4 unidentified children in the classroom who presents with challenging behaviors. DECAs will be completed by December 2009, and again in Spring of 2010, by the teacher. The child’s identity will not be known to the ECMH consultant, supervisor or program evaluator.

a. Provide justification for the waiver.

This data will serve as a de-identified child control group.

b. Describe how the proposed research presents no more than minimal risk to participants.

The DECA will be completed by the teacher, however the scoring of the measure will not be shared with the teacher, thus communicating no meaningful information to the teacher that may affect her manner with the child he/she selected.

Since the teacher is self-nominating the child and able to complete the measure privately, no public identification of the child occurs. The completion of the DECA does not preclude the teacher from discussing her concerns about the child’s behavior with the parent, nor advising the parent about further evaluation or treatment options.

c. Why will a waiver of informed consent not adversely affect the rights and welfare of participants?

The young child will be unaware the data was collected. Parent rights and the welfare of the child are not adversely affected given the administrative process collecting control group data.
d. Why is it impracticable to carry out the research without a waiver or alteration of informed consent?

Parental consent would require the teacher to inform the parents of the child's behavioral presentation in the classroom, request permission to provide contact information to the program supervisor and/or evaluator for the purpose of scheduling a meeting to consent the parent. It may or may not have been the teacher's intention to otherwise make contact with the parent surrounding the child's behavioral presentation in the classroom.

The contact with the mental health professional and/or program evaluator is judged to create greater discomfort and, given that services can not be provided through the Early Childhood Mental Health Consultation Program for the child identified to be the control classroom, that process does not result in access to services other than those typically available to families in the community. Resources provided to the Teachers at the point of the consenting to serve as a Comparison Classroom do provides a mechanism for referral, and increase the teacher's access to referral information.

e. How will pertinent information be provided to participants, if appropriate, at a later date?

The data will be completely de-identified, so the results of an individual's child DECA would not be able to be shared at a later point.

Even if waiver of written informed consent is granted, you will likely be required to obtain verbal permission that reflects the elements of informed consent (if appropriate). Please specify below information to be read/given to participants.

n/a

Attach copies of all consent documents or text and label as APPENDIX A. Please use the template provided at the end of this document.

Informed consent is a process, not just a form. Potential participants/representatives must be given the information they need to make an informed decision to participate in this research. How will you provide information/obtain permission?

How and where will the consent process occur? How will it be structured to enhance independent and thoughtful decision-making? What steps will be taken to avoid coercion or undue influence?
Teacher consent is scheduled to occur during the initial preschool teacher staff meeting. Time will be set aside allowing for individualized review of the consent form with teacher who are voluntarily participating in the program. If addition time is needed for further questions, then TCMH staff is able to meet individually with the teacher at his or her school.

The preschool teachers, their supervisors, and administrative personnel in the school districts have participated in the development of the grant application. This involved review of the proposed program, which was presented by the ECMH supervisor. As such, staff who have participated in those meetings have a reasonable understanding of what is proposed; new staff may request more time to evaluate his or her interest in participating.

Initial contact with parents or guardians of the students referred for individualized intervention by the classroom teachers can occur through notes, phone calls, or face-to-face meetings. Consent, however, requires a face-to-face meeting which will ideally take place at the school. At the beginning of the year, families will have received a Program Overview handout informing families that the ECMH consultant will be present in the classroom and working with the teacher. At the point of consent, the purpose of the program, what the project involves, how information will be kept confidential, how information will be communicated between the agencies participating (school district, TCMH, and Ohio University), the potential risks and benefits, compensation, and that participate is a voluntary decision and that the can withdraw consent at any point by informing the ECMH consultant, teacher or supervisor. If a parents withdraws, the ECMH staff will obtain a signature from the parent reflecting their decision.

**Will the investigator(s) be obtaining all of the informed consents? X No**

If not, identify by name and training who will be describing the research to subjects/representatives and inviting their participation?

The consents will be obtained by the ECMH Consultant (listed as a research assistant), her supervisor (listed as a co-investigator) and the Evaluator (listed as Principal Investigator). All have completed IRB, all have a minimum of master’s level educational preparation. Both co-investigators are independently licensed mental health professionals.

**Will all adult participants have the capacity to give informed consent? If not, explain procedures to be followed.**

Yes.

**If any participants will be minors, include procedures/form for parental consent and for the assent from the minor.**

The students who will be receiving individualized services through the ECMH consultation program will be preschoolers, typically three or four years of age. An assent form is attached, which focuses on introducing the ECMH consultant to the child. This individual should be familiar to the child because she will have been working with the
classroom teacher since the time the teacher consented to participate. The assent form uses a story board to introduce the idea of the child working with the consultant to help him manage his feelings and helping him have fun at school. Students will indicate assent by marking or coloring a smiley face of the form. The child is assenting to talking and playing with the ECMH consultant (see Child Assent Form).

Given the very young age of participants it is not judged appropriate to seek assent regarding the broader construct of resiliency, learning, the relationship between the participating organizations, or the supervisory relationship between the ECMH consultant and the ECMH supervisor. Those details are delineated in the parent consent process, which will always precede seeking the child’s assent.

The child will typically be assented in the classroom during individual active learning time when kids are selecting activities. This is a common procedure when children are working with specialists, such speech pathologists.

Initial contact with parents or guardians of the students referred for individualized intervention by the classroom teachers can occur through notes, phone calls, or face-to-face meetings. Consent, however, requires a face-to-face meeting which will ideally take place at the school. At the beginning of the year, families will have received a Program Overview handout informing families that the ECMH consultant will be present in the classroom and working with the teacher. At the point of consent, the purpose of the program, what the project involves, how information will be kept confidential, how information will be communicated between the agencies participating (school district, TCMH, and Ohio University), the potential risks and benefits, compensation, and that participate is a voluntary decision and that can withdraw consent at any point by informing the ECMH consultant, teacher or supervisor. If a parent withdraws, the ECMH staff will obtain a signature from the parent reflecting their decision when possible. (Parent Consent Form)

**Will participants be deceived or incompletely informed regarding any aspect of the study?**

☐ Yes  ☒ No

If yes, provide rationale for use of deception.

n/a

If yes, attach copies of post-study debriefing information and label as APPENDIX D. Additionally, complete the questions related to a consent form waiver or alteration on page 9.

n/a
Investigator Assurance

I certify that the information provided in this outline form is complete and correct.

I understand that as Principal Investigator, I have ultimate responsibility for the protection of the rights and welfare of human subjects, conduct of the study and the ethical performance of the project.

I agree to comply with Ohio University policies on research and investigation involving human subjects (O.U. Policy # 19.052), as well as with all applicable federal, state and local laws regarding the protection of human subjects in research, including, but not limited to the following:

- The project will be performed by qualified personnel, according to the OU approved protocol.
- No changes will be made in the protocol or consent form until approved by the OU IRB.
- Legally effective informed consent will be obtained from human subjects if applicable, and documentation of informed consent will be retained, in a secure environment, for three years after termination of the project.
- Adverse events will be reported to the OU IRB promptly, and no later than within 5 working days of the occurrence.
- All protocols are approved for a maximum period of one year. Research must stop at the end of that approval period unless the protocol is re-approved for another term.

I further certify that the proposed research is not currently underway and will not begin until approval has been obtained. A signed approval form, on Office of Research Compliance letterhead, communicates IRB approval.

Primary Investigator:

(please print name) Jane Hamel-Lambert, PhD

Co-Investigator:

(please print name) Sherry Shamblin, PCC-S

The following three consents follow:

Parent Consent
Child Assent
Teacher Consent
Building Capacity-Raising Resiliency: Parent Consent

Principal Investigator: Jane Hamel-Lambert, Ph.D.
347 Grosvenor Hall, Ohio University, Athens, OH 45701, 593-2289

Co-Investigator: Sherry Shamblin PCC-S
90 Hospital Drive, TCMH, Athens, OH 45701, 592-3091

2009-2010 PARENT CONSENT FORM AND RELEASE OF INFORMATION

What is the purpose of this program? We want to find out if preschool children who receive early childhood mental health consultation services show more initiative, have better self-control, and get along better with adults and other children, and have fewer challenging behaviors. We also want to find out if teachers who work with an early childhood mental health consultant report greater confidence in their skills to work with children who have challenging classroom behaviors.

What will the program involve? This project is a joint project between Ohio University, Tri-County Mental Health and Counseling (TCMHC), and your child’s school. Since the beginning of the school year, Valerie Wang, MEd has been working with your child’s classroom teacher. She is an Early Childhood Mental Health Consultant trained to help teachers create a classroom environment that best supports your child’s development. The Early Childhood Mental Health Consultant is also able to work individually with children if parents consent to be part of the program and the evaluation of those services.

As part of the project, you and your child will participate in a behavioral assessment to determine areas for improvement. This will include you and your child’s teacher completing a behavioral questionnaire about your child; this form is called the DECA. The early childhood mental health consultant from TCMHC will do a classroom observation. The consultant will review these with her clinical supervisor then discuss the results with you and your child’s teacher. Next, you will all work together to develop a classroom intervention plan for your child. The consultant and the teacher will work with your child in the classroom using the interventions listed on his/her plan you have helped develop. The consultant and teacher would like to meet with you regularly to review progress and update this plan. You can also request a meeting with them at any time. If your child needs additional help meeting his goals, you will be given information about resources and assessments that might be helpful and assistance in accessing these services.

Again in February and at the end of the school year, you and the teacher will be asked to complete the behavioral questionnaire, just like the first one, to find out if your child’s behaviors are improving. You will also be asked to complete satisfaction surveys at the end of the year. If you are interested, you and your child can participate in a summer program, called the Incredible Years that helps children learn self-control skills and helps parents learn new strategies for challenging behaviors. On completion of the
summer programs, you family will receive a backpack filled with back-to-school supplies valued around $10.

By consenting for both you and your child to participate in this project you are also giving permission for (1) the ECMH consultant from Tri-County Mental Health, her clinical supervisor, and teacher to exchange information that may assist with classroom strategies, (2) the Evaluator from Ohio University, the consultant, and her supervisor to share information for the analyzing whether or not the program met our goals of improving your child’s behavior and increasing the teacher’s confidence. The information shared with the evaluator is done in a manner that protects your confidentiality. Forms will be coded by a unique number that identifies your child, without having your child’s actual name on the form.

**How will information be kept private?** All information that we gather from parents, teachers, and the school will be kept strictly confidential or will be disclosed only with parental permission. Children’s names and parents’ names will not appear on any of the project materials; instead each child will be assigned a code number that will identify the materials, as explained above. The information being used to evaluate the program’s effectiveness will be stored by the Evaluator at Ohio University in a locked filing cabinet. This would include the teacher and parent DECA forms, your Satisfaction Survey, and evaluation forms from the summer program, which is called the Incredible Years (IY) Program. The IY Questionnaires ask about your parenting skills and your child’s behaviors.

The consultant will keep copies of these materials and any additional information used to developing individualized intervention for your child. This information will be stored at Tri-County Mental Health Center and Counseling Services, Inc. The confidentiality of this information is protected. While not expected, the consultant, her supervisor, or the evaluator are required to break confidentiality if safety issues arise (a child is at risk of hurting himself or others, child abuse is discovered, etc.)

**What are the potential risks?** All of the strategies we are using in this project have been used safely and effectively with other preschool children. However, there may be a few risks to children participating in this project.

1. First, children will participate in assessments and classroom strategies designed to help them to make changes in their behavior. At times, children may think that these strategies are difficult and may become stressed by the challenge of trying to change their classroom behavior.

2. Teachers and other school staff will be involved in the assessments and interventions. They will know that your child is participating in the program. It is also possible your child’s classmates may learn about his/her participation and he/she may feel embarrassment.

3. It is common for behavior problems to temporarily get worse before getting better. If your child’s behavior worsens beyond a two-week period, you will be informed and will be provided with referral information if appropriate.
**Where are the benefits?** Although not guaranteed, benefits that may be reasonably expected for your child are:

1. Improved relationships with teachers and classmates
2. Increased self-control skills

You may benefit from:

1. Better understanding of your child’s social/emotional development and what you can do to support it.
2. Better understanding of your child’s challenging behaviors and what you can do to help

Finally, information that is obtained from this project may be useful scientifically and possibly helpful to others.

**Is my child required to participate?** Your participation is voluntary and will not bias present or future relationships with the preschool or any community agency, and will not influence the care that is otherwise available to you or your child in the school or community. If you consent to participate, you are free to stop participation at any time without prejudice.

If I have any concerns regarding this program, now or during the course of the program, I may contact Dr. Jane Hamel-Lambert, 740-593-2289 or Sherry Shamblin, PCC-S at 740-592-3091. Additionally, if I have any questions regarding my child’s rights as a research participant, I may contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, 740-593-0664.

I certify that I have read and understand this consent form. I agree to allow myself and my child, ____________________________, of whom I am legal guardian, to participate in the project described. I agree that the known risks to my child have been explained to my satisfaction. I understand that my child will be asked if he/she wants to participate and must agree to participate before he/she completes any part of the project. Further, I understand that no compensation is available from Ohio University or Tri-County Mental Health and Counseling, Inc. for any injury resulting in my participation or my child’s participation in this research. Finally, I certify that my participation and my child’s participation in this research is given voluntarily and I understand that I and/or my child may discontinue participation at any time without penalty or loss of benefits to which I or my child may otherwise be entitled.

My signature below means that I have freely agreed to have my child take part in this project and that I have given my permission for my child’s teacher and school to release/exchange any and all information regarding my child’s behavior and academic performance with TCMH and Ohio University. I understand that I need to complete the DECA during the three assessment time points so that project staff will have updated information on my child’s behavior and that I will be asked to complete a satisfaction survey at the end of the school year. If I participate in the Incredible Years summer program, I will complete the questionnaires associated with that program. I certify that I have been given a copy of this consent to take with me.
<table>
<thead>
<tr>
<th>Child’s full Name (Print)</th>
<th>Child’s Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>
Child Assent Form: Child’s Name __________________________________________

Being a kid isn’t always easy.

Sometimes kids get mad or have a hard time following the teacher’s words.

My job is to help kids with their feelings and to have fun at school.

So we can do that. I would like to play with you in your class.

If that’s ok with you, color the happy face. If it’s not ok with you, color the frowny face.
Building Capacity-Raising Resiliency: Teacher Consent

Principal Investigator: Jane Hamel-Lambert, Ph.D.
347 Grosvenor Hall, Ohio University, Athens, OH 45701, 593-2289

Co-Investigator: Sherry Shamblin PCC-S
90 Hospital Drive, TCMH, Athens, OH 45701, 592-3091

2009-2010 TEACHER CONSENT FORM

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the program is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

What is the purpose of the program?

Building Capacity – Raising Resiliency is aimed at improving early childhood outcomes and increasing the capacity of early childhood educators to address mental health issues in the classroom. This will be accomplished through the implementation of an Early Childhood Mental Health consultation program (ECMH-CP) in public preschools. The Early Childhood Mental Health Consultation program consultant and supervisor (aka Co-Investigator) are employees of Tri-County Mental Health and Counseling Center Inc. The Principal Investigator, who serves as the program evaluator is an employee of Ohio University. Thus the project is a partnership between your school, TriCounty Mental Health and Ohio University.

Consultation services offered through Building Capacity – Raising Resiliency will provide universal (delivered by the teacher for all the children in the class), targeted (delivered by the teacher in the classroom to meet the needs of a specific child) or intensive (delivered by a specialized professional to meet the needs of a specific child enrolled as a client the local community mental health center, which may include a classroom component) interventions.

Parents and families of young children consenting to individualized services will also be offered health education through the Family Navigator Program to build awareness, increase understanding of his/her child’s behavioral problems and facilitate participation in recommended services. Additional evaluation services may also be offered to children receiving intensive services through a local psychologist, who will work cooperative with the classroom teacher and school psychologist (as authorized by the family) to ensure the child’s educational needs are being fully accommodated.
The Building Capacity – Raising Resiliency program involves a research and evaluation component. Specifically we are interested in evaluating whether having an early childhood mental health consultation program in preschool classrooms improves teacher skills (i.e., building capacity) and improves child outcomes for students receiving individualized services (i.e., raising resiliency). Staggering the start of services across the three years of the project allows us to compare the outcomes of the classrooms receiving services with the outcomes in the classrooms not receiving services. The classroom not receiving services, but agreeing to participate, serve as the Wait List Control classrooms. Building Capacity – Raising Resiliency is a three year (May 2009 – April 2012) grant funded project.

**Teachers with Early Childhood Mental Health Consultation Program services:**

**Teachers in preschool classrooms in Chauncey, Alexander, and Trimble are eligible to consent to participate with active services.**

9. Teachers who consent to participate will be asked to complete rating scales. The Teacher Opinion Scale (TOS) is completed twice, at the time of consent and during the last month of school. The TOS is a 12-item survey instrument designed to assess teacher self-perception regarding teacher ability to affect the lives of children in the classroom. Items ask about the teacher's confidence in his/her ability to manage challenging behaviors, to respond effectively, and to influence the child's development. The Teacher Satisfaction Survey is completed during the last month of school. This measures satisfaction with the consultation services.

10. The Early Childhood Mental Health Consultation Program offers universal services to the classroom and teacher. In the fall teachers agree to meet with the Early Childhood Mental Health consultant to discuss results of the DECA Reflective Checklist for teachers, their own observations about the classroom and then develop a Classroom Plan with goals and objectives which they are agreeing to implement and track across the academic year.

11. The Early Childhood Mental Health Consultation Program offers individualized services to child when parents give consent. Teachers, who are working with the consultant, agree to facilitate enrollment of students in individualized services when they are concerns about challenging behaviors in the classroom. Teachers are asked to initially discuss concerns with the child’s parents, and when interested provide parents with the contact information for the ECMH consultant. If a child in a classroom is consented for individual services, the teacher agrees to complete behavioral rating scales three times during the school year (at consent, Feb-Mar, May-June)

12. Teacher who consent to participate agree to participate in a focus group session
conducted in early summer to evaluate the program, to be organized by the project evaluator. Your input will be used to make improvements in the design and implementation of Building Capacity – Raising Resiliency in subsequent years, as well as provide information for others designing and implementing similar programs.

**Teachers in Wait List Control Classroom:**

**Teachers in preschool classrooms in Amesville, Coolville Elementary, The Plains and West Elementary can consent to participate in Year One as wait-list control groups.**

13. Teachers who consent to participate as a Wait List Control classroom will be asked to complete rating scales. The Teacher Opinion Scale is a 12-item survey instrument designed to assess teacher self-perception regarding teacher ability to affect the lives of children in the classroom. Items ask about the teacher's confidence in his/her ability to manage challenging behaviors, to respond effectively, and to influence the child's development. This is completed twice; once at the time of consent, and again during the last month of school.

14. Teachers who consent to participate as a wait list control group also agree to complete behavioral checklists on children who present with challenging behaviors in the classroom. Because these children will not being receiving any services, the identity of the selected children will only be known to the teacher. Consented teachers will be asked to complete the behavioral checklist on 3 or 4 children (20% of the classroom) three times across the year: at the time of consent or prior to December 1st, between mid Feb and mid March, and during the last month of school. Teachers will be required to remember which students were selected, and to complete the repeated measures on the same individuals. Because the identity of those individuals will not be known to the evaluator, the teacher will work with the evaluator to design a strategy for ensuring accurate data collection. To help families access needed or recommended services, teachers will be given a list of school and community resources available to help them with the behavioral health needs of their students.

15. Teachers who consent to participate as a wait list control group also agree to allow the Early Childhood Mental Health consultant observe the classroom during the last month of school to complete the Devereux Early Childhood Assessment (DECA) Reflective Checklists for Teachers. The Reflective Questionnaire is a part of the DECA system designed to assess how well the learning environment promotes resiliency. It contains 54 items divided into the following categories: the physical environment, the daily program, the activities/experiences, the teacher’s supportive interactions, and the efforts to partner with families.
Risks and Discomforts

There are few risks to teachers participating in this project. Teachers may find that completing the individual assessment measures takes a portion of their planning and paperwork time and that the task of completing the measures is not enjoyable. Teachers in the Early Childhood Mental Health Consultation Program may find some aspects of the classroom interventions challenging to implement. However, all strategies used in the program have been used with other teachers in preschool classrooms. Most teachers report that they find the strategies to be useful. Additionally, teachers may experience more frequent parent interactions in order to answer parent questions related to the program and as part of the project. However, many teachers find these more frequent parental interactions lead to a more collaborative relationship between the parents and themselves.

Benefits

Potential benefits to Teachers in the Early Childhood Mental Health Program may include a reduction in stress, a reduction in disruptive behavior in the classroom, improved resiliency factors for children in their class, and improved relationships with children and families participating. Finally, information that is obtained from this project, as well as lessons learned, may be useful to others engaged in early childhood mental health consultation programs.

Confidentiality and Records

Ohio University’s employee Jane Hamel-Lambert, PhD is the Evaluator for this project. All information gathered from teachers and the school will be kept strictly confidential. Teachers’ names will not appear on any of the project materials; instead, each teacher will be assigned a code number that will be used to identify materials. Similarly, consented students are assigned a code to protect the confidentiality.

De-identified teacher data (all teachers: Teacher Opinion Scales, DECA Reflective Checklists; teachers with active services: Classroom Plan, satisfaction surveys) will be filed under the Teacher IDs. De-identified student data (DECAs on all, and parent satisfaction surveys, Incredible Years data for consented students) will be filed under the student ID. In the wait list control group, students are not identified, not consented and therefore no student ids are assigned. Data entered into the database for analysis will be protected by a password; paper forms will be stored either by teacher id or student id by the evaluator.

Teachers whose classroom received services through the ECMH program will be asked to participate in a focus group to evaluate the program. The focus group will be digitally recorded and transcribed. Prior to transcription that digital recording will be kept in a locked filing cabinet in the evaluator’s office. The transcripts will be fully de-identified so that no names are in the transcript, which will be stored in a locked filing cabinet and electronically saved in a password protected file on the Evaluator’s Computer. The digital tapes will be destroyed.
disseminated the project’s advisory council. The evaluation aspect of this program involves the completion of 3 assessments and the implementation of a classroom plan. Student data is collected only those whose parents consent for individualized services. Teachers agree that scientific data not identifiable with any persons in the project may be presented at meetings and published so that the information from the project can be useful to others. Because the program is funded by the Federal Office of Rural Health Policy, a branch of the HRSA, progress reports requiring indicators of program progress are reported annually. Copies of the progress reports will be made available to any participate on request to Jane Hamel-Lambert or Sherry Shamblin.

**Compensation**

Teachers who consent to participate and work with the ECMH Consultant will receive $300 to use for classroom resources at the time of consent. Those teachers are also consenting to participate in the summer focus group, for which they will be paid an additional $50. Teachers who consent to participate as a Wait List Control group will receive $150 to use for classroom resources at the time of consent.

Ohio University Finance Office policy requires the name, address, and social security numbers of participants will need to be collected and provided to the Finance Office at OU when an individual is compensated $100 or more in a calendar year.

**Am I required to participate?**

Participation is completely voluntary. Teachers are free to stop participation at any time without prejudice. If teachers have any concerns regarding this project now, or during the course of the project, they may contact the Principal Investigator, Jane Hamel-Lambert, PhD, at hamel-lj@ohio.edu or 740-593-2289, or Co-Investigator, Sherry Shamblin, PCC-S, at sshamblin@tcmhcs.org, or 740-592-3091. Additionally, if you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

I certify that I have read and understand this consent from. I agree to participate in the project described. I agree that the known risks have been explained to my satisfaction. I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. Finally, I certify that my participation in this research is given voluntarily and I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I or may otherwise be entitled. By accepting below, I freely agree to participate in this project. I certify that I have been given a copy of this consent form to take with me.

Signature_________________________________________ Date________

Printed Name_____________________________________

Version Date: [July 2, 2009]
### Ohio University
Institutional Review Board
Periodic Review Form

<table>
<thead>
<tr>
<th>Proposal Title</th>
<th>Building Capacity - Raising Resiliency</th>
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#### Principal Investigator Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Jane Hamel-Lambert</th>
<th>Department</th>
<th>Family Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Sherry Shamblin</td>
<td>Department</td>
<td>Tri-County Mental Health</td>
</tr>
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#### Indicate Study Status:

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<th>Open to continuing enrollment of new participants</th>
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<tr>
<td></td>
<td>Enrollment closed, plan to re-open enrollment once approved</td>
</tr>
<tr>
<td></td>
<td>Enrollment closed, participants are still receiving study treatment</td>
</tr>
<tr>
<td></td>
<td>Enrollment closed, only data analysis occurring</td>
</tr>
<tr>
<td></td>
<td>Completed (no enrollment, no treatment, no analysis occurring)</td>
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Provide the number of participants enrolled in the study:

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<th>23</th>
<th>Male</th>
<th>9</th>
<th>Total</th>
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1. Summarize all revisions previously reviewed and approved by IRB:

- **Amendment 1:** Permission to change the date from August to September for a introductory meeting. (date: 8/13/09)
- **Amendment 2:** Permission to add Holly Raffle as co-investigator. (date: 5/17/10)
- **Amendment 3:** Permission to conduct web-based survey to collect classroom demographics and teacher demographic data. (date 6/17/10)
- **Amendment 4:** Permission to conduct focus group / script. (date 6/4/10)
2. Are there any revisions to be considered in this review?  
   YES ☒  NO ☒

   If yes, please respond to items a – d below.
   A. Replace the DECA Reflective Checklist with the Preschool Mental Health Climate Scale by Gilliam 2009 (See attached copy).
   B. Replace the Parent Satisfaction Survey with the Relationship Quality Scale–Parent/Caregiver (See attached Copy)
   C. Replace the Teacher Satisfaction Survey with the Relationship Quality Scale–ECE Provider (See attached Copy)
   D. Eliminate the Consultation Plan and % Goals Obtained as part of the study.
   E. Collect de-identified Child DECA’s on entire classroom population
   
   Insert modified instrument table.

   a. Describe the proposed changes and why they are being made.

   A. The DECA Reflective Checklist is being replaced because it was not sensitive enough to provide a meaningful measure of classroom environmental changes. The Preschool Mental Health Climate Scale (PMHCS) contains a 5-point scale with items that are directly addressed in this study. This tool is recommended by Early Childhood Mental Health Consultation programs at Georgetown University and the University of Maryland, both national leaders in this field. The PMHCS will be completed pre/post teacher consultation and will be completed in the spring with any wait-list control group classrooms.

   B. The Parent Satisfaction Survey is being replaced by the Relationship Quality Scale–Parent/Caregiver Version (RQS–P/C). The RQS–R/C addresses specific consultation behaviors that were present/absent within the consultation process as opposed to only assessing a caregiver’s satisfaction with the service. This tool also contains items that address the impact the consultant has on the caregiver–teacher relationship. This modification was also recommended by Early Childhood Mental Health Consultation programs at Georgetown University and the University of Maryland. The RQS–P/C will be completed by parents of enrolled children post–services.

   C. The Teacher Satisfaction Survey is being replaced by the Relationship Quality Scale–ECE Provider (RQS–ECE). The
RQA-ECE addresses specific consultation behaviors that were present/absent within the consultation process as opposed to only assessing the teacher’s satisfaction with the service. This tool also contains items that address the impact of the consultation process on the caregiver–teacher relationship. This modification was also recommended by the Early Childhood Mental Health Consultation programs at Georgetown University and the University of Maryland. The RQS-ECE will be completed by consented teachers on enrolled/consented children post-services.

D. The Consultation Plan/Goals obtained did not provide a meaningful measure of change in teacher behavior as a result of the consultation process. Information from this form is best use for programmatic purposes, not research purposes.

E. De-Identified Child DECA’s will be completed on all children in a participating classroom. This change will give the ability to measure aggregate changes in a classroom profile on the acquisition of the social–emotional resiliency factors of attachment, self-control, and independence. This process will occur in the same manner as the IRB-approved process for collecting the de-identified DECA’s completed by Wait-List Control teachers. At the beginning of the year, a consented teacher will assign an ID to each child in the class and complete a de-identified DECA. A list connecting the child’s ID number and name will be kept by the teacher in a locked file cabinet. The teacher is the only person who will have access to this information. The consultant will score these and create a classroom profile which will be used to inform the strategies a consultant and teacher work on through the year. At the end of the year, the teacher will be provided DECA’s with matching ID numbers and complete them for the corresponding children. After the spring administration, teachers will destroy the list connecting student ID numbers to names. As established in our original protocol, classroom teachers commonly gather information on the social–emotional development of their students. This process simply allows the consultant to access an aggregated, de-identified classroom profile for the purposes of consulting with the teacher in order to help the teacher better address the needs of his/her class.

b. Describe how, if at all, the proposed changes affect the risks of the study.

The proposed changes to the instruments do not affect the risks of the study.
F. The proposed change to the collection of deidentified DECAs on all children may increase the risk to a small degree, given the teacher completing the instruments will need to provide focused attention on each child's behavior. However, the data will be de-identified and the DECA scores will be aggregated, creating a 'classroom behavior profile' that will be used to provide consultation to the teacher. Although the DECAs are completed for individual children, the scores are not linked to the individual children. As established in our original protocol, classroom teachers commonly gather information on the social-emotional development of their students. This process simply allows the consultant to access an aggregated, de-identified classroom profile for the purposes of consulting with the teacher in order to help the teacher better address the needs of his/her class.

c. Describe how, if at all, the proposed changes affect the benefits of the study.

The proposed changes in instrumentation and data collection will improve the benefits of the study by enhancing the classroom specific data, which will enable consultation services to be more closely tailored to the specific needs of the classroom.

d. Does the proposed change affect the consent/assent document(s)?

If yes:

| YES | X | NO |

Will any participants need to be re-consented as a result of the changes? If so, please describe process to be used. Include two copies of the revised consent/assent documents, one with changes highlighted, and one without highlighting.

Participants will not need to be re-consented. Participation in the study begins and ends with the start of a new school year. As a standard part of the study, participants are given a choice to consent into the program at the beginning of a new school year. The only change in the consent process is that we will use the amended consent forms for this process in YR Two of the study.

3. Provide a synopsis of the results to date (include the progress of the study as compared to the hypothesis). If the risk/benefit assessment has been altered based on the results obtained from the study thus far, describe.
All expected Teachers eligible for the ECMH Program and Wait-List Teachers consented to participate in the study. All of the Wait-List teachers remained in the study and completed all the assigned instruments resulting in a full set of data for the “Wait-List Control Group.” Of the teachers receiving the ECMH Program, only one teacher left the study due to a change in her employment status. The remaining ECMH enrolled teachers completed all of the assigned instruments and tasks. The data set and the results of the focus group conducted by Dr. Raffle are still in the process of being analyzed at that this time. However, preliminary narrative feedback from teachers suggests that the “universal level” teacher-consultation portion of the program lacked sufficient structure, making it difficult for teachers and the consultant to effectively engage services.

18 children were consented into the targeted consultation level of services. As designed, children consented into the program at various times throughout the school year. Data is being entered and analyses are forthcoming later this summer. The frequency and intensive of the service that each child received varied greatly, which is a recognized, inherent challenge in the model.

Another result was that the vast majority of the children enrolled for targeted services came from one school. This was not a result of this school having a larger base of students from which to draw. One factor effecting enrollment was that teachers at this school developed specific strategies to identify children for referrals. Additional factors that led to this phenomenon will be analyzed through the focus group material provided by Dr. Raffle.

This data is still in the process of being collected. However, preliminary feedback from Parent Satisfaction Surveys suggests that parents felt that the ECMH Consultant was easy to access, formed a positive relationship with them and their children, and provided useful, implementable suggestions.

The remaining portion of the study, the summer Incredible Years Group, will begin the first week of July.

4. Have there been any:

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<td>Adverse events or unanticipated results?</td>
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<td>Withdrawal of subjects from research?</td>
<td>Yes</td>
<td>x</td>
<td>No</td>
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<td>Complaints about the research?</td>
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<td>Enrollment Problems?</td>
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<tr>
<td>Literature, findings, or other information that has become available since starting study that indicates a need to amend the study?</td>
<td>Yes</td>
<td>x</td>
<td>No</td>
</tr>
</tbody>
</table>
Changes to funding status? | Yes | No | X

a. If you answered *yes* to any of the above questions, please explain below or attach explanatory material.

Withdrawal of subjects: One teacher resigned from the school district in September 2010, after she had consented to participate, resulting in her withdrawal from the study.

Lit Findings/Consultation: (1) “What Works: A Study of Effective Early Childhood Mental Health Consultation Programs” by Duran, F., Hebburn, K., Irvine, M., Kaufman, R., Anthony, B., Horen, N., and Perry, D. released August 2009 and widely disseminated via the internet and free webinar trainings on the material conducted by Georgetown University. This report reviewed research data from 6 quality ECMH programs across the nation and included recommendations for program evaluation. (2) The Innovations Center at the University of Maryland School of Medicine released made their ECMH Consultant Manual publicly available and also contained recommendations for program evaluation. (3) Finally, consultation was conducted with staff from both of these institutions. All informed the instrumentation changes for this Year Two revision.
### Proposal #
09F035

### Funding Source
Federal Grant UT 15899

### Proposal Title
Building Capacity–Raising Resiliency

### Principal Investigator Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Jane Hamel–Lambert</th>
<th>Department</th>
<th>Family Medicine</th>
</tr>
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### Co–Investigator Investigator Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Sherry Shamblin, PCC–S</th>
<th>Department</th>
<th>Counselor Education</th>
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### Indicate Study Status:

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<th>Open to continuing enrollment of new participants</th>
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<td></td>
<td>Enrollment closed, plan to re–open enrollment once approved</td>
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<td></td>
<td>Enrollment closed, participants still receiving treatment/intervention</td>
</tr>
<tr>
<td></td>
<td>Enrollment closed, only data analysis occurring on identifiable data</td>
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<tr>
<td></td>
<td>Completed (no enrollment, no treatment/intervention, data has no identifiers)</td>
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### Provide the total number of participants enrolled in the study, to date:

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<td></td>
<td>Female</td>
<td>44</td>
<td>Male</td>
<td>19</td>
<td>Total</td>
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5. Summarize all amendment submissions approved by IRB (after original approval):

**Amendment 1:** Permission to change the date from August to September for an introductory meeting (Date 8/13/09)
Amendment 2: Permission to add Holly Raffle as co-investigator (Date 5/17/10)

Amendment 3: Permission to conduct web-based survey to collect classroom demographics and teacher demographic data (Date 6/17/10)

Amendment 4: Permission to conduct focus group/script (Date 6/4/10)

Amendment 5: Permission to individually interview school administrators for program evaluation purposes (6/18/10)

Amendment 6: Permission to conduct the web-based classroom and demographic survey to Wait-List Control teachers from 2009-2010; and all participating teachers for 2010-2011 (10/7/10)

Amendment 7: Permission to add Rena Scarberry as a research assistant; add additional schools; mid-year DECA’s; whole classroom DECA’s for control classrooms; and reporting of consultation time.

6. Are there any revisions to be considered in this review? [YES] [X] [NO]

If yes, please respond to items a – d below.

e. Describe the proposed changes and why they are being made.

1. Due to changes in job responsibilities, Dr. Jane Hamel-Lambert has asked to be removed as an investigator on the project. Sherry Shamblin, co-investigator on the project and doctoral student in Counselor Education, will move to primary investigator status under the sponsorship of her academic advisor, Dr. Tom Davis. Ms. Shamblin will assume all duties outlined in the original protocol that were being conducted by Dr. Hamel-Lambert. See Appendix 2 for Dr. Davis’s contact information and signed assurances. His CITI is on file.

2. Due to the change in the Primary Investigator, project data will no longer be stored at Dr. Hamel-Lambert’s office at Ohio University. Project data will be stored at Ms. Shamblin’s office at Tri-County Mental Health in a locked file.
cabinet. Other than this change in location, all protocols approved in the original proposal and amendments will be followed by Ms. Shamblin.

3. Valerie Wang and Rena Scarberry have resigned from Tri-County Mental Health and need to be removed as research assistants on the project.

4. Add Jamie Linscott as a research assistant. See Appendix 3 for the attached copy of her CITI training.

5. The Family Navigator Services and the additional psychological assessments are no longer part of the programmatic services being offered. These services were NEVER part of the study. We are removing this language from the consent forms and the Program Overview in order to be consistent with the services being offered within the program.

6. Edits have been made in the Program Overview handout to reflect the changes listed in items 1–5. See Appendix 9 and 10.

7. Grant funding ends April 30th, which occurs before the end of the school year. Additionally, enough funding remains to only conduct one more focus group. Consequently, we would like to conduct the focus group in January 2012, instead of May 2011 when it was originally scheduled. This will allow the independent evaluator (Holly Raffle) to obtain teacher feedback while she is still funded on the project.

8. Due to reduced funding for YR 3 of the project, financial incentives for teacher participation will be reduced to $100 for consented participating teachers and $100 for consented Wait–List Control teachers. Incentives for the focus group have been reduced to $25.00. Teachers were informed about this prior to YR 3 and this information is contained in the attached revised consent.

9. Based on feedback from school staff, consultation staff, and our grant Technical Assistance provider, Stacey Willocks, the size of the project has been reduced. With the reduction in YR 3 grant funds, we will focus on conducting the study at two participating schools (Trimble Elementary and Coolville Elementary) and a maximum of two Wait–List Control Classrooms will be recruited. Teachers at all schools were informed of this
decision at the end of the school year in May 2011.
10. Based on consultation from Dr. Deborah Perry from Georgetown University, the following changes in tools are being made: Addition of a Teacher Incredible Years pre/post questionnaire, completion of the Relationship Quality Scales at the beginning of targeted consultation not just at the end of service.

f. Describe how, if at all, the proposed changes affect the risks of the study.

1–4: The staff changes are expected to have minimal risks to the study.
5. The Family Navigator services and psychological assessments are still available to schools participating in this study. The services are simply not being offered as part of the programmatic services offered by the Early Childhood Mental Health Consultation Program. Since these services are still available to schools, and were never part of our study, the removal of this language from program documents involves minimal risk to the study.
6. Changing the Program Overview Handout is expected to have minimal risk to the study.
7. Changing the timing of the focus group is expected to have minimal risk to the study.
8. Reduced incentives may make recruiting “Wait–List Control” classes more challenging. However, teachers were informed of this change before the end of YR 2, and no negative feedback was received.
9. Reduced Participating and Wait–List Control schools means that the data set for the study will be smaller which may impact generalizability of the study.
10. The changes in tools are expected to have minimal risk to the study.

g. Describe how, if at all, the proposed changes affect the benefits of the study.

1–4: Staff changes are expected to have no additional benefit for the study.
5. Removing the language about Family Navigator services and psychological services reduce confusion related to these services and should benefit the study.
6. Changing the Program Overview Handout should benefit the study.
7. Changing the timing of the focus group is expected to allow us to obtain teacher feedback prior to the ending of the funded grant year.
8. Reduced incentives are not likely to add increased benefit, however, this is a necessary step based on budget constraints.
9. Reduced participating schools will likely result in increased consultation time at these sites because their early childhood consultant will be less overextended. This is likely to benefit both consented teachers and consented children.
10. The changes in the tools are expected to enhance the project evaluation component which should have increased benefit for the study.

h. Does the proposed change affect the consent/assent document(s)?

If yes: 
YES X NO

Will any participants need to be re-consented as a result of the changes? If so, please describe process to be used. Include two copies of the revised consent/assent documents, one with changes highlighted, and one without highlighting.

Participants will not need to be re-consented. Participation in the study begins and ends with the start of a new school year. As a standard part of the study, participants are given a choice to consent into the program at the beginning of a new school year. The only change in the consent process is that we will use the amended consent forms for this process in YR Three of the study.

7. Provide a synopsis of the results to date (include the progress of the study as compared to the hypothesis). If the risk/benefit assessment has been altered based on the results obtained from the study thus far, describe.

YR ONE: Summary

All expected Teachers eligible for the ECMH Program and Wait-List Teachers consented to participate in the study. All of the Wait-List teachers remained in the study and completed all the assigned instruments resulting in a full set of data for the “Wait-List Control Group.” Of the teachers receiving the ECMH Program, only one teacher left the study due to a change in her employment status. The remaining ECMH enrolled teachers completed all of the assigned instruments and tasks. Narrative feedback from teacher and the focus group results suggest that the “universal level” teacher- consultation portion of the program
lacked sufficient structure, making it difficult for teachers and the consultant to effectively engage services.

18 children were consented into the targeted consultation level of services. As designed, children consented into the program at various times throughout the school year. The frequency and intensity of the service that each child received varied greatly, which is a recognized inherent challenge in the model.

Another result was that the vast majority of the children enrolled for targeted services came from one school. This was not a result of this school having a larger base of students from which to draw. One factor effecting enrollment was that teachers at this school developed specific strategies to identify children for referrals.

Feedback from Parent Satisfaction Surveys suggests that parents felt that the ECMH Consultant was easy to access, formed a positive relationship with them and their children, and provided useful, implementable suggestions.

The remaining portion of the study, the summer Incredible Years Group, was completed in July 2010.

YR TWO: The Data for YR ONE was analyzed. Results are attached in Appendix 1.

The opportunity to participate in the study was expanded to all schools systems identified Athens County and Athens City. 10 teachers consented to participate in the services, 2 teachers consented to be “Wait-List Control” classrooms for a second year, and 1 teacher declined participation. An additional consultant, Rena Scarberry was added to serve Alexander Classrooms. In October, one consented teacher withdrew citing that the increased workload of her job (she was assigned an afternoon class to teach), combined with the collection of Whole classroom DECA’s as part of the study was simply too much.

19 children were consented for targeted consultation services, with 3 children being withdrawn because they moved out of the school system being served.

During the spring, there was a Technical Assistance Site Visit from the HRSA Grant consultant, Stacey Willocks. During this visit, teacher feedback led to the conclusion that many of the structural concerns at the universal targeted level still existed and that consultation staff were overextended. The recommendation was to reduce the number of schools participating in the study for YR 3 to those schools with the most children enrolled in targeted consultation (Trimble and Coolville). Increased clinical structure was developed for YR 3’s universal consultation.

Dr. Deborah Perry, from Georgetown University, reviewed the program format proposed for YR 3, agreed with the additional
consultation structure for the universal consultation services and recommended the collection of an additional data tool to evaluate the program effectiveness.

YR 2 Data has all been collected and is in the process of statistical analysis. The Summer Incredible Years Group will begin the final week of July pending approval of this application. The YR 3 Consent process is scheduled to occur when the 2011–2012 school year begins.

8. Have there been any:

| Adverse events or unanticipated results? | Yes | No | XX |
| Withdrawal of subjects from research? | Yes | XX | No |
| Complaints about the research? | Yes | No | XX |
| Enrollment Problems? | Yes | No | XX |
| Literature, findings, or other information that has become available since starting study that indicates a need to amend the study? | Yes | XX | No |
| Changes to funding status? | Yes | No | XX |

a. If you answered ‘yes’ to any of the above questions, please explain below or attach explanatory material.

1. 1 consented teacher withdrew in October due to increased work load at her school and 3 consented children moved and were removed from the study.
2. Team had in–person consultation with Dr. Deborah Perry, from Georgetown University, the National Center for Early Childhood Mental Health Consultation which resulted in additional changes in tools. Study was also amended based on feedback from our HRSA Grant TA provider, Stacey Willocks from Georgia State, and Letitia Manning the HRSA Program Officer which resulted in reducing the size of the study to fewer classrooms.

9. Provide a copy of all currently approved informed consent documents, assent documents, and a copy of any debriefing information, if applicable. Please do not submit any document that contains participant signatures.

Copies are attached.
Ohio University
Institutional Review Board
Project Amendment/Revision Form

Federal regulations require IRB approval prior to implementing proposed changes to research projects. Such changes include any change to the originally approved proposal, including, but not limited to changes in number of participants, changes in recruitment/research procedures, and changes in supporting documents (consent form, debriefing form, questionnaires, advertisements, etc.)

Please complete this form, and attach all revised documents or supporting information.

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Principal Investigator Information

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<tr>
<th>Name</th>
<th>Sherry Shamblin</th>
<th>Department</th>
<th>Counselor Education</th>
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<table>
<thead>
<tr>
<th>Address</th>
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<tr>
<th>Email</th>
<th><a href="mailto:sshamblin@tcmhcs.org">sshamblin@tcmhcs.org</a></th>
<th>Phone</th>
<th>740–592–3091 ext 4631</th>
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Advisor Information

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<tr>
<th>Name</th>
<th>Thomas Davis</th>
<th>Department</th>
<th>Counseling &amp; Higher Ed</th>
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Study Status

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<tr>
<th>Study Status</th>
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<tbody>
<tr>
<td>Active (currently in progress)</td>
</tr>
<tr>
<td>Project on Hold (pending approval of this amendment)</td>
</tr>
<tr>
<td>Project not yet started (no participants enrolled)</td>
</tr>
<tr>
<td>Closed to new participant entry (data analysis/intervention occurring)</td>
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10. Describe the proposed changes and why they are being made.

Proposed Amendment to change the title of the study/project:

Current project title is the same as the HRSA Outreach grant funding this study. However, the HRSA Outreach grant contains other programs/projects that are not associated with this study/project. The early childhood mental health program covered by this IRB protocol, number 09F035, is only one part of the HRSA Outreach grant. In order to avoid confusion with the grant program having the same name, we propose to change the title of this study to “Partnerships for Early Childhood Mental Health”.

11. Describe how, if at all, the proposed changes affect the risks of the study.

The proposed change is not expected to affect the risks of the study.

12. Describe how, if at all, the proposed changes affect the benefits of the study.

The proposed change is not expected to affect the benefits of this study.

13. Does the revision affect the consent/assent document(s)?

Yes [X] No

a. If yes, will any participants need to be re-consented as a result of the changes? If so, please describe process to be used. Include two copies of the revised consent/assent documents, one with changes highlighted, and one without highlighting.

Participants will not need to be reconsented. The school year has not yet started and participants had not yet been consented. We will wait until this amendment is approved before consenting participants.
The following research study has been approved by the Institutional Review Board at Ohio University for the period listed below.

**Project:** Building Capacity - Raising Resiliency

**Researcher(s):**
- Sherry Shamblin
- Holly Raffle

**Advisor:**
- Thomas E. Davis

**Department:**
- Family Medicine

**Approval Date:** 7/21/11

**Expiration Date:** 7/20/12

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.
The amendment, detailed below, and submitted for the following research study has been approved by the Institutional Review Board at Ohio University.

**Project:** Partnerships for Early Childhood Mental Health

**Amendment:** Title Change; Revised Consent Forms

**Primary Investigator:** Sherry Shamblin

**Co-Investigator(s):** Holly Raffle

**Advisor:** Thomas E. Davis

**Department:** Family Medicine

Rebecca G. Cale, AAB, CIP
Office of Research Compliance

**Protocol Expiration Date:** 7/20/2012

08/15/11

Date