FINAL REPORT

# FIRST STEPS
## TO SUCCESS IN ETOBICOKE

IMPLEMENTATION PROCESS &
EVALUATION RESULTS

PREPARED BY THE PROVINCIAL SYSTEM
SUPPORT PROGRAM (PSSP) AT CAMH

FEBRUARY 20
2020

# ABOUT PSSP

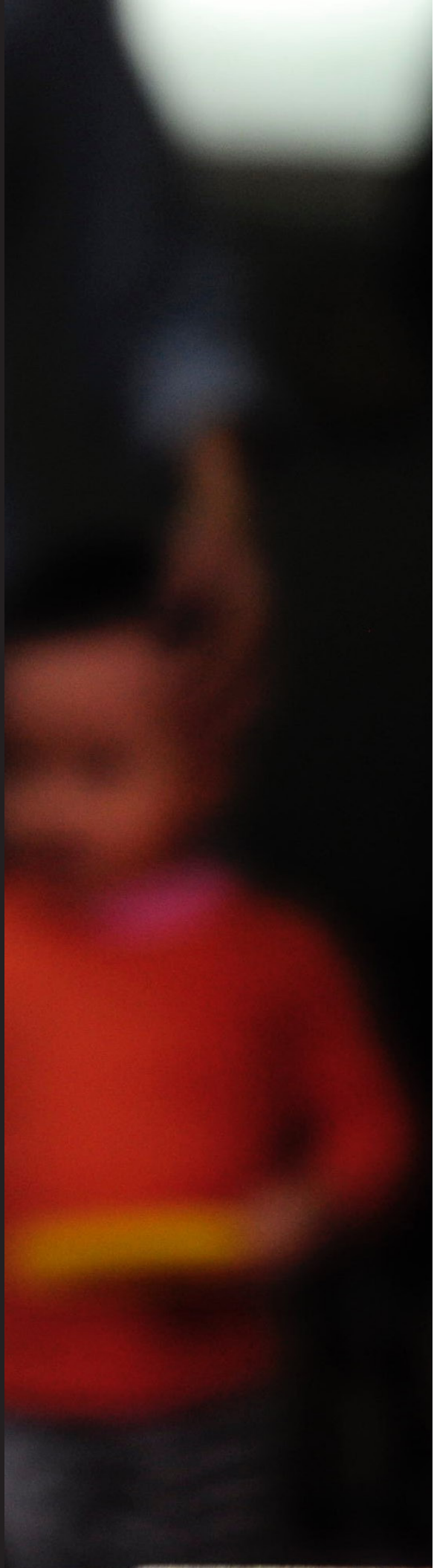
## WHY WE EXIST

Ontarians access mental health and addictions help from many different services and sectors. That means a coordinated approach to support people affected by these issues is vital to ensure the best possible outcomes.

## WHAT WE DO

The Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health works with communities, service providers and other partners across Ontario to move evidence to action to create sustainable, system-level change. With offices in Toronto and across the province, PSSP is on the ground, collaborating with stakeholders to build a better system through our work in implementation, knowledge exchange, evaluation, and health equity.

camh
mental health is health



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# EXECUTIVE SUMMARY

*First Steps to Success in Etobicoke* was a pilot project that aimed to strengthen the skills of local service providers, to build a workforce that more effectively provides social-emotional support for infants and toddlers to reduce their risk of future mental health challenges. This report describes the intervention selected for the *First Steps to Success in Etobicoke* pilot project, our implementation process, the impact of the intervention, and the lessons we learned.

Healthy social-emotional development in young children refers to a range of skills including self-regulation, empathy, confidence, and prosocial behaviour. Problems that interfere with this development can result in the onset of challenging behaviours in infants and toddlers that have lasting negative consequences and interfere with social adjustment.[1] The Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children (Pyramid Model) is an evidence-based framework designed to increase the ability of early childhood educators and professionals to foster healthy social-emotional development.

*First Steps to Success in Etobicoke* piloted the implementation of the Pyramid Model at eight sites, including City of Toronto childcares, women's shelter services, community mental health and addiction, settlement services, and a community resource hub. With the inclusion of unconventional settings outside of childcare, the pilot project was experimental in its scope and the cross-sectoral partnerships that were created. A few of our key findings:

- Fidelity of staff practices to the model increased from 78% to 91%, demonstrating a 13% increase during the pilot project. Skills related to responding to the emotions of young children and teaching them about feelings increased dramatically from 29% at baseline to 75% by the end of the project.
- Site leads reported that their practices improved based on the training and coaching. They used simpler language with the children, were more mindful of infants' emotions, and used more materials with children and families. The project gave them more strategies to incorporate their knowledge into practice. Coaches gave them the specific language and skills needed to feel more confident in their ability to interact with infants and support their social-emotional development.
- While the intent of the evaluation was not to explore the impact on children, the infants and toddlers appeared to show improvement in their emotional regulation in how they were calmer, more resilient, and less aggressive. The children were more aware of their emotions and better understood why they were experiencing the emotion. Children also became more attentive and curious about the emotions of their peers.
- *First Steps to Success in Etobicoke* encouraged new and stronger collaboration between community partners. It brought a range service providers in the community onto the same page, delivering the same tools and messages to families about the importance of social-emotional development.

We recommend professional capacity-building to support the promotion of social-emotional development in any setting where professionals regularly interact with infants and toddlers. Implementing and sustaining the Pyramid Model requires a clear investment from the system in the human resources needed for coaching, fidelity assessment, and coordination. Aligning with existing provincial priorities and leveraging system players already doing similar work by reframing their roles can help maximize efficiency and impact.

# BACKGROUND & KEY PARTNERS

## BACKGROUND

As part of *Open Minds, Health Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, a number of Service Collaboratives were established to help local systems improve coordination and access to mental health and addictions services. The Provincial System Support Program (PSSP) at CAMH has led this work.

A cross-section of service providers from the early childhood development sector came together to form the *Etobicoke 0-3 Service Collaborative* in order to develop a plan for addressing the mental health needs of infants and toddlers from birth to age three. Young children stood out as a vulnerable population in Etobicoke when specific indicators of risk were considered, including low income, single-parent families, newcomers, visible minorities, and low birth weight.[2, 3] Families who experience these vulnerabilities required a system that was intentionally investing in care that meets their needs.

The work of the *Etobicoke 0-3 Service Collaborative* led to the *First Steps to Success in Etobicoke* pilot project. This report describes the intervention selected for this pilot project, our implementation process, the impact of the intervention on the community, and the lessons we learned through this work.

## OUR GOAL

The objective of *First Steps to Success in Etobicoke* was to build an effective workforce that would promote the wellness of infants and toddlers, prevent mental health challenges from developing, and provide the individualized support necessary to foster healthy social-emotional development in young children. This was considered a significant precursor to positive mental health in older children and adults. The intervention we selected to meet these goals was a systematic and evidence-based approach called The Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children.

## KEY PARTNERS

Implementing Sites:

- Albion Early Learning and Child Care Centre
- Delta Family Resource Centre
- Ernestine's Women's Shelter
- Humber College Child Development Centre
- The Jean Tweed Centre
- Kipling Early Learning and Child Care Centre
- Rexdale Women's Centre
- Rowntree Early Learning and Child Care Centre

Coaching Supports:

- Toronto Public Health
- Toronto Children's Services
- Humber College

# SYSTEM GAP

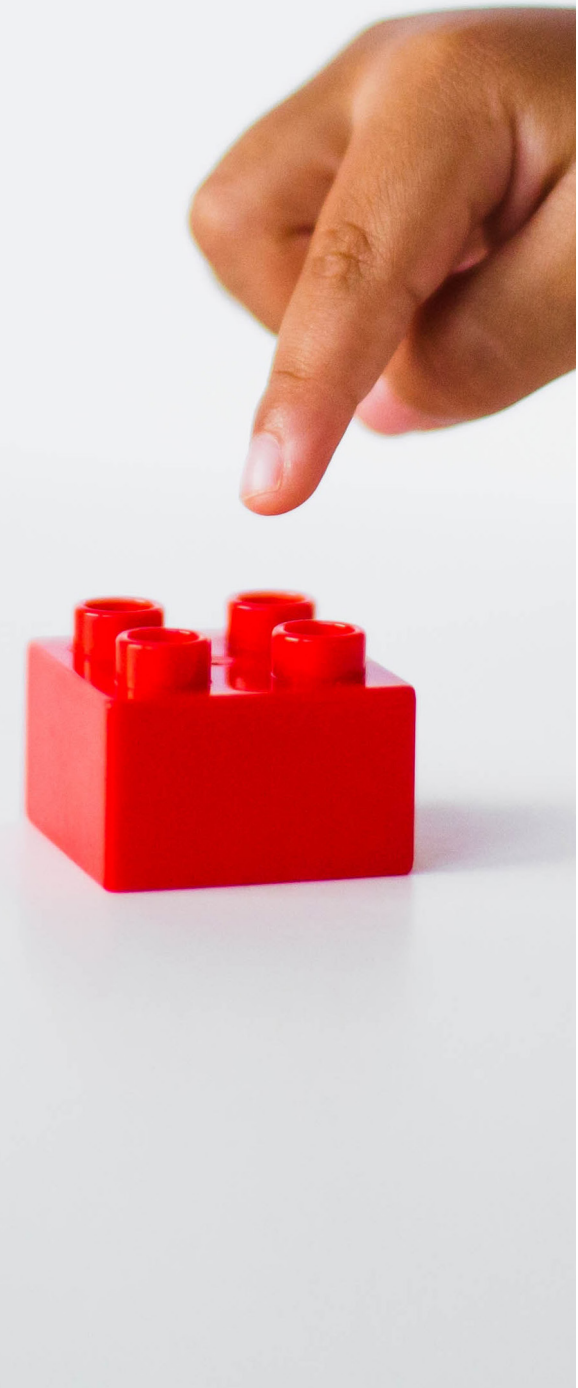
The system-level gap identified by the *Etobicoke 0-3 Service Collaborative* was: "Lack of knowledge and timely response by cross-sectoral service providers in Etobicoke to support infant mental health needs when families are accessing services."

## HOW WE GOT HERE

In 2017, the PSSP team facilitated a thorough exploration process that aimed to uncover the gaps in the system of infant mental health (IMH) services in Etobicoke. We conducted a series of stakeholder consultations across sectors. These included:

- 21 interviews with a range of service providers working with infants, toddlers, and their families. Sectors consulted included child welfare, child and youth mental health, adult mental health and addictions, and primary care (i.e. physicians, nurse practitioners, social workers from community health centres, family health teams, and hospitals).
- Four focus groups with 33 parents and caretakers of infants and children connected with local community and mental health services in Etobicoke.
- Ten *Etobicoke 0-3 Service Collaborative* meetings with cross-sectoral service providers from the region with the goal of identifying the system gap.

Through this process, the first system-level gap that emerged was the "lack of service pathways for infant mental health services."



However, our consultations showed multiple challenges in developing the supports needed for such a pathway, including inadequate early identification of infant mental health (IMH) risk indicators, limited knowledge among service providers, and lack of available IMH-specific treatment programs in Etobicoke. We concluded that we could not develop a service pathway for a system that did not exist. Instead, the *Etobicoke 0-3 Service Collaborative* agreed to address one of the following five barriers:

*Limited family knowledge and awareness of IMH.* We heard that families have trouble identifying potential issues with their infant's social-emotional well-being. Education on topics such as attachment, child development, positive parenting practices, and positive relationships with infants would help support caregivers to access supports earlier.

*Limited service provider knowledge of IMH.* We learned that frontline staff at childcare programs would be better able to identify indicators of risk if they were deliberate about prioritizing IMH. Parents also described primary care practitioners as having little to no knowledge of community supports and as being unlikely to ask about infant social-emotional wellness.

*Limited awareness of IMH programs and services among service providers.* In order for providers to make appropriate referrals, they would need clear knowledge of services and the processes required for access. Consultation results showed that there was limited awareness of IMH programs and services among service providers in Etobicoke. We opted not to address this gap on its own because it could create more demand for services that have high wait-times already, and once identified there are limited services for families in need.

*Limited 'indicated intervention' and treatment for complex cases in Etobicoke.* As part of indicated interventions and treatments, dyadic caregiver-child approaches are used to "enhance reciprocity, sensitivity, responsiveness, interactional guidance or modified interaction guidance."[4] There were limited to no such treatment services in Etobicoke. Most services in the region fell under early intervention and universal prevention. The two agencies that support children's mental health in Etobicoke had limited offerings for specialized IMH services.

*Limited knowledge among service providers to support IMH while families wait for services.* We learned through meetings and consultations that cross-sectoral service providers who work with families have limited IMH knowledge, and would not necessarily know how to provide basic strategies to support IMH once signs and risks are identified. This is a system-level gap that we could address by developing a sustainable intervention that prioritized IMH identification and integration of basic strategies within service delivery.

In response to this final barrier, the *Etobicoke 0-3 Service Collaborative* chose to focus on building the capacity of cross-sectoral service providers to build healthy social-emotional development when working with families and young children in order to intentionally promote, prevent and intervene early. Building professional competencies would ensure health promotion and prevention services were following a more intentional and systematic framework to reduce risks for infant mental health challenges, thus potentially reducing the wait lists for specialized services in the long-term.

# CHOOSING OUR INTERVENTION

Core competencies in infant mental health (IMH) and social-emotional development were designed to work across various systems and professions, to create a continuum of services and skills. Building capacity on core competencies and embedding them within organizations required:

- selection of the specific competencies to be enhanced,
- identification of the actionable skills or knowledge that reflect such competencies,
- development of an implementation plan to ensure new skills and knowledge are learned with fidelity, and
- evaluation of clear outcome measures over time.

The competencies would need to contribute to health promotion, prevention and early intervention in Etobicoke and would require a strong commitment from participating organizations to ensure sustainability.

At this time, there were no standards in place in Canada around core competencies in social-emotional development or IMH across professions. Though out of scope for our purposes, a long-term objective would be to invest in a provincial system of core competencies for infant mental health. For the current pilot project, the PSSP team researched three potential interventions that would meet our need to build an effective workforce in Etobicoke. They included P-5 Competencies Training, IMHP Competencies Reformulation & Training, and the Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children (Pyramid Model).

*Etobicoke 0-3 Service Collaborative* members reviewed three information briefs outlining these different intervention options, including their benefits, the implementation process, expected outcomes, evidence, roles and responsibilities, resources, limitations, and sustainability. We also presented members with a set of criteria that reflected the project expectations and parameters needed for our funder, The Ministry of Health and Long-Term Care. The selection criteria included:

- value (for the agency, families, and the system)
- alignment (with other system initiatives and agency directions)
- resources available (to support implementation and sustainability)
- evidence (robust base, existing evaluation tools to track impact & fidelity)
- readiness of the option (level of adaptation & planning required prior to implementation)
- inspiration (to ensure adequate motivation of partners to drive decision-making)

The *Etobicoke 0-3 Service Collaborative* members assessed each option in light of the criteria. Based on the results, they chose to implement the Pyramid Model.

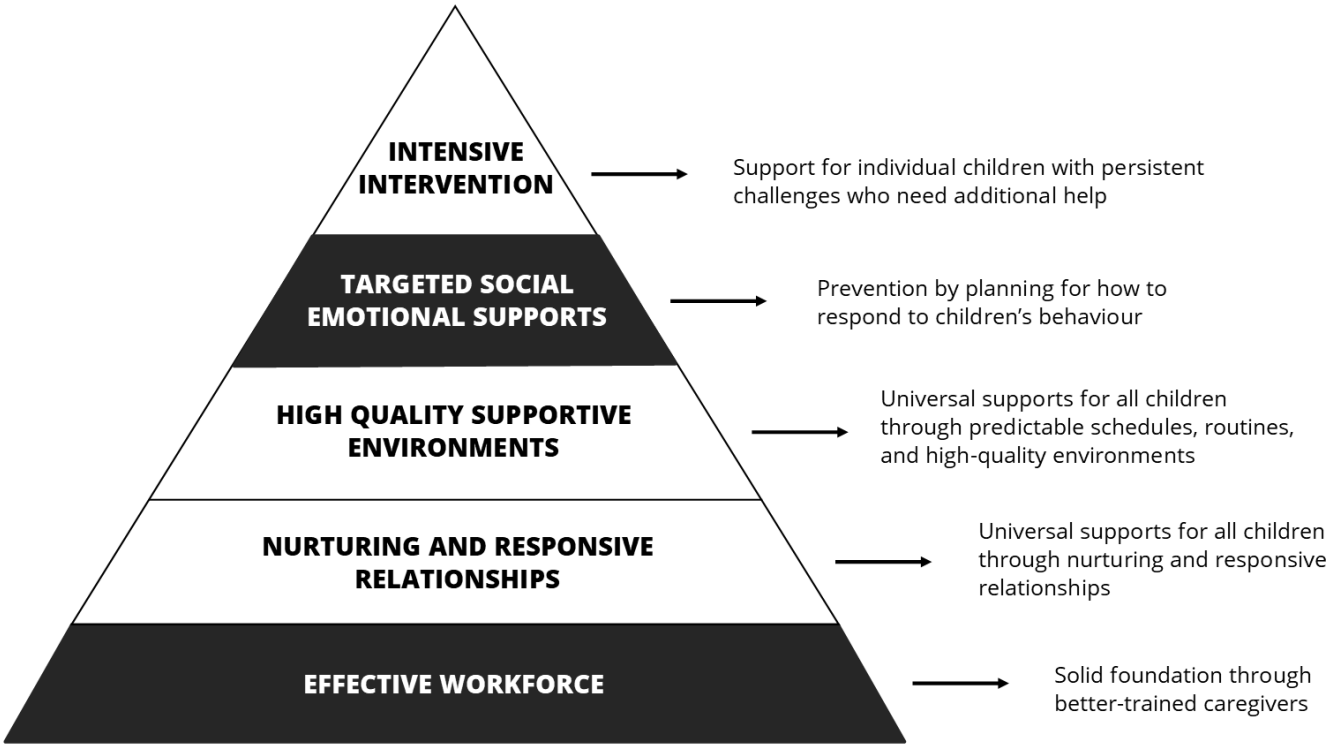
At this point, the *Etobicoke 0-3 Service Collaborative* reorganized itself as the *First Steps to Success in Etobicoke* initiative. Its goal was to strengthen the skills of local service providers in a variety of settings to build a workforce that more effectively provides social-emotional support for infants and toddlers to reduce their risk of future mental health challenges.

# THE PYRAMID MODEL

## WHAT IS IT?

The Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children (Pyramid Model) is an evidence-based framework designed to increase the skills and confidence of early childhood educators and professionals. It was developed by two federally-funded research and training centers in the United States: The Center on the Social and Emotional Foundations for Early Learning (CSEFEL),[5] and the Technical Assistance Center on Social and Emotional Interventions (TACSEI).[6]

The Pyramid Model builds on the tiered public health approach to promote the social, emotional and behavioural development of infants and toddlers. This model enhances services across levels, including universal supports for all children, targeted prevention approaches for those who are more at risk, and intensive individualized interventions for the children who need the most support.[6] Its focus on prevention and promotion reduces the risk of children needing more intensive supports.[7]



The practices identified in the Pyramid Model are based on a systematic review of research on early childhood classroom intervention related to positive social-emotional outcomes and decreased challenging behaviours.[8] The model provides a comprehensive approach to implementing practices related to professional competencies, including:

***Professional Development:*** Coordinators offer ongoing training of Pyramid Model practices to front-line practitioners, coaches, and program-wide leadership.

***Coaching:*** A strength of the Pyramid Model is its emphasis on coaching, which has been shown to help support and sustain evidence-based practice changes over time.[9,10] Coaches receive additional training and provide on-site coaching related to Pyramid Model practices for staff of implementing programs. They provide ongoing observational feedback and work collaboratively with staff to identify areas for growth. Effective coaching ensures fluency of new learning by adapting skills to the unique context of specific implementing sites.

***Evaluation:*** This includes validated fidelity assessments, program-based data collection tools, measurement of project outcomes and impact of implementation.

***Family Engagement:*** Participating agencies offer educational opportunities for families, ensure communication mechanisms between staff and families, and provide information and resources for families.

***Leadership Development:*** Representation from participating organizations at the leadership level ensures adequate oversight. Leaders from implementing sites champion social-emotional development.

# EVIDENCE

## RATIONALE

Healthy social-emotional development in young children refers to a range of skills related to self-regulation, empathy, confidence, and prosocial behaviour.[1] Problems that interfere with this development can result in the onset of challenging behaviours in infants and toddlers that have lasting negative consequences and interfere with social adjustment.[11, 12, 13, 14] These social-emotional deficits contribute to decreased positive feedback from teachers at later ages, and higher rates of expulsion, school failure, dropout, and community isolation.[7, 11, 15]

Social skills training and universal approaches to care that target social-emotional competence through positive reinforcement of appropriate behaviours can help prevent the development of these challenging behaviours.[7, 11, 12, 16] Early intervention that fosters the social-emotional development needed to protect children from future stressors can reduce the need for more costly interventions at later ages.[13, 15]

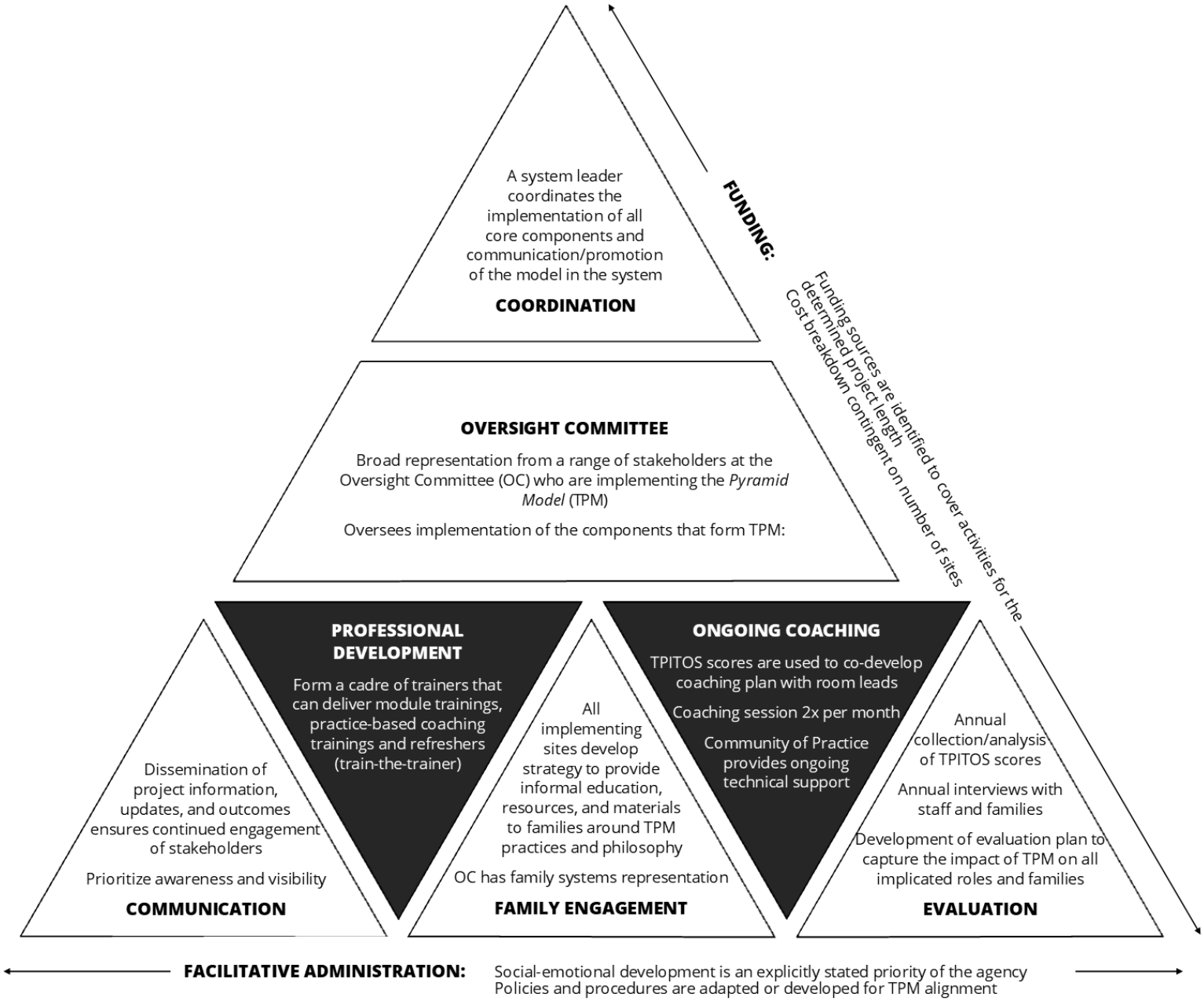
The Pyramid Model's focus on promotion and prevention reduces the risk of children needing more intensive supports to as low as 4%,[7, 13] which is essential for staff who are more focused on managing problem behaviours after they occur[1]. Estimates of the proportion of young children with problem behaviours range from 10-40% and evidence suggests this statistic is increasing.[7, 12, 15, 17] Early childhood educators report that they lack necessary skills and struggle to meet the needs of these children.[1, 12, 13, 15, 17] Referrals to behavioural specialists can be difficult to access and frontline staff end up experiencing stress and burnout.[7, 9, 17]

The ongoing, strengths-based coaching employed by the Pyramid Model ensures early childhood workers are applying the principles to their everyday practice with significantly increased levels of fidelity.[9, 10] Studies have demonstrated reliable improvements in teacher scores on standardized observation tools associated with Pyramid Model practices, as well as reductions in staff behaviours considered unhelpful for children's development.[1, 9, 12] Frontline workers themselves have also reacted positively to the Pyramid Model, indicating that they felt more confident in their ability to manage challenging behaviours. They have reported being less stressed, more patient, and less likely to require additional specialized services for crisis intervention.[12, 17]

Outcomes for children affected by this intervention are promising. They include marked increases in social skills and significant reductions in problem behaviours.[9, 12] Rates of expulsion have decreased to half their previous rates when the Pyramid Model was implemented on a large scale.[15] Adults providing sensitive and attuned care for young children is also related to more secure attachment to caregivers.[14]

Evidence suggests that there can be challenges when implementing the Pyramid Model across families from diverse cultures.[18, 19] Language barriers, misinterpretation of behaviours, variations in how challenging behaviour is conceptualized, views that universal practices perpetuate the social norms of a Eurocentric majority, and lack of trust between service providers and families all contribute to this tension.[14, 18, 19] Despite challenges, the Pyramid Model practices are flexible and can be adapted to meet the needs of the target population when culturally responsive practices are incorporated into the intervention.[18, 19]

# CORE COMPONENTS OF THE MODEL



# ADAPTING TO OUR CONTEXT

## MOVING INTO IMPLEMENTATION

*First Steps to Success in Etobicoke* piloted the implementation of the Pyramid Model at eight sites, some of which were unconventional settings. In Etobicoke, many families relying on subsidies for childcare had to face long waitlists and instead deferred to other community resources to meet their needs. Although the model was designed for implementation in childcare settings, the stakeholders we convened worked in a variety of settings, including:

- Childcare
- Emergency Shelter for Women Escaping Violence
- Community Mental Health and Addiction
- Settlement Services
- Community Resource Hub

Childcare settings had coaching supports available through Resource Consultants – a pre-existing resource childcare staff relied upon for children with additional support needs. The Resource Consultants already provided coaching to some extent, and the City of Toronto acknowledged this alignment and readily participated in the pilot program.

With the inclusion of the unconventional settings outside of childcare, the pilot project was experimental in its scope and the cross-sectoral partnerships that were created. To establish appropriate coaches for these sites, we facilitated a strategic partnership with Toronto Public Health (TPH). TPH nurses were integrated into the project to provide coaching to the community child and family programs.

Both of these system partnerships were unique and resulted in many new learnings about implementing the Pyramid Model and its utility across sectors. The partnerships also fostered many lasting connections across agencies.

Given these unconventional circumstances and the limitations of a brief, pilot period, we made adaptations and enhancements to strengthen implementation. Building on the benchmarks of quality established by the Pyramid Model Consortium,[20] we infused novel elements where we needed to and formulated the core components to help the project succeed in our context. What follows is a list of each core component, explaining how the benchmarks *(italicized)* were operationalized and adapted.

## COORDINATION

*A team member has been identified as the Pyramid Model Community Coordinator (i.e., lead contact) for all Pyramid Model adoption efforts within your community.* PSSP provided a dedicated implementation team that provided coordination of *First Steps to Success in Etobicoke* for the duration of the pilot year, with the understanding that for the project to be scaled and sustained, a community coordinator would need to take over this role. The scope of coordination included managing internal and external communications, tracking implementation progress, taking meeting minutes, providing agency-specific supports, maintaining community relationships, organizing logistics of key activities, developing pertinent resources, and providing a project budget.

## FUNDING

*Funding sources to cover activities for at least three years can be identified.* We secured funding for the duration of the pilot period through the Ministry of Health and Long-term Care. At the time of this report, conversations with key stakeholders to explore alternate funding sources are ongoing.

*Participating programs commit to cover costs of staff time, supporting materials, and other expenses.* In addition to basic materials and expenses, the PSSP team covered costs to backfill staff in order for project staff to attend trainings. Several agencies provided in-kind supports such as meeting spaces and staff time to participate in the project. Because of the cross-sectoral scope of the pilot, some agencies had fewer resources and were not able to provide these in-kind supports. It was important for us to provide fiscal support to implementing sites with fewer resources in order to ensure that all agencies were able to participate equitably in all aspects of implementation.

## OVERSIGHT COMMITTEE

*Team has broad representation from a range of stakeholders and program agencies (special education, early childhood, education, families, child care, mental health, etc.).* A leadership team that we called the Oversight Committee convened regularly with representation from each of the implementing sites and coach organizations. We added to this benchmark by designating two community stakeholders as co-chairs, primarily for facilitation and agenda planning, to bolster their sense of ownership over the project.

*Team has established a clear mission/purpose. The team purpose or mission statement is written. Team members are able to clearly communicate the purpose of the leadership team.* Co-developed by the Oversight Committee, the project's Terms of Reference included a clear purpose statement, a group agreement built on the team's shared values to ensure respectful engagement throughout the project, and a pre-determined decision-making process in order to articulate the importance of consensus and conflict resolution.

*Team develops an implementation plan that includes all critical elements. A written implementation plan guides the work of the team. The team reviews the plan and updates their progress at each meeting. Action steps are identified to ensure achievement of the goals.* As the coordinating body, our PSSP implementation team developed an overall implementation plan for the initiative that included all core components. The Oversight Committee was responsible for reviewing and providing feedback on the implementation plan and key activities.

*Team reviews and revises the plan at least annually.* Through integrated quality improvement mechanisms, we reviewed the plan frequently during the 16-month pilot project.

## PROFESSIONAL DEVELOPMENT

*Leadership team has established a network or cadre of trainers to build & sustain program-wide adoption of the Pyramid and Pyramid Model practices.* Because of the short-term nature of the pilot period, we did not invest in building a cadre of trainers. Instead, trainings were delivered by Getting Ready for Inclusion Today (GRIT), an early childhood education program based in Edmonton, Alberta.

*Training capacity includes providing ongoing training opportunities for training practitioners (Pyramid Model practices), training coaches who work directly with practitioners in the implementation of practices, training behavior specialists who can guide the tertiary behavior support process, and training program-wide leadership teams in the adoption/ implementation process.* GRIT delivered Modules 1, 2, and 3 of the Pyramid Model to frontline staff from implementing sites, site supervisors, coaches, and other interested stakeholders. All coaches and their supervisors participated in Practice-Based Coaching and Teaching Pyramid Infant-Toddler Observation Scale (TPITOS) Reliability Training. One of our Oversight Committee members provided a training session in trauma-informed care to all sites coaches and supervisors. This was a novel addition to the implementation process that we included because a trauma-informed lens is crucial when working with diverse populations. We offered each of these trainings only once during the lifetime of the pilot. Module 4 was not delivered as a devoted training opportunity to the leadership during the pilot because of their established familiarity with the topics; instead, we incorporated some of the content through Oversight Committee meetings.

*Opportunities for refresher trainings for existing teams and networking with peers are established.* In lieu of refresher trainings given the short timeframe, we provided networking opportunities to help support maintenance and create opportunities for group problem-solving.

## ONGOING COACHING SUPPORT

*Coaches to facilitate program-wide adoption of the Pyramid Model are identified and trained.* With the support of the City of Toronto, Humber College, and Toronto Public Health (TPH), we were able to leverage Resource Consultants as coaches for the childcare settings and TPH nurses as coaches for additional sites. Coaches received the full set of training sessions, including all core modules, Practice-based Coaching, and TPITOS Reliability.

*A plan for providing ongoing, onsite technical assistance on the adoption of the Pyramid Model is developed and implemented.* Coaches participated in a Community of Practice on a bimonthly basis. The purpose of this structure was to discuss and develop coaching practice in an ongoing way with opportunities to share experiences, identify implementation challenges, generate strategies, explore resources to identify capacity-building needs, and practice critical self-reflection through an anti-oppressive lens.

*A mentor/coach is available to meet at least monthly with each emerging program team (emerging teams are teams that have not met the implementation criteria), and at least quarterly with established teams.* Coaches worked with frontline staff from each implementing site to co-develop a coaching plan based on their scores on the TPITOS fidelity assessment. Coaches visited each program twice monthly to observe, provide support and update the coaching plan. Each coaching visit included one hour of in-room observation and 30 minutes of one-on-one coaching with the site lead.

*Leadership team identifies staff or resources to support the development of behavior support plans for persistent challenging behavior.* This was outside the scope of intervention for the non-childcare programs in the pilot. For childcare settings, the Resource Consultants provided their support when challenging behavioural needs were identified.

## COMMUNICATION & VISIBILITY

*Leadership team develops an awareness presentation to recruit programs, schools, and childcare centers.* The PSSP team developed and delivered a presentation to recruit members of the *Etobicoke 0-3 Service Collaborative* and other relevant partners to implement the Pyramid Model.

*Dissemination strategies are identified & implemented to ensure that stakeholders are kept aware of activities & accomplishments (e.g., website, newsletter, conferences).* The PSSP team's knowledge broker created and disseminated multiple information briefs that captured the progress of the project and updated all project participants and families at implementing sites. In order to ensure that the materials were accessible to a diverse array of families, we translated the briefs into French, Spanish, Hindi, and Arabic. These languages were chosen in consultation with Oversight Committee members.

*Leadership team provides update on the process and data on the outcomes to program staff on a regular basis.* Members of the Oversight Committee acted as a conduit between the project team and the implementing sites, providing updates to their staff about successes and challenges as needed. As the coordinating body, we disseminated a midpoint information brief highlighting early outcome data for frontline staff to review, as well as a final meeting in which we shared raw data from the final evaluation.

## FAMILY ENGAGEMENT

*Leadership team has family-systems representation.* The Oversight Committee did not have family representation. The fast-paced launch of the committee along with the precedent set by the group from which it was formed, which did not involve family consultation beyond one focus group, did not permit meaningful engagement.

*Training opportunities are developed for families.* As an intermediary project team, privacy policies prevented us from working with families directly. Given the importance of engaging families in the Pyramid Model content while honouring the differences across sites, our team created a family engagement workbook. The workbook allowed each site's Agency Implementation Team to select a different aspect of family engagement to target (e.g. collecting feedback more meaningfully, engaging in a more trauma-informed way, sharing information about social-emotional development, etc.). They were empowered to do their own research as a team to design a strategy to implement.

*Multiple mechanisms for communicating with families about the initiative are developed.* In addition to the two family information briefs our team created for dissemination, implementing staff were encouraged to take time to provide informal education, resources and materials to families around the practices and strategies in the Pyramid Model. In some instances, use of the family engagement workbook led to increased communication via families working with staff to create new resources.

## FACILITATIVE ADMINISTRATION

*Child social-emotional/behavior is one of the top five goals for the program, coalition, community, or district.* Site supervisors identified the social-emotional development of infants and toddlers as an explicit commitment in the expression of interest that each pilot site submitted to the implementation team. The project itself emerged from the *Etobicoke 0-3 Service Collaborative*, which had the goal of addressing the mental health of children aged 0-3.

*Team has administrative support from the community. Program or district administrators attend meetings and trainings, are active in problem-solving to ensure the success of the initiative, and are visibly supportive of the adoption of the model.* Members of leadership facilitated Agency Implementation Team (AIT) meetings with their program staff and attended Oversight Committee meetings and trainings. AIT members problem-solved and disseminated their new learning throughout their agency.

*Leadership team reports to the administrative unit(s) at least annually on the activities & outcomes related to child behavior goal(s).* At least twice during the pilot, members of the Oversight Committee reported to the Executive Directors of participating agencies on the activities and outcomes related to the implementation of *First Steps to Success in Etobicoke.*

*Program-Wide Pyramid Model adoption policy statement developed & endorsed.* Site supervisors discussed policies impacting implementation with staff, which they brought to the Oversight Committee for exploration and discussion. The pilot started with one implementing room at each site; in sites where there were multiple infant or toddler rooms, staff agreed that implementation would be staged if the initiative continued beyond the pilot period.

*Participating schools/programs/centers accept requirements to participate (e.g., sign agreement, MOU, etc.).* Participating agencies laid out their site's plans in an Expression of Interest and accepted the requirements of the project through an MOU.

## IMPLEMENTING AGENCIES

*Team establishes recruitment and acceptance criteria for programs participating in the initiative.* The PSSP team developed an Expression of Interest template that assessed organizational readiness. We established recruitment and acceptance criteria.

*Community has identified the centers, schools, or programs that can be used as local demonstrations of process & outcomes. Etobicoke 0-3 Service Collaborative* members self-identified their agencies and programs to be used as local demonstration sites (i.e. implementing agencies).

*Centers, schools or programs are recruited into initiative annually.* The PSSP team generated scale-out interest among funders throughout implementation of *First Steps to Success in Etobicoke* by sharing progress and outcomes with all relevant stakeholders.

## EVALUATION

*Leadership team has developed evaluation process for assessing: a) extent to which teams are implementing program-wide adoption, b) impact of program-wide adoption on child outcomes, & c) extent to which the leadership team's action plan is implemented.* The Oversight Committee and PSSP team co-developed an evaluation plan for assessing the extent to which programs are implementing the Pyramid Model and the impact of implementation on staff's skill development. Methods included focus groups with supervisors, focus groups with coaches, individual staff interviews at midpoint and endpoint, as well as the TPITOS data collection at three time points.

*Program-based information systems (e.g., data collection tools & evaluation processes) are in place.* TPITOS was conducted at three time points with site leads from each of the eight implementing organizations. Further documentation included a coaching log detailing the focus of each coaching visit and action plan templates that tracked staff's ongoing progress toward their goals.

*Process is identified for participating programs/ agencies to enter and summarize data.* Coaches worked with the PSSP team to complete the data entry and summaries.

*Action plan is updated/revised as needed based on the ongoing data-based outcomes.* The implementation plan that all participating staff, supervisors and coaches worked from was adapted and revised as needed throughout the pilot. Frontline staff updated or revised their individual action plans based on progress identified through coaching visits.

*Team disseminates, celebrates and acknowledges outcomes and accomplishments at least quarterly.* The PSSP team coordinated a celebration and acknowledgement of preliminary findings at the end of the pilot period.

# LOGIC MODEL

## OBJECTIVES

| OVERSIGHT COMMITTEE | PROFESSIONAL TRAINING | ONGOING COACHING | FAMILY ENGAGEMENT |
|---|---|---|---|
| Center decision-making, provide feedback to implementation plan and evaluation, oversee quality improvement<br>Integrate training content:<br>*Leadership strategies* | Provide training opportunities to frontline staff in Etobicoke:<br>*Social-emotional development within the context of relationships*<br>*Responsive routines, environments, and targeted strategies*<br>*Individualized intervention* | Coaches are trained to deliver bi-monthly practice-based coaching sessions to site staff<br>Support application of new skills, develop staff goals, attend C.o.P.<br>Complete TPITOS assessment, coaching logs, and action plans | Staff receive training to create mechanisms for communication with caregivers<br>Staff provide education to families about the importance of social-emotional development of infants and toddlers |

## OUTPUTS

| | | | |
|---|---|---|---|
| Meeting agendas and minutes<br>Key decisions | # of trainings<br># of implementing staff, coaches, supervisors and sites attending | Site lead TPITOS score reports<br>Action plans for each goal; coaching logs | Mechanisms for communication between staff and caregivers |

## SHORT-TERM OUTCOMES

| | | | |
|---|---|---|---|
| Increased leadership strategies relevant to adoption of model<br>Increased feedback to implementation plan/project cycles and evaluation plan/quality improvement, using data to identify problems and areas of growth<br>Increased community resource-sharing to achieve model fidelity | Increased knowledge of infant/toddler social-emotional development, competence using new strategies, and understanding of trauma-informed care<br>Increased support, collaboration, and mentorship with colleagues<br>Increased referrals to outside organizations | Increased staff TPITOS scores<br>Action plans are enacted and coaching goals are achieved<br>Coaches share experiences, challenges, and successes with each other<br>Adaptation of coaching style to provide best fit for relationship | Increased communication between staff and families of infants and toddlers<br>Increased caregiver knowledge of social-emotional development<br>Increased use of appropriate strategies at home |

## LONG-TERM OUTCOMES

| | | | |
|---|---|---|---|
| Build essential and relevant leadership strategies to adopt the model at the agency/system level<br>Increased discussion about opportunities for sustainability of the model past the pilot period | Decreased behaviour incident reports<br>Increased mentorship of other colleagues to implement *Pyramid Model* practices<br>Tailored needs met for equity-seeking groups | Increased focus on content in sessions | Decreased behaviour incident reports |

## IMPACT

**INCREASE STAFF ABILITY TO SUPPORT SOCIAL-EMOTIONAL DEVELOPMENT OF INFANTS AND TODDLERS**

# KEY ACTIVITIES

## MODULE TRAININGS

Day 1: Modules 1 & 2 – 45 people trained
Day 2: Module 3 – 30 people trained
Implementing staff, coaches, and supervisors from participating agencies received this training content. Participants shared that the material was familiar to them; however, it served as a valuable reminder and framing for the practices embedded in the TPITOS.

## COACHING TRAINING

15 people from Toronto Public Health, Humber College, and Toronto Children's Services attended 2-day Practice-Based Coaching training. The training supported coaches' understanding of foundational coaching practices and the coaching relationship.

## TPITOS RELIABILITY TRAINING

17 project participants (and 3 PSSP staff) were certified to use the Teaching Pyramid Infant-Toddler Observation Scale (TPITOS). At midpoint and endpoint, coaches participated in TPITOS administration with support from the PSSP team.

## TRAUMA-INFORMED TRAINING

Site leadership and all eight coaches were trained in foundational trauma-informed philosophy. Leaders and coaches were tasked with sharing key learnings with staff.

## COACHING

Bi-monthly or monthly throughout the pilot, coaches and site leads engaged in visits for observation and action-planning. We learned that coaches and site leads saw the practice as mutually beneficial; it strengthened staff practices from both perspectives and resulted in bi-directional learning.

## COMMUNITY OF PRACTICE

All coaches participated in a total of six Community of Practice (C.o.P.) meetings, held every two months. Coaches provided feedback on the coaching process and activities, problem-solved about challenges to coaching, and provided updates about their relationship with staff and its impact.

## OVERSIGHT COMMITTEE MEETINGS

Leaders from each implementing site and supervisors from each coaching agency participated in a total of ten meetings. Committee members provided feedback on the evaluation plan, consistently provided updates on successes and challenges to implementation, and shared resources developed during the pilot with each other.

## AGENCY IMPLEMENTATION TEAMS

Each implementing site created an Agency Implementation Team (AIT), which consisted of supervisors and two to three additional staff. Although our evaluation revealed that teams did not convene regularly, each site did complete the family engagement workbook and customize a plan to strengthen family engagement.

## MENTORSHIP FROM GRIT

Alberta's Getting Ready for Inclusion Today (GRIT) delivered module trainings and Practice-Based Coaching. We formed a bi-directional consultation relationship with GRIT, streamlining much of the implementation decision-making process and leveraging reciprocal sharing of materials to strengthen implementation.

## SUSTAINABILITY ENGAGEMENT

Conversations with Toronto Public Health, Humber College, Toronto Children's Services, and Ministry stakeholders began before the end of the pilot period to strategize for sustainability. Toronto Children's Services is now committed to participating in a scale-out, maintaining implementation at existing childcare sites and adding four new sites.

## EVALUATION ACTIVITIES

See next section for full description of data collection and evaluation methods, including TPITOS observation and reporting.

## PROJECT CELEBRATION

We brought together all implementing sites, coaches, and stakeholders to learn about preliminary findings from the project evaluation and celebrate successes.

## KNOWLEDGE EXCHANGE

We created information briefs at various stages of the project to highlight milestones. They included:

- *Visual Timeline (1 page):* Part of the recruitment and site selection stage, this outlined agency commitment through key dates and milestones
- *Project Information (4 pages):* This built awareness of the project among key stakeholders.
- *Information for Families #1 (1 page):* Designed to preempt any concerns families had, this explained social-emotional development and what staff would be learning during the project.
- *Evidence Brief (2 pages):* This established the rationale for the project by demonstrating the link between the need for intervention and the evidence supporting the Pyramid Model's effectiveness. It was meant to build momentum and buy-in for the intervention.
- *Project Update (1 page):* Still early in the pilot period, this highlighted the trainings delivered.
- *Evaluation Information (4 pages):* To help staff feel more comfortable, this outlined the TPITOS for everyone in the project, how it fit into the evaluation plan, and why evaluation is important.
- *Information for Families #2 (2 pages):* This described what staff were learning, and identified six basic strategies that families could try at home.
- *Resources Package (20 pages):* To maximize peer learning, we compiled the strategies site leads had developed and were using in their programs.
- *Midpoint Results (8 pages):* Capturing themes from our midpoint interviews and a comparison of baseline and midpoint TPITOS scores, this highlighted the project's potential effectiveness and was used to fuel sustainability planning. It also featured three video interviews with implementing staff about the project's benefits.

Depending on the function of the information brief, approximately 50-100 copies were printed for dissemination across project stakeholders. Digital versions were shared widely across audiences.

# GOALS OF EVALUATION

The PSSP team led the *First Steps to Success in Etobicoke* evaluation (i.e. design, data collection, analysis, reporting). The Oversight Committee also functioned as an evaluation sub-committee to review and provide feedback on evaluation plans and processes. Although child outcomes emerged from the qualitative data as a theme, the main evaluation focus was on staff and implementation outcomes. There were four main goals of the evaluation:

1. ***Fidelity:*** monitor the fidelity of staff practices to the Pyramid Model of service.

2. ***Quality Improvement:*** evaluate our implementation process to improve and/or adapt the intervention components.

3. ***Track Changes in Staff Practices:*** track any changes or improvements in staff Pyramid Model practices and action goals.

4. ***Inform Scale-out:*** provide evidence from which to develop recommendations for scale-out and sustainability.

## TIME POINTS

There were three main time points of data collection:

- **Time 1: January 2018 (baseline)**
- **Time 2: October 2018 (midpoint)**
- **Time 3: February 2019 (endpoint)**

The following pages outline our data collection tools, sources, and methods for the evaluation.

# METHODS

| | | |
|---|---|---|
| **TRAINING FEEDBACK FORMS** | TRAINING ATTENDEES | *Frequency:* 2 time points (pre- and post- training)<br>Method: 5-point rating scale and open-ended questions |
| | | *Purpose:* Pre-survey captured attendees' knowledge of how to support social-emotional development in infants and toddlers prior to training. Post-survey captured changes to knowledge level, as well as what worked well about the training day and what needed to be improved to better orient everyone to the model and their role in the project. |
| | | *Analysis:* Comparison of pre- and post- scores. Lessons learned from open-ended questions. |
| **TPITOS** | SITE LEAD | *Frequency:* Time 1 conducted by CAMH staff, Time 2 conducted by CAMH staff and coaches, Time 3 conducted by CAMH staff and coaches |
| | | *Purpose:* The Teaching Pyramid Infant-Toddler Observation Scale (TPITOS) is an observation tool that provides a snapshot of staff behaviors in the classroom environment. 78 indicators are associated with supporting and promoting the social-emotional development of infants and toddlers. Observation of the implementing staff member occurs over a two-hour period across at least three childcare activities (i.e. free play, structured group, mealtime, personal care, and outdoors). Interview questions collect information about practices not readily observed during the observation. |
| | | *Analysis:* Inter-rater reliability of 75% was assessed when two observers were present. The 78 indicators are scored using observation and interview items for site leads across the three time points. Red flag items were averaged across the three time points. |
| **INTERVIEWS** | SITE LEADS & COACHES | *Frequency:* Site leads interviewed at midpoint and endpoint (Time 2 and Time 3). Coaches interviewed at endpoint (Time 3). |
| | | *Purpose:* To explore the experiences of implementing the Pyramid Model to inform implementation and scale-out. |
| | | *Analysis:* Thematic analysis by PSSP team members. |
| **FOCUS GROUP** | OVERSIGHT COMMITTEE | *Frequency:* Midpoint and endpoint (Time 2 and Time 3) |
| | | *Purpose:* To discuss the impact of the project, successes, challenges, and perceived outcomes. The midpoint focused on quality improvement and the endpoint focused on feedback for the scale-out. |
| | | *Analysis:* Thematic analysis by PSSP team members. |

| | | |
|---|---|---|
| **FAMILY ENGAGEMENT PLANS** | AGENCY TEAMS | *Frequency:* Teams completed the self-directed workbook at midpoint to enhance existing family engagement. |
| | | *Purpose:* To plan, research, design, and implement a customized site plan to engage families related to integrated feedback, trauma-informed engagement or knowledge-sharing. |
| | | *Analysis:* Most sites did not submit plans for analysis. Sites verbally reported back in Oversight Committee meetings and submitted resources they created. |
| **ACTION PLANS** | SITE LEAD & COACHES | *Frequency:* Self-directed, informed by TPITOS results. Completed as needed, with bi-monthly review of goals. |
| | | *Purpose:* To ensure documentation of ongoing planning and provide a structure to monitor goals as achieved or in-progress. |
| | | *Analysis:* Goals are summarized in the site lead profiles found in the next section. |
| **COACHING LOGS** | COACHES | *Frequency:* Completed after every coaching visit, typically bi-monthly. |
| | | *Purpose:* To document the strategies used during the observation period, identify the focus of meetings, and check in with staff about the visit itself. |
| | | *Analysis:* Coaching strategies and sessions are summarized in the site lead profiles. |
| **COACH REFLECTION SURVEY** | COACHES | *Frequency:* Completed at midpoint. |
| | | *Purpose:* To check in with coaches about their coaching relationships and processes, and to provide an opportunity for self-reflection. |
| | | *Analysis:* The PSSP team summarized the survey questions and used them to inform project planning. |
| **MEETING MINUTES** | PSSP TEAM | *Frequency:* All Community of Practice meetings, Oversight Committee meetings, and internal team meetings. |
| | | *Purpose:* To document activities and utility; collect and integrate continuous feedback; document project process and progress. |
| | | *Analysis:* Iterative analysis by PSSP team members. |

INTERVIEW EXCERPT

# THERE WERE A LOT OF CHANGES THAT HAPPENED WITH THE TODDLERS. I WAS ACTUALLY SEEING IT. SO WE WERE BOTH FEELING THAT WHAT WE WERE DOING WAS MAKING A DIFFERENCE.

APRIL 2019

PARTICIPATING COACH

# TRAINING RESULTS

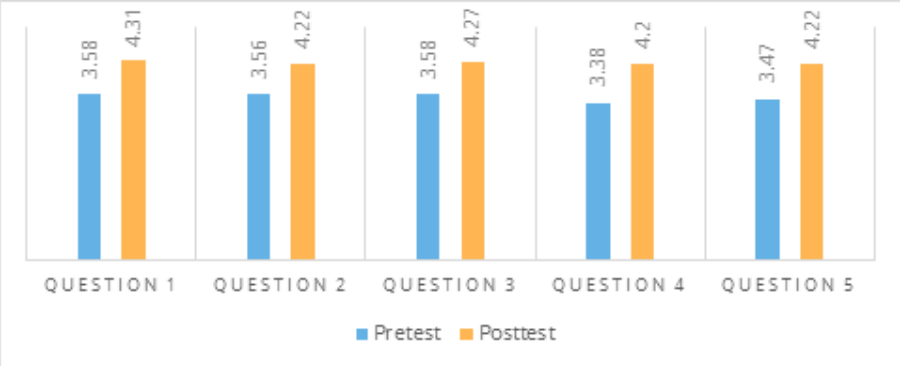
There were four professional training sessions for implementing site leads, additional staff, coaches, and site management, including:

1. Module 1: Social-emotional development in the context of relationships and Module 2: Responsive routines, environments, and targeted strategies
2. Module 3: Individualized interventions
3. Practice-Based Coaching
4. TPITOS Reliability Training

Attendees of all Module trainings completed a pretest-posttest assessment. Practice-Based Coaching did not include a pretest-posttest assessment. Teaching Pyramid Infant-Toddler Observation Scale (TPITOS) Reliability Training was provided by the Pyramid Model Consortium and included a thorough evaluation period at the end of the day in order to be certified on use of the tool.

## MODULE 1 & 2 TRAINING

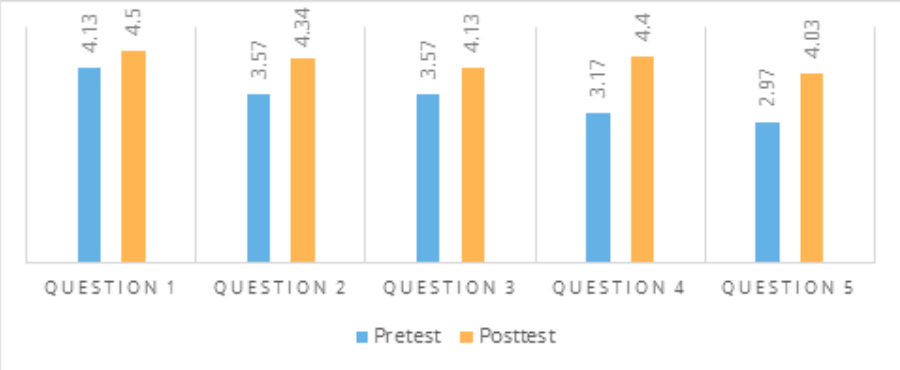
There were 45 attendees of the Modules 1 & 2 professional training. As measured by a 5-point rating scale, self-reported knowledge of supporting social-emotional development for infants and toddlers increased.




| SURVEY QUESTIONS | | |
|---|---|---|
| KNOWLEDGE OF THE FOLLOWING: | 1 | What social-emotional development means for infants and toddlers |
| | 2 | How culture impacts staff support of social-emotional development |
| | 3 | The key ways a quality environment can promote social emotional development |
| | 4 | How to implement targeted strategies to intentionally build social-emotional skills in infants and toddlers |
| | 5 | How to engage families in the social-emotional development of their children |

## MODULE 3 TRAINING

There were 30 attendees of the Module 3 professional training. As measured by a 5-point rating scale, self-reported knowledge of challenging behaviours and trauma-informed practices increased.




**SURVEY QUESTIONS**

| KNOWLEDGE OF THE FOLLOWING: | |
|---|---|
| 1 | What challenging behavior is |
| 2 | The process of providing positive behavior supports |
| 3 | How to obtain parental consent when working with children who express challenging behaviours. |
| 4 | How to evaluate the positive behavior support plan |
| 5 | How to use trauma-informed practices when working with children and families |

# TPITOS RESULTS

## WHAT DO THESE SCORES MEAN?

We used the Teaching Pyramid Infant Toddler Observation Scale (TPITOS) results to measure staff fidelity to practices associated with the Pyramid Model and to track changes in staff's practices over time. The assessment included a two-hour observation followed by an interview with the site lead.

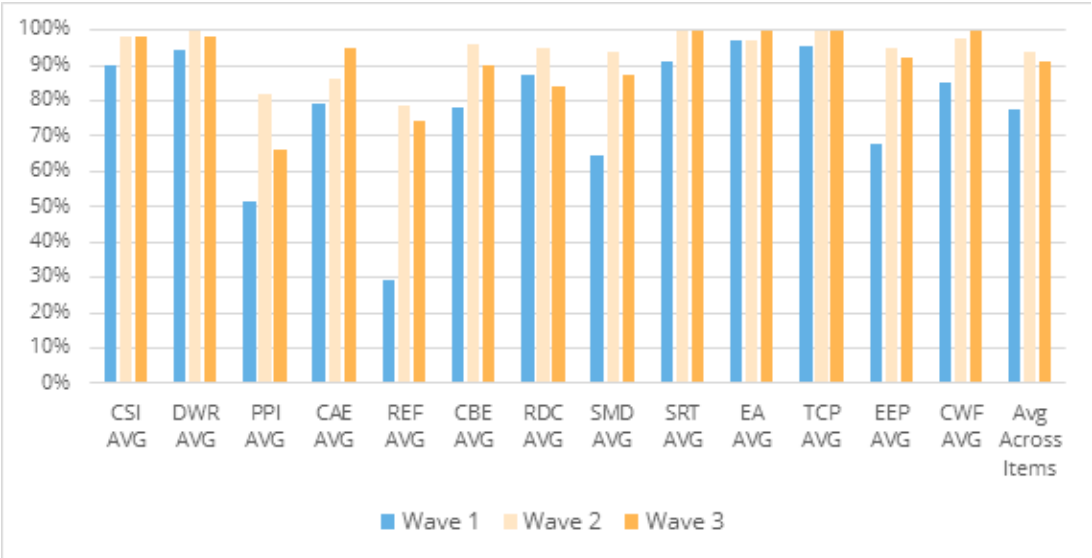
There are 13 indicator items on the TPITOS, listed below. Each of these items refers to a different category of adult behaviours and environmental variables that help promote healthy social-emotional development of infants and toddlers.[21]

The following section describes how site leads scored on these items, before (Time 1), during (Time 2), and after (Time 3) the project. First, we provide an overview of average scores across indicator items for all site leads combined.

The next few pages then explore eight individual site profiles. These integrate site leads' TPITOS data with information about staff goals acquired through their action plans and coach logs. These are snapshots that do not capture all of the thoughtfulness and hard work put into the project by the site lead and their coach. Discussion centers on items that did not reach fidelity, based on the cut-off score of 75%.

| | |
|---|---|
| **CSI** | opportunities for communication and relationship building |
| **DWR** | demonstrates warmth and responsivity |
| **PPI** | promotes positive peer interactions |
| **CAE** | promotes engagement |
| **REF** | responsive to emotions and teaches about feelings |
| **CBE** | communicates appropriate behavioral expectations |
| **RDC** | responds to distress and manages challenging behaviors |
| **SMD** | uses strategies for children with disabilities or dual-language learners |
| **SRT** | conveys planned schedule, routines and transitions |
| **EA** | environment appropriately arranged |
| **TCP** | collaborates with colleagues |
| **EEP** | uses effective strategies to engage parents |
| **CWF** | promotes family involvement |
| **AVG** | average across items |

## AVERAGE SCORES

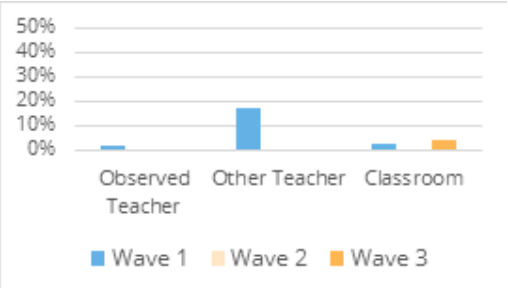



The average percentages across the three time points were 78%, 94%, and 91% respectively. Though baseline scores were high to begin with, these averages show a 16% increase from Time 1 to Time 2. The decrease of 3% from Time 2 to Time 3 may be due to some expected program drift and the length of time since receiving training. There was a 13% overall increase in fidelity to the model during the project.

The only item that fell below 50% at any time was REF (responsive to emotions and teaches about feelings) at Time 1 (29%). It increased to 75% at Time 3. This 46% improvement may have resulted from the PSSP team communicating the low scores on REF to the Oversight Committee, as well as low individual scores prompting staff to focus action goals around REF.

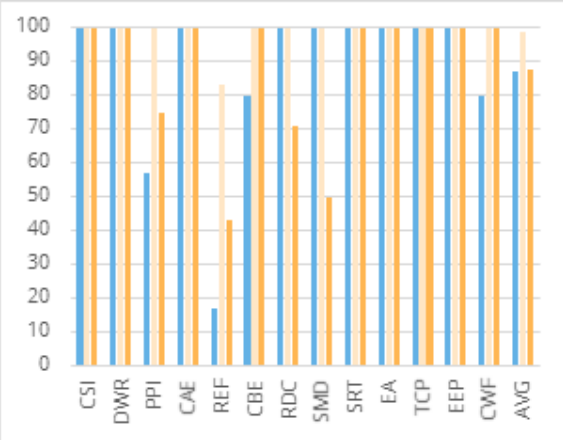
## RED FLAGS

There were minimal red flags across the three time points. Red flags refer to staff behaviours that are incongruent with Pyramid Model practices and may impede social-emotional development.[21] Time 1 had the highest red flags observed (17%). The person responsible for the red flags was an Early Child Educator student and the site lead discussed feedback with them directly. Red flags were rare by Time 3, at 0% for the observed site leads and only 4% for the classroom environment.



# SITE PROFILES

## SITE LEAD A

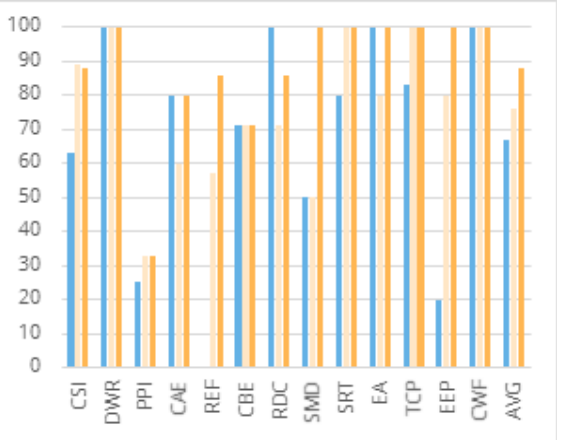



Site Lead A's average scores for the three time points were 84%, 98%, and 88%, respectively. Her PPI and REF practices did not reach fidelity at baseline. During the project, PPI increased from 57% at Time 1 to 75% at Time 3. REF increased from 17% at Time 1 to 43% at Time 3.

Site Lead A's action goals were to increase daily peer interactions and play, increase her responsiveness to children's emotional expression through labelling and a broader emotional vocabulary, and to increase her awareness of her own emotions in response to real-life classroom situations.

Coaching strategies included reflective conversation, review of online resources to support social-emotional development, discussion of new strategies, creation of tools that help teach emotions in developmentally appropriate ways, and dissemination of information to staff and caregivers. Her coach helped her adapt to a new program room, review individual needs of children, acknowledge her strengths, and identify areas of ongoing growth.

## SITE LEAD B

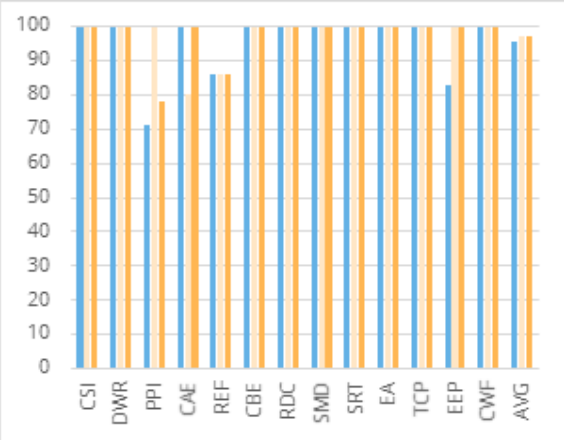



Site Lead B's average scores for the three time points were 64%, 76%, and 84% respectively. The CSI, PPI, REF, CBE, SMD, and EEP practices did not reach fidelity at baseline. Her CSI practices increased to 89% at Time 3, and her REF practices increased from 0% to 86% by Time 3. PPI practices did not reach fidelity by the end of the project. Her SMD practices were at 50% for Time 1 and 2 but increased significantly at Time 3 to 100%. EEP was 20% at Time 1 but increased significantly at Time 3 to 100%.

Site Lead B's action goals were to encourage expression of feelings through language, support acceptance of basic emotions, and model appropriate peer interactions through creative play. The site lead went on to create a number of resources and activities related to the children's emotions, and even included families in weekly circle time.

Coaching centered on praising improved performance, focusing on real-life opportunities in the classroom, reflective conversation, and TPITOS review.

## SITE LEAD C

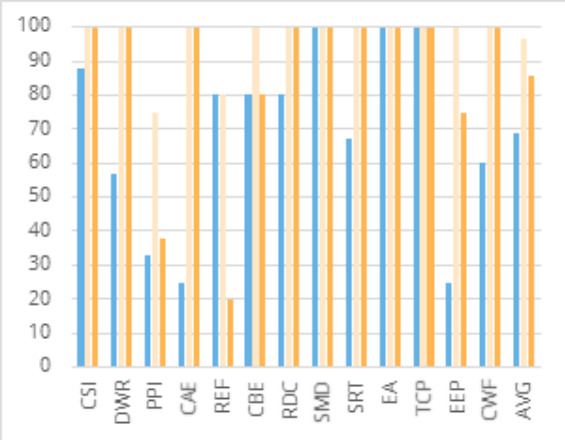



Site Lead C's average scores for the 3 time points were 95%, 97%, and 95% respectively. The only score not at fidelity at any time was PPI at baseline (71%), and it increased to 78% by the end of the project.

Site Lead C's goals included modeling social skills (e.g. sharing, gentle touching, using words), helping children understand each other's intentions, facilitating communication, acknowledging children's feelings, and giving toddlers more choices. Through her focus on these goals, she began using a checklist to follow when mediating conflict between children.

Her coach helped her ask questions about children's emotional expressions and point out voice tone and facial expressions to help toddlers better understand each other. Other coaching strategies included reflective conversation, ongoing performance feedback, role play, material provision, problem-solving discussion, case scenarios, and use of video for role modelling.

## SITE LEAD D

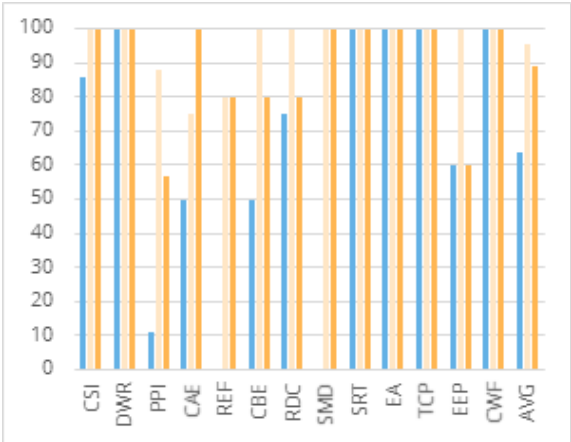



Site Lead D's average scores across time points were 67%, 95%, and 82% respectively. DWR, PPI, CAE, SRT, and EEP items did not reach fidelity at baseline. DWR increased from 57% to 100% at Time 3. PPI increased from 33% to 75% at Time 2, and decreased back to 38% at Time 3. Her CAE and SRT practices were 25% and 67% at baseline, respectively, but both increased to 100%. EEP was below 50% at Time 1 and increased to 75% at Time 3. Her REF practices, at 80% for baseline and midpoint, actually decreased to 20% at Time 3.

Site Lead D's first action goal was to develop and implement strategies that encouraged toddlers to identify both positive and negative emotions and find ways to deal with negative emotions safely. Her second goal was to label her own emotions during classroom activities as a form of modelling to teach about emotions.

In addition to regular reflective conversation, performance feedback and problem solving, coaching included use of case scenarios, as well as positive praise for successful interactions, patience, and strategies used. They discussed emotional labelling, created new resources, and celebrated successes.

## SITE LEAD E

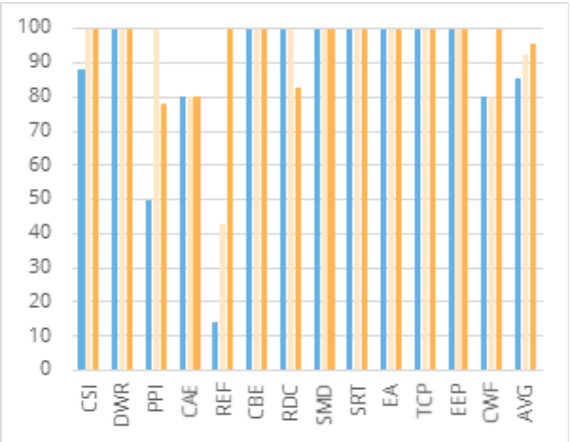



Site Lead E's average scores across the three time points were 65%, 95%, and 88% respectively. Her PPI, CAE, REF, CBE, SMD, and EEP did not reach fidelity at baseline. Her EEP practices scored 60% at Time 1, increased to 100% at Time 2, and decreased back to 60% at Time 3. From Time 1 to Time 3, PPI increased from 11% to 57%, CAE increased from 50% to 100%, REF increased from 0% to 80%, CBE increased from 50% to 80%, and SMD increased from 0% to 100%.

Site Lead E's action goals were to promote children's active engagement and to be more responsive to children's emotional expressions in order to teach about feelings. She worked with her coach to problem-solve, reflect on what could have been done differently in the classroom, and explore new strategies and resources, like sensory objects, emotional labelling, and "feelings" blocks.

Her coach helped her to ensure that all activities incorporated children's active engagement to build self-confidence and that all program staff were promoting emotional expression. They also used coaching time to work through Site Lead E's anxiety about being observed and assessed through TPITOS.

## SITE LEAD F

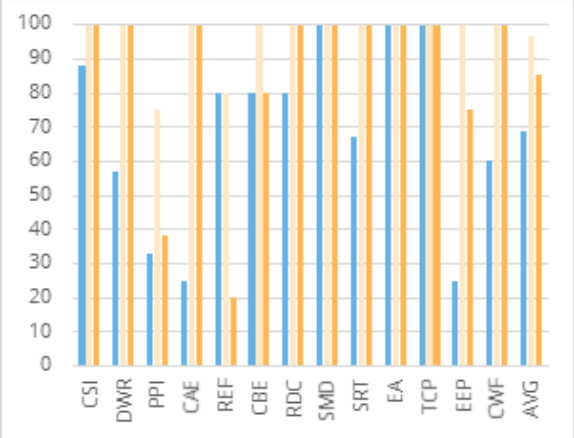



Site Lead F's average scores for the three time points were 82%, 92%, and 95% respectively. PPI and REF practices did not reach fidelity at baseline but increased from 50% to 78% and from 14% to 100% at Time 3, respectively.

Site Lead F's action goals were to label emotions and problem-solve during daily toddler interactions, use photos of the children as a tool for identifying different emotional expressions, and help children label the different steps involved in routine activities to promote language development.

Along with problem-solving, reflective conversations, material provision, and demonstration, coaching sessions also included discussion of specific examples observed in the room and how she could have incorporated more emotional labelling. They worked together to review family engagement plans, created a vision for the center based around supporting social-emotional development, adapted resources to better reflect the children's needs, and celebrated the site lead's progress and confidence.

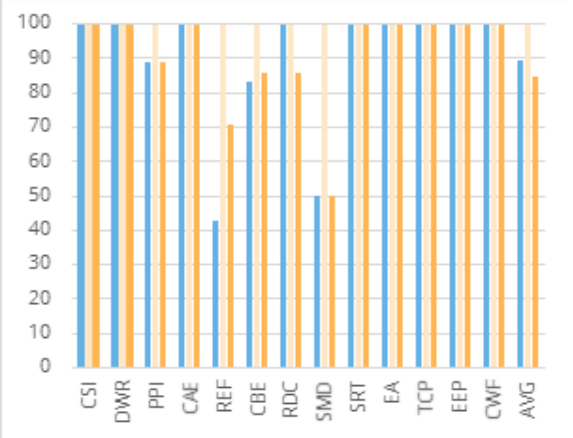
## SITE LEAD G




Site Lead G's average scores were 69%, 97%, and 86% respectively. Her DWR, PPI, CAE, SRT, EEP, and CWF practices did not reach fidelity at baseline. All items reached fidelity at Time 3 except for PPI, which increased from 33% to 38%, and REF, which decreased from 80% to 20%. From Time 1 to Time 3, DWR increased from 57% to 100%, CAE increased from 25% to 100%, SRT increased from 67% to 100%, EEP increased from 25% to 75%, and CWF increased from 60% to 100%.

This site did not submit their action plan or coaching logs for evaluation so there are no goals or strategies to discuss.

## SITE LEAD H




Site Lead H's average scores for the three time points were 90%, 100%, and 92% respectively. Only her REF and SMD practices were not at fidelity at baseline. They never reached fidelity, with REF increasing from 43% to 71% and SMD remaining at 50%. At Time 2 she received a perfect score, with all practices at 100%.

Minimal information was available for this site; however, one of Site Lead H's goals was to promote children's active engagement. With the support of her team, she planned to strengthen this area of focus daily but did not detail how she did so. There were no other action plans or coaching logs submitted.

## ITEMS NOT AT FIDELITY

| | SITE A | SITE B | SITE C | SITE D | SITE E | SITE F | SITE G | SITE H |
|---|---|---|---|---|---|---|---|---|
| **TIME 1** | PPI, REF | CSI, PPI, REF, CBE, SMD, EEP | PPI | DWR, PPI, CAE, SRT, EEP | PPI, CAE, REF, CBE, SMD, EEP | PPI, REF | DWR, PPI, CAE, SRT, EEP, CWF | REF, SMD |
| **TIME 3** | REF, RDC, SMD | PPI, CBE | | PPI, REF | PPI, EEP | | PPI, REF | REF, SMD |

# FOCUS GROUP & INTERVIEW THEMES

*We pulled the following themes from a variety of sources, including interviews with site leads and coaches, and focus groups with oversight committee members.*

## PROJECT IMPACT

*Improved practice.* Most site leads reported that their practices related to social-emotional development evolved. They used simpler language with the children, were more mindful of emotions and how infants expressed them, and used more materials (e.g. posters, pamphlets, puppets, books, music, feeling cube, feeling chart). Many believed they already knew about social-emotional development through previous education, but the project gave them more strategies and confidence to incorporate this knowledge into their practice.

Coaches reported tremendous growth in site leads; they were calmer, more able to label emotions in children and themselves, and more active about sharing information with colleagues. They also observed site leads asking families more questions about their home life and their child's behaviour.

*More confidence.* Most site leads reported that their coaches gave them the specific language and skills needed to feel more confident in their abilities. Coaches also described site leads as having more confidence both generally and specifically in the context of conversations with families. They observed staff having ongoing conversations with families about social-emotional development instead of just when issues arose. At the project midpoint, some coaches reported seeing the site leads take more authentic ownership of their role and its importance.

*Improvement in children's emotional regulation.* While the intent of the evaluation was not to explore the impact on children, most site leads identified changes in the children's behaviours as a direct outcome of their improved practice. Children appeared to show improvement in their emotional regulation in how they were calmer, more resilient, and less aggressive. The children were more aware of their emotions and better understood why they were experiencing the emotion. Children also became more attentive, observant, and curious about the emotions of their peers. Coaches observed children become better at connecting facial expressions with emotion words.

*Engagement of families.* Site leads reported feeling more confident talking to families about social-emotional development in a way that did not shame them. Some site leads based their approach with families on the strength-based non-judgmental relationship they had with their coach. They were more confident asking about home life and teaching families how to incorporate social-emotional skills at home. However, they also reported that there was a lack of resources for non-English-speaking families and suggested resources be translated to other common languages. Some identified that the trainings helped them to be more inclusive with families from different cultural backgrounds (e.g., different cultural traditions they were not aware of) while others felt that they required more intense training in this area.

Site leads saw improved social skills and emotional language in families and felt a deepened relationship with them. They described the pleasure in hearing caregivers start talking about emotions with their children.

While site leads reported an improvement in family engagement, they also identified challenges. Those working in the unconventional settings do not work with the same families on a regular basis so it was more difficult to describe any overall changes in their behaviours. They also found it more challenging when families were resistant to learning about using new and different strategies. Some of these families held beliefs and fears that coddling their children would make them soft. Different site leads reported varying levels of comfort challenging these families on their beliefs, with some thinking there were not able to make an impact.

Oversight Committee members reported that before the project, their staff tended only to speak to families in response to issues that arose. Through the training and coaching, social-emotional development has now been incorporated into all conversations with families. Some acknowledged the need for family engagement at their agency to become more meaningful than simply providing information.

*Better system collaboration.* The project encouraged new and stronger collaboration with their community partners. *First Steps to Success in Etobicoke* was an anchor that brought service providers in the community onto the same page, delivering the same messages to families about the importance of social-emotional development. It was also beneficial to have agency leadership learn alongside frontline staff.

## COACHING IS THE HEART OF THE MODEL

*Mentorship.* Most site leads reported that the mentorship they received through the coaching relationship was the most valuable part of the project. Having good rapport with their coach was important because it created trust in the relationship. Coaches described their experience of coaching as rewarding. The bi-directional learning and customized approach lent itself to an openness in providing and receiving feedback. This personal relationship-building strengthened coaches' ability to help staff through the anxiety of the TPITOS observation experience. In some cases, significant time and energy was devoted to validating site leads through these concerns.

Site leads reported that while they could do better at mentoring othes at their organization, the coaching relationship made it easier to transfer knowledge to the rest of their team. Some coaches engaged with families, children and other staff when on site, which made everyone more comfortable with their presence in the room. While other staff were interested in the model, some site leads felt they did not have enough information to explain it adequately.

*Positive experience of coaching.* Everyone described a positive experience with their coach, mainly attributed to easy communication and scheduling, warm personalities, and an approach that was supportive versus critical and judgmental. They appreciated having someone to model appropriate behaviour, provide them with tools and guidelines, and brainstorm with. Coaches shared new ideas to

INTERVIEW EXCERPT

# PARTICIPATING IN THE INITIATIVE HAS MADE ME A MORE MINDFUL AND REFLECTIVE PRACTITIONER, AND HIGHLIGHTED THE SIGNIFICANCE OF NURTURING AND RESPONSIVE RELATIONSHIPS.

MARCH 2019

SITE LEAD

enhance the environment, pointed out what the site lead was doing well that they were not aware of, and gave feedback on action goals. Site leads reported that because of their positive experience, they felt more confident in other aspects of their lives both personally and professionally, they were able to transform the positivity into their relationships with children's caregivers, and their team worked better together. Coaches appreciated what they considered a valuable learning experience that strengthened their skills in adult education, role modelling, and giving sensitive feedback.

*Strength-based approach.* Coaches focused their feedback on the positive work staff were doing and worked to build upon strengths. Critical feedback was infrequent and only presented as an opportunity to improve. The Community of Practice and training helped coaches learned about strength-based approaches if they did not already possess this skill.

*Self-reflection.* Most site leads reported how the mentorship helped them become more aware of their practices and reflect on language used with the children and families. They were more observant of their own actions, children's actions, and their own emotions.

*Previous relationship with coach.* Site leads that had a previous relationship with their coach through their regular roles found it easier to dive right into the work. It provided a smoother transition, helped break the ice, and increased comfort and openness. Site leads that were new to their coach needed more time to build the relationship. In these cases, frequent visits early in the project helped to build trust.

*Meeting coordination.* Strong organization and communication was essential. Meeting more frequently at the beginning of the project helped everyone become more familiar with the Pyramid Model and what was expected of their role. Meetings became less frequent as this familiarity increased. Coaches often used text messaging to send reminders of meetings and follow up with goals. Coaches described how scheduling was more difficult in the summer and during staff changes.

*Content expertise.* Toronto Public Health nurses acting as coaches in unconventional settings were less familiar with daycare routines than the Resource Consultants regularly working in childcares. However, nurses were knowledgeable in child development, which was valuable when supporting site leads' work particularly with high risk families.

## HOW TO IMPROVE PROFESSIONAL TRAINING

*Module training.* Most site leads found the trainings helpful, describing how even though the information was not new to them, it reinforced how to be intentional about supporting social-emotional development. In particular, they thought the use of videos and tangible case scenarios helped bring the theory to life. Some identified that it would have been more helpful for all staff from each participating organization to attend the training to ensure that everyone in their environment was on board with the model. Most site leads reported some confusion about the order of the trainings. Some also felt that when starting implementation, they were not comfortable with the expectations of their role.

*Materials.* Site leads and coaches both described the need to revise or adapt the Pyramid Model materials. For example, the TPITOS had to be adapted for settings where parents are not always on site, family resources needed to be translated to other languages, and the videos in the training felt outdated.

*Online training.* Online training was convenient for the one site lead who could not attend trainings in person. However, it was geared more to older children as opposed to infants and it did not offer the same richness of experience provided by the in-person trainings.

*Trauma-Informed training.* Coaches and agency leadership shared with their treams what they learned about trauma-informed approaches from the training faciliated by The Jean Tweed Centre. Although site leads felt that coaches having this trauma-informed lens helped them start having challenging conversations with families, most described the need for more training. They felt this would help them feel comfortable and confident engaging families with this trauma-informed lens in mind. They wanted to learn more strategies for how to connect with families, particularly those from different cultural backgrounds.

## TPITOS ADMINISTRATION

Overall site leads and coaches saw the TPITOS to be of value but had some concerns with how it was administered. For example, in sites lacking the structured activities needed for the observation, the TPITOS did not necessarily do justice to the work the site lead was doing. Of most concern though was who was conducting the observations. Because the baseline TPITOS (Time 1) was completed by the PSSP team, this made it challenging for the coaches to answer any follow-up questions their site lead had in the beginning. It would have been helpful for us to have provided more feedback to site leads around skills to work on based on our observations. Some coaches preferred to do their own observation, which was the case at midpoint (Time 2). After performing this full TPITOS assessment, they became more familiar with the model, which smoothed out the goal-setting and action-planning process.

## CHALLENGES

*Staff supports.* Because they were the only staff on site being coached, some felt they did not have a support system with whom to problem-solve. They suggested having an online forum to connect staff and share resources. Agency Implementation Teams (AITs) helped meet this need, although they were primarily about addressing things like funding and resources. Having the supervisor on this team helped make decisions and move the project forward. In some sites, AITs were unsuccessful because it was difficult to find time to meet.

*Language barrier.* Some site leads found it challenging to engage families who did not speak English as their first language because it was harder to build trust and communicate.

*Anxiety-provoking.* External staff from outside the program coming into site lead's working environment to conduct the first TPITOS observation induced anxiety in most staff. The second TPITOS assessment was less anxiety-provoking; by this point they were more familiar with the model and had developed a relationship with their coach based on trust and non-judgment. When coaches conducted the observation, it was less intrusive and flowed more with the rest of their workday.

*Lack of time.* It was challenging for site leads to find time to work on action goals and complete paperwork for the project, which required time outside of their normal work to focus on. They felt that there was not a lot of backfill staff support to allow them to do this. In some cases, coaches helped create tools and activities to save time. Site leads had difficulty finding time to engage families in conversations about the project because they seemed too busy.

*Referrals did not increase.* Some site leads spoke about how the training increased their ability to identify and better support children through challenging behaviours instead of simply referring to an external service where they would be on waitlist. Others explained that their sites work only briefly with the children in their care so they do not have time to make referrals. At these sites there is a behaviour specialist on staff who does work with the family and connect them to services if needed. Other reasons that frequency of referrals did not increase included long waitlists, a shortage of community services for this age group, and families not being willing to acknowledge an issue in their child.

## SUSTAINABILITY & SCALE-OUT

Oversight members described the importance of devoting time to conversations about sustainability within their agency, in the larger community, and as a project team. They were motivated to keep the changes alive and supported scale-out because they believed having more staff trained would help sustainability by embedding Pyramid Model practices across programming. They identified that it would be helpful to have devoted time to reflect on the coaching and current practices so adjustments can be made. They suggested periodically bringing together participating sites to discuss how they have been supporting social-emotional development at their agency. They also see value in funding the spread of the model across all childcares in Toronto.

# OTHER FEEDBACK

Attendees of all Module trainings completed feedback surveys. Practice-Based Coaching and TPITOS Reliability Training did not include distribution of feedback surveys; however, participant feedback was collected through Community of Practice meetings. The following were suggested improvements that can be applied to future trainings:

- Host implementation meetings with each implementing group (i.e. coach, staff, supervisor) before beginning implementation
- Reorganize the sequence of trainings (i.e. TPITOS first, then Module Trainings, then Practice-Based Coaching)
- Expose staff to coaching materials before trainings to make expectations clearer
- Reorganize Agency Implementation Team booklet order to reflect training content and share in advance for people to use at their sites
- Arrange seating during training to ensure coaches are seated with the site lead they will be working with
- Emphasize stronger links between content and practice
- Add more case studies and videos
- Include more content on emotions, self-reflection, cultural competency, working with diverse families, working with children with special needs, working with infants versus toddlers, and trauma-informed practice
- Increase exposure to TPITOS content in module trainings and reframe it as less of a test to minimize pressure

Through a reflection survey at the midpoint and individual interviews at the endpoint, coaches were able to provide feedback on their experience of being oriented to the model, the Community of Practice, and their role as a coach. They suggested the following:

- Host the first Community of Practice meeting before trainings occur to clarify the project and fully establish expectations and scope
- Provide binder of materials to get started
- Provide more meetings at the beginning, then scale back the meetings over time
- Start each meeting with a roundtable of successes
- Keep meetings bi-monthly and in Etobicoke
- Create a mechanism for coaches and sites to be informed about activities occurring across all sites
- Find ways to stay connected between meetings to problem-solve and discuss (e.g. online message board)
- Establish a PSSP team member as a primary contact with more regular, accessible, informal communication
- Keep TPITOS administrators consistent at all points
- Provide videotaping instead of site visits for TPITOS to ensure that everything is captured

# SYSTEM RECOMMENDATIONS

**1.0**

Commit the time it takes to truly understand the needs of the system by engaging relevant stakeholders. Through our fulsome research process, we were able to respond to a real community need, which inevitably sustained engagement and buy-in.

**2.0**

Build investment at the system level in order to implement and sustain the model because this project requires a high volume of human resources for coaching, administering the fidelity assessment, and coordinating all of the components of implementation.

**3.0**

Continuously invest in professional capacity-building to support the promotion of social-emotional development of children aged 0-3 through all childcare settings and in any other setting where professionals regularly interact with infants and toddlers.

**4.0**

Strategize across sectors to standardize core competencies in social-emotional development for professionals working with infants and toddlers.

**5.0**

Embed Pyramid Model practices within the Early Childhood Education (ECE) curriculum. Our findings in the pilot project suggest an opportunity to strengthen social-emotional development skills for all childcare professionals.

**6.0**

Integrate professional development with ongoing coaching in order to meaningfully build and sustain knowledge and skills.

**7.0**

Align with existing system priorities and be explicit about how Pyramid Model practices fit with city and provincial priorities.

**8.0**

Leverage system players who are already doing similar work and reframe their roles instead of adding new resources (e.g. TPH nurses and Resource Consultants both provided coaching to sites they already had a relationship with through their position).

# LESSONS LEARNED

## TPITOS ADMINISTRATION

- The same observers should conduct the fidelity assessment at each site consistently across time points.
- To reduce bias, coaches should not conduct TPITOS observation and scoring with their own site lead. If coaches want to be involved, they could administer the TPITOS at other sites.
- Each TPITOS should be administered by two people in order to establish more objective scoring and reliability.

## TRAINING & MATERIALS

- Materials should be adapted to better fit non-childcare settings; in particular the TPITOS was challenging to administer in settings with mixed-age groups and fewer scheduled activities.
- All materials and trainings should be more strengths-based; staff should feel like they are improving their skills and engaging in professional development as opposed to participating in an assessment. This process is uncomfortable so it is important that coaches and leaders do their best to be intentional about reinforcing strengths.
- Instead of a one-off training for a few stakeholders, a trauma-informed lens should be embedded in all materials and training. A dedicated project-wide focus would help staff understand what more practical approaches might look like in their setting.
- An online repository to access and share resources would centralize information.
- Professional trainings are an opportunity to more clearly connect content to project roles and day-to-day implementation.

## SCOPE

- Coordinators should plan for multi-year implementation in order to achieve and sustain fidelity to Pyramid Model practices.
- While starting small helps embed the philosophies and practices of the Pyramid Model into organizational culture, program-wide implementation is the priority.

## IMPLEMENTATION SUPPORT

- A dedicated coordinating team is needed to oversee the implementation of all core components of the project.
- A dedicated evaluation team is needed to collect and aggregate TPITOS data and to design a fulsome outcome evaluation.

## STAFF SUPPORT

- Staff need time to prepare for coaching meetings.
- Organizations need their participating staff to be backfilled to allow them to participate in coaching and attend trainings. Staff should be remunerated for the time they contribute.
- A team-based approach to action planning is ideal. Staff feel supported when the entire program room is engaged in the project rather than the onus being on one person.

## FAMILY ENGAGEMENT

- The Pyramid Model's recommendations on family engagement describe how to engage families equitably within leadership structures in ways we did not.[22]
- Implementing teams need a structure for planning for family engagement that makes the project's content and processes more accessible to caregivers at each site.

## STAFF ENGAGEMENT

- An online forum would help maintain connection between all implementing participants in order to share learnings, problem-solve, and build relationships across sites.
- Collaborative decision-making with leaders from each implementing site creates a sense of community ownership and keeps participating organizations engaged.
- A strengths-based orientation needs to be emphasized to all implementing groups.
- Coaches should be engaged in a Community of Practice regularly throughout implementation. It provides a consistent opportunity to problem-solve, strengthen practice, share resources and increase engagement in the project.

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# CONTACT

The results of this pilot project and continued interest from participants has led to a scale-out called *First Steps to Success Toronto*. Childcare centres will continue to receive coaching from Resource Consultants provided by Toronto Children's Services and Humber College.

We have developed a companion guide to this report containing the following resources:

- Implementation Plan
- Action Plan Template
- Coaching Log Template
- Focus Group/Interview Guide
- Practice Profile
- Family Engagement Workbook
- Communication Briefs
- Training Feedback Form
- Coach Reflection Survey
- Expression of Interest

If you would like to access these resources or have questions about the pilot project or the scale-out, please contact:

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