

WHAT WORKS?

A Study of Effective Early Childhood Mental Health Consultation Programs



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This report is dedicated to our friend and colleague, Dr. Jane Knitzer, whose career was devoted to improving the lives of vulnerable children and their families. Jane always began her advocacy with “what the science tells us” and then made the case for which policy options naturally follow. We hope that others will use the information in this study to inform their research, policies and practices on effective early childhood mental health consultation across the country.

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Full report available at <http://gucchd.georgetown.edu>

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Executive Summary



In recent years, there has been growing concern among many in the early care and education (ECE) community that increasing numbers of very young children are manifesting behavior problems. According to the Center for Mental Health in Schools (2005), the prevalence of clinically significant emotional and behavioral disabilities among young children ranges from 4 to 10%, with significantly higher estimates for low-income children. In very young children these behaviors can be severe enough to warrant their removal from their preschool programs (Gilliam, 2005), setting into motion a cascade of negative experiences. Early childhood mental health consultation (ECMHC) is emerging as an effective strategy for addressing these challenging behaviors and supporting young children's social/emotional development in ECE settings (Gilliam & Shahar, 2006). As such, states and communities have begun investing in mental health consultation, underscoring the need for accurate, data-driven information about the components of effective consultation.

To attend to this need, the Georgetown University Center for Child and Human Development (GUCCHD) embarked on this study to address critical knowledge gaps in the field and provide data-driven guidance around consultation program design. With funding from the Annie E. Casey Foundation and the A.L. Mailman Family Foundation, GUCCHD explored the following key questions:

1. What are the essential components of effective mental health consultation programs?
2. What are the skills, competencies, and credentials of effective consultants?
3. What are the training, supervision and support needs of consultants?
4. What level of intervention intensity (i.e., frequency and duration) is needed to produce good outcomes?
5. Which outcomes should be targeted and how should they be measured?

WHAT IS EARLY CHILDHOOD MENTAL HEALTH CONSULTATION?

Mental health consultation in early childhood settings is a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more caregivers, typically an early care and education provider and/or family member. Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age 6 and their families (adapted from Cohen & Kaufmann, 2000).

These questions were investigated through two-day site visits to six consultation programs that have demonstrated positive child, family, ECE staff and/or ECE program outcomes:

- **Child Care Expulsion Prevention** (Michigan);
- **Early Childhood Consultation Partnership** (Connecticut);
- **Early Intervention Program/Instituto Familiar de la Raza** (San Francisco, CA);
- **Early Intervention Project** (Baltimore City, MD);
- **Kid Connects** (Boulder, CO); and
- **Together for Kids** (Central Massachusetts).

Snapshots of each of these programs, as well as detailed program summaries, are available later in this report.

As part of these site visits, the study team conducted interviews with a diverse array of stakeholders (i.e., those providing and receiving consultation services, as well as state/local program partners and program evaluators) and gathered supporting data and materials to learn about the programs' designs and practices and assess commonalities. In addition to exploring the questions

listed above, the study also examined several topics of special interest to the study funders (i.e., cultural and linguistic competency and consultation to children in foster care, children with special needs, and kith and kin providers).

Further, to gain a better understanding of the extent to which consultation efforts are occurring nationally, the study incorporated a brief online scan of the ECMHC activities in all states and territories through a questionnaire disseminated to Children's Mental Health Directors and Early Childhood Comprehensive System Coordinators. Finally, to ensure thorough consideration of the implications of the study findings and generate a diverse array of recommendations, the study team convened a meeting of experts that included researchers, state administrators, consultation program administrators/providers and other mental health professionals.

This report summarizes the findings of this study and offers key recommendations for policymakers/funders, ECMHC providers, ECE program administrators, and researchers/evaluators.

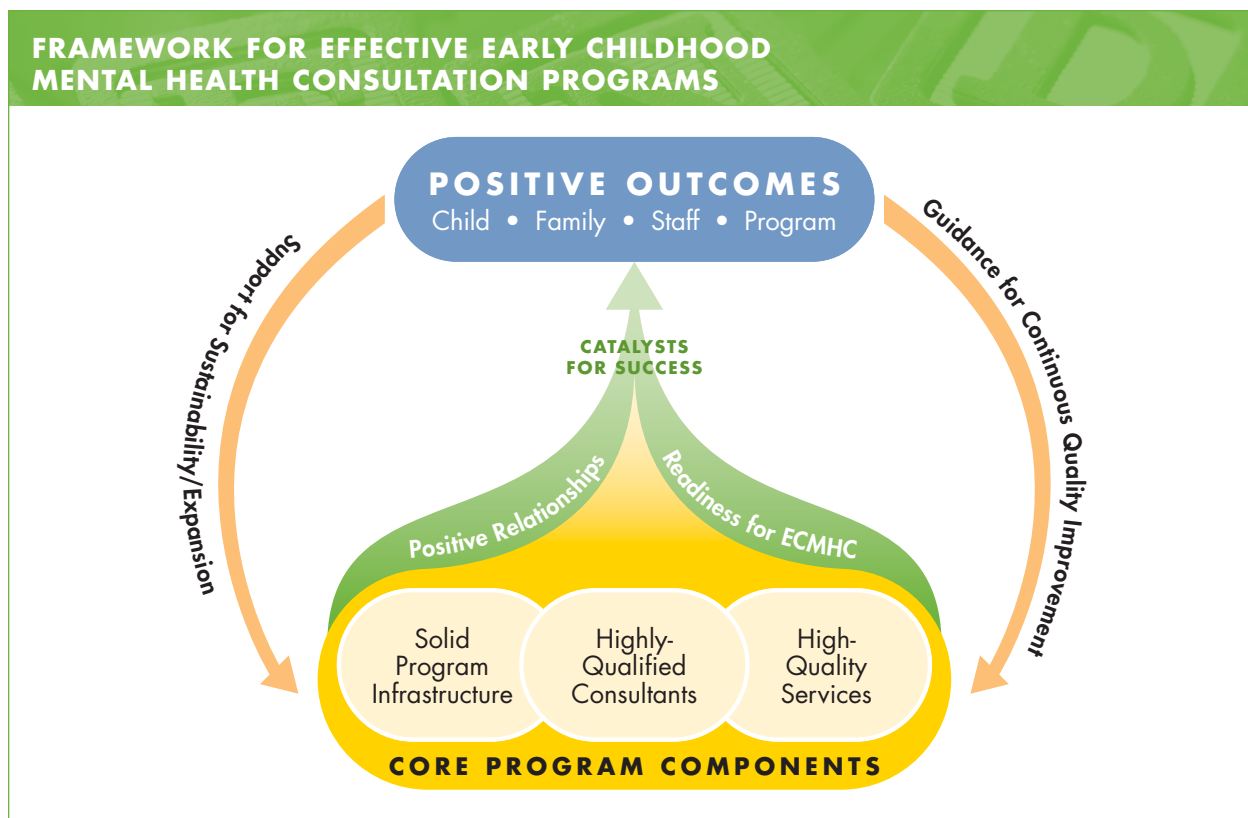
Key Findings

Through in-depth site visits to the six selected programs, this study was able to address many key questions in the field and examine challenges and lessons learned in moving consultation programs from conceptualization to implementation. A summary of findings is provided below.

Research Questions

1. What are the essential components of effective mental health consultation programs?

The framework for effective mental health consultation that emerged from the cross-site analysis is depicted below.



This framework suggests that there are five factors that are important in the design of an effective ECMHC program (i.e., a program that achieves positive outcomes). First, **three core program components** must be in place:

- 1) solid program infrastructure (e.g., strong leadership, clear model design, strategic partnerships, evaluation, etc.);
- 2) highly-qualified mental health consultants; and
- 3) high-quality services.

Further, there are two other elements that are essential to achieving positive outcomes and, in fact, serve as **catalysts for success** (i.e., as yeast is to other ingredients in making bread). These elements are:

- 1) the quality of the relationships between and among consultants and consultees; and
- 2) the readiness of families and ECE providers/programs for ECMHC (e.g., openness to gaining new skills and knowledge, opportunities for collaboration).

This diagram also underscores the importance of using evaluation findings/outcome data to guide program enhancements (i.e., a continuous quality improvement process) and to educate funders and other key stakeholders about the program's impact in order to promote sustainability and/or expansion.

2. **What are the skills, competencies, and credentials of effective consultants?**

Education: master's degree in a mental health field (e.g., social work, psychology, marriage and family therapy).

"She [the mental health consultant] has a way of telling you how to do things differently without making you feel like she's telling you you've done something wrong."—CENTER-BASED TEACHER

Core Knowledge: child development, infant and early childhood mental health, early childhood settings, best/evidence-based practices related to infant and early childhood mental health, child/family/early childhood service systems, and community resources.

Key Skills: relationship-building, communication, able to work with infants/young children in group settings, and able to motivate parents/providers to try new strategies.

Key Attributes/Characteristics: respectful, trustworthy, open-minded/non-judgmental, reflective, approachable, good listener, compassionate, team player, flexible, and patient.

3. **What are the training, supervision and support needs of consultants?**

Training Topics: detailed overview of consultation program model (e.g., philosophy and processes), early childhood mental health topics (see Core Knowledge, above, for examples), and consultation topics (e.g., how to approach the work, how consultation differs from direct therapy).

Training Methods: standardized curriculum, pre-service and in-service training, mentoring and/or shadowing opportunities with a senior consultant, and ongoing professional development opportunities through internal and/or external trainings and seminars.

Supervision: clinical and administrative supervision, regular and ongoing, and reflective in nature (i.e., provides support and knowledge to guide decision-making and offers empathy to help supervisees explore their reactions to the work and manage stress; Parlakian, 2002).

Support: in addition to reflective supervision, which is inherently supportive, consultants need formal and informal opportunities to network with peers in order to share resources and discuss challenges.

4. What level of intervention intensity (i.e., frequency and duration) is needed to produce good outcomes?

This question is one that needs further exploration, as the primarily qualitative design of this study could not determine the dosage of consultation that leads to positive outcomes. What findings from this study *did* show is that there is great variability across the study sites regarding frequency and duration of services. This diversity is reflective of the variation in program models (i.e., program guidance regarding service duration/intensity), as well community characteristics (e.g., rural vs. urban areas). In addition, the variation is indicative of programs' recognition of the individualized nature of ECMHC and the need for flexibility to ensure that the needs of children, families and providers/programs are met.

5. Which outcomes should be targeted and how should they be measured?

Overall, in designing evaluations of ECMHC programs, there is a need to attend to multiple levels of outcomes, including child, family, ECE staff/providers and ECE programs. In selecting what to measure and how to measure it, some key questions for evaluators to consider are:

- What outcomes can reasonably be expected from the given program model?
- What measurement tools are best suited to the population being served (e.g., infants/toddlers, diverse cultures)?
- Who will collect the data and how might that impact the findings?

For a full list of recommendations by study participants on what outcomes/constructs to measure, as well as an array of measurement tools that have been employed by the study sites' evaluators to assess outcomes, see page 88.

Additional Cross-Site Findings

Core Values and Practices

- Centrality of relationships
- Emphasis on capacity-building of ECE providers and parents/caregivers
- Need for collaboration between and among consultants and consultees
- Need for family involvement at all stages of service planning and delivery
- Importance of having consultants with early childhood mental health expertise
- Adoption of a holistic, promotion/prevention/intervention approach that seeks to improve the mental health of all infants and young children
- Individualization of services

Supplementing Consultation Activities

Half of the sites augment consultation services with direct therapy, particularly therapy for children. These sites include direct therapy in their programs' service array, as opposed to solely referring consultees to other community resources for these services.

Serving Unique Settings and Populations

Collectively, the six study sites served the settings and populations listed below and offered the following tips and thoughts for consideration:

Family child care

- Since family child care settings typically serve multiple ages in one classroom, consultants need to adapt their classroom-based strategies accordingly.
- Many family child care homes are operated by one provider, thus consultants should arrange their visiting schedule around naptime when they need one-on-one time with the provider.
- Family child care providers may be apprehensive about consultation, as it involves having a consultant come into their homes.

Kith and kin care (i.e., family, friends and neighbor care)

- To engage kith and kin providers, consider hosting informal gatherings such as play groups or “coffee clubs.”

Children in foster care

- Consultants may need to provide significant in-home support to foster parents to help them facilitate the child's adjustment to his/her new placement.

Given that many children in foster care have experienced trauma, consultants should be well-trained on this issue and help to educate providers and foster families on how to identify trauma symptoms and support children affected by trauma.

- At the onset of services, it is critical to establish who has legal guardianship of the child and whom to engage in implementing strategies at home.
- Given the transient nature of foster placements and the fact that foster parents are often inundated with service referrals when a new child enters their care, consultants may have difficulty engaging foster parents.

Children with special health care needs and disabilities

- Consultants should familiarize themselves with community resources for infants and young children with special needs (e.g., early intervention services).
- As children approach kindergarten age, consultants should consider offering workshops on special education services and/or providing families with assistance in pursuing Individualized Education Plans (IEP)¹ for their children with special needs.

¹Under the Individuals with Disabilities Act (IDEA), public schools are required to develop an Individualized Education Plan (IEP) for every student who is found to meet the federal and state requirements for special education. The IEP outlines goals set for a child during the school year, as well as any special support needed to help them achieve them.

National Scan Highlights

Thirty-five (35) states and territories responded to the National Scan. Of those respondents, 29 (83%) confirmed that ECMHC services are available in their state and 6 (17%) indicated that ECMHC services were not currently available, although several provided descriptions of how their state/territory was moving in that direction. Some of the key findings across the 29 states currently offering mental health consultation are provided below.

- Twenty-one respondents (72%) reported offering consultation statewide; eight of those states indicated having a single service delivery model across the state.
- Most states identified Mental Health (72%) and/or Early Care and Education (59%) as the lead or coordinating agency/agencies for their consultation programs.
- Most states indicated having state-level partners in one or more of the following systems: Early Intervention (86%), Early/Head Start (79%), Education (76%), Child Welfare (72%) and Special Education (69%). These partners helped as referral sources and collaborated on service delivery.
- Looking across federal, state, and local sources of funding, respondents most frequently identified sources of funding for ECMHC services as State General Funds (41%), Child Care Development Funds (34%), Mental Health (32%), and Private Funds (28%).
- The majority of respondents (66%) reported providing ECMHC services in licensed non-profit and licensed private center-based settings. The least frequently identified setting was unlicensed informal child care (including kith and kin)—at 10% of respondents.
- Nine respondents (31%) reported state-level requirements around competencies for mental health consultants. Among those states, the three most frequently cited requirements were 1) knowledge of early childhood mental health (41%), 2) knowledge of child development (including social/emotional; 35%), and 3) obtaining an advanced degree (master's or doctorate; 35%).
- Most respondents (61%) indicated that there is a coordinated evaluation of ECMHC in their state, although methodologies varied.

Challenges

The site visits and the National Scan shed light on some of the major challenges faced by states, territories and communities in developing and implementing effective consultation programs. These challenges are described below with guidance regarding how programs have addressed these challenges when available.

1. **System infrastructure:** A strong system infrastructure is needed to promote sustainability of ECMHC programs and provide consultants with a diverse array of community resources to help fully meet the needs of the children, families and providers they are serving. Consultants cited a number of gaps in community-based

resources including a lack of infant/early childhood mental health clinicians as well as bilingual service providers.

2. **Funding:** ECMHC programs need adequate funding from diverse funding streams to support service delivery and sustainability. Currently, funding is limited for promotion and prevention activities like consultation, and programs face significant challenges in trying to capture Medicaid dollars to support ECMHC efforts.
3. **Consultant workforce:** A highly-skilled workforce is critical to effective ECMHC, yet there are few mental health professionals who are trained with the necessary skill set of a consultant. Further, it can be challenging to recruit and retain consultants, as salaries tend to be less competitive than in other mental health professions and the position is highly demanding. Study participants cited the need to identify core competencies for consultants and to promote development of those competencies through strong pre-service and in-service training. Ongoing support and supervision was also mentioned as a mechanism to promote continuous professional development and staff retention.
4. **Stigma:** A pervasive challenge that is difficult to address is misgivings about involvement with any “mental health” program, particularly among parents/caregivers. ECMHC programs try to overcome this barrier in a number of ways, including using non-mental health terminology and explaining that services are designed to help children thrive in early childhood settings and, later, school settings.
5. **Family engagement:** Engaging parents/caregivers can be difficult because they believe the services are unwarranted, unfamiliar or stigmatizing, or because various factors impede their ability to actively participate in consultation activities (e.g., transportation, time constraints).

Consultants employ a number of different strategies to boost family engagement, most of which involve relationship-building to develop interest in consultation services and flexible scheduling to accommodate family needs.

6. **Provider engagement:** Consultants often meet with some level of resistance when meeting and working with an ECE provider for the first time. This resistance may stem from concerns about being judged or reservations about whether the consultant can really help. To address this common challenge,

consultants try to clarify any provider misconceptions up front, establish that they are there as a “helper,” and build trust in their abilities by responding to the providers’ immediate needs effectively.

7. **The nature of consultation:** Consultation is a capacity-building intervention and different from the “traditional” or direct therapeutic services that are more familiar to many providers and families. As such, role confusion about what a consultant does or does not do is a common challenge in delivering ECMHC services. Another challenge for consultants is achieving behavior change in providers and family members, which requires both skills and patience. A final challenge is managing expectations—particularly among funders and other program partners—about caseload sizes and duration of services. Given the intensive, capacity-building and individualized nature

of consultation, it is difficult to manage large caseload sizes or to predict how long each case will last, as it is contingent upon the complexity of the case and the consultee's progress toward behavior change/skill enhancement.

8. **Outreach and awareness:** Currently, there is still a need for greater awareness of early childhood mental health and the value of incorporating mental health when building early childhood systems and supports. Outreach efforts around these key areas are an important component of expanding the availability of ECMHC services.

Recommendations

As previously discussed, this study engaged a small group of experts in the field of early childhood mental health consultation to serve in an advisory capacity and discuss the policy, programmatic and research implications of this study's findings. In collaboration with the GUCCHD study team, this advisory group generated the following recommendations targeting four key audiences: policymakers/funders, ECMHC providers, ECE program administrators, and researchers/evaluators.

For Policymakers/Funders

State and local policymakers (e.g., elected officials, state and local administrators) and funders need accurate information to make good decisions as they seek solutions and supports to promote the healthy social and emotional development of young children and their families through consultation.

- **Encourage data collection.** To help guide decision-making, policymakers and funders should promote data collection among states, communities and/or grantees that documents the need for supports to promote the healthy social and emotional development of young children; the evidence that early childhood mental health consultation “works” (e.g., reduces expulsion rates and prevalence of challenging behaviors in early care and education settings); and the cost-benefit of mental health consultation as an early intervention strategy.
- **Infuse consultation into child-serving systems.** Policymakers and funders should support the integration of mental health consultation in all child-serving systems, including early intervention, early care and education, and special education. For example, policymakers and funders should influence the early care and education field by integrating early childhood mental health consultation into existing quality rating systems and credentialing processes at the local, state, and/or national levels (e.g., National Association for the Education of Young Children/NAEYC).
- **Support workforce development.** Policymakers and funders should promote efforts that will expand the pool of qualified mental health consultants. For example, policymakers and funders should help to standardize mental health consultant competencies and support adoption of those qualifications across ECMHC programs.

Further, policymakers and funders should partner with higher education systems to infuse training and education on early childhood mental health and ECMHC into school curricula.

- **Make diverse funding opportunities available.** Policymakers and funders should support fiscal policies and procedures that create diverse funding opportunities for workforce development, establishment of ECMHC programs, and compensation for consultation services. These may include federal earmarks, state budget line-items, and sustainable options such as having mental health consultation defined as a billable service.
- **Have realistic expectations.** Policymakers and funders should understand the nature of consultation services and have realistic expectations of the time and costs involved in delivering these services.

For ECMHC Providers

ECMHC program administrators and mental health consultants need a theoretical foundation and a clearly articulated model to guide their work with children, families, providers and programs. Further, program administrators need a clear vision, commitment, and organizational structure to engage state and community partners, to establish and sustain an early childhood mental health consultation program, and to support consultants.

- **Identify core competencies.** Program administrators and mental health consultants should help inform the development of a standardized set of core competencies for providing effective early childhood mental health consultation. Further, ECMHC providers should identify strategies to help consultants cultivate this necessary skill set.


By reflecting on and responding to the question—“What is a highly-qualified mental health consultant?”—ECMHC providers can help articulate the knowledge, skills and attributes that are essential to the provision of quality consultation and the development of a highly-skilled consultant workforce.

- **Have an explicit theoretical approach.** Program administrators and mental health consultants should have a sound and explicit theoretical foundation to guide their work, especially one that emphasizes the relationship-based nature of working with young children, families, and early care and education providers that is essential in mental health consultation.

- **Articulate your model.** Program administrators and mental health consultants should be able to articulate the consultation model so that diverse audiences and partners—national, state, and local—can understand the philosophy and approach for early childhood mental health consultation. In addition, both should be able to describe the model in a way that addresses role clarity, the process of consultation, and specific defining constructs or activities involved in this work. Effective ECMHC providers should be able to respond to the question—“What do consultants do?”—in ways that

are meaningful to families, early care and education providers, and others who can influence the field of early childhood services and supports.

- **Establish supervision and supports.** It is essential to build supports for mental health consultants, such as reflective supervision, peer support, and training and technical assistance. To address the stress involved in their work, mental health consultants must take care of themselves and have supervision and supports that provide opportunity for reflection, guidance, and skill development. Program administrators must recognize the parallel process of supporting consultants who can then support young children, families and early care and education providers in order to sustain successful early childhood mental health consultation.
- **Champion consultation.** ECMHC program administrators should be the knowledgeable “voice” that champions early childhood mental health consultation, engaging others, building partnerships, and promoting consultation as an effective intervention strategy. Mental health consultants should promote consultation through their work as a provider and advocate for early childhood mental health, supported families, and skilled providers.
- **Engage families.** Program administrators play a key leadership role in framing all early childhood mental health consultation services in the context of family involvement and cultural and linguistic competence. Mental health consultants must recognize the essential role that families play in their children’s development and welcome their perspectives, work in partnership, and solicit their feedback to promote the healthy social and emotional development of their children and the family.
- **Build a network.** Program administrators as well as consultants should create opportunities for networking among their peers and key partners (e.g., child care administrators, early intervention providers, etc.) to build interest in early childhood mental health consultation, address mutual concerns and challenges, and share promising strategies and successes.
- **Develop strategic partnerships.** To support consultation efforts and promote sustainability, program administrators should forge partnerships across various systems and stakeholders. For example, partnering with the higher education system to implement pre-service training on early childhood mental health and core consultation competencies can bolster efforts to build a strong consultant workforce.
- **Include evaluation.** Management information systems and a clear evaluation plan contribute to setting benchmarks for program implementation, fidelity to the model, and measurement of outcomes. Consultants are essential participants in evaluation efforts and can benefit from feedback on the consultation process and outcomes for children and families. Evaluation is critical to program operations, quality improvement, documentation of program effectiveness, and contributions to the evidence base.



Right from the start, program administrators must include evaluation as part of the early childhood mental health consultation model.

For ECE Program Administrators

Early care and education program administrators need a clear vision, commitment, and program supports to promote the healthy social and emotional development of young children and their families, including early childhood mental health consultation.

- **Value early childhood mental health.** ECE administrators have a responsibility to attend to the social and emotional well-being of infants and young children in their programs. As such, ECE administrators should be well-versed in factors that support early childhood mental health, including positive relationships and nurturing environments, and work closely with families and ECE staff to ensure those supports are in place.
- **Address promotion, prevention, and intervention.** ECE administrators should make the most of early childhood mental health consultation by accessing a full array of consultation services from 1) supporting all children through mental health *promotion* activities to 2) addressing concerns early to prevent the onset of behavioral issues among children at-risk to 3) addressing troubling or challenging behaviors (*intervention*).
- **Support readiness for consultation.** ECE administrators can greatly influence staff and family readiness to engage in ECMHC. First, administrators can set a positive tone about consultation and the benefits that it provides to children, families, providers and programs. Further, administrators can help consultants integrate into the ECE program by including them in staff meetings and family nights, and making accommodations in program operations that provide staff opportunities to collaborate with the consultant (e.g., arranging for a floater to provide classroom coverage on a regular basis).

For Researchers/Evaluators

Researchers and evaluators should design effective strategies for both research and evaluation by asking the right questions, identifying indicators, using valid measures, establishing data collection processes, and sharing outcomes to help determine features of effective early childhood mental health consultation that will promote the healthy social and emotional development of young children and their families.

- **Establish the evidence base.** Research and evaluation efforts should be focused on establishing early childhood mental health consultation as an effective, evidence-based intervention.
- **Be realistic about cost.** When planning research and evaluation, be sure to establish a clear and adequate cost for these efforts. When seeking funding, consider ways to make research and evaluation a “line-item” (e.g., 15% of a project or program budget).
- **Follow research guidelines.** Research and evaluation should adhere to the following guidelines: 1) employ a participatory process to develop designs and procedures, 2) develop a logic model and theory of change, 3) identify appropriate and valid measures (including those that address fidelity), 4) combine management information

system (MIS) data (e.g., demographic, quantitative process data, etc.) with evaluation data that measures outcomes (e.g., effect of mental health consultation), 5) make research and evaluation processes explicit (e.g., visits—over time, how long, etc.), 6) design strategies and provide supports that will not overburden study participants and that encourage participation, and 7) share research outcomes with all those who participated in the research process for feedback toward quality improvement and to demonstrate effectiveness.

Conclusion

This synthesis of the practices, experiences, and lessons learned of diverse stakeholders from six ECMHC programs with demonstrated positive outcomes offers a wealth of information to guide states and communities in shaping effective early childhood mental health consultation programs. It also provides a roadmap of remaining areas of growth and exploration for the field. Through analysis of study findings and consideration of their implications, the following overarching needs for moving the field forward were recognized:

- **Build consensus** around the core values, principles, and components of early childhood mental health consultation; the competencies and qualifications for mental health consultants; and the important outcomes for children, families, and ECE providers.
- **Engage families and cross-system partners** as stakeholders in the effort to promote early childhood mental health consultation as a strategy to support healthy social and emotional development for young children and families.
- **Identify key research questions that remain and support efforts to address those questions** to help build the evidence base for effective early childhood mental health consultation.

The key remaining research questions identified through this study include:

- What is the “dosage” of consultation needed for efficacy?
- What is the cost-benefit of ECMHC?
- What are the longitudinal impacts of ECMHC?
- What is the impact of each model component on outcomes (e.g., consultant skills, service array)?
- Which consultation models are most effective for which children, families and/or settings?
- What is the impact of ECMHC on family child care versus center-based care?
- What are the best measurement tools for evaluating ECMHC and where is there need for development of new tools?

Through the collaborative efforts of diverse key stakeholders (e.g., policymakers/funders, ECMHC providers, ECE program administrators, and researchers/evaluators), much progress has been made to increase access to ECMHC and address the rise in challenging behaviors among young children in early care and education settings. With further collaboration, states and communities can continue to expand consultation efforts, enhance the efficacy of services, and establish long-term sustainability for this emerging evidence-based practice.

Introduction

1

SECTION

In recent years, there has been growing concern among many in the early care and education (ECE) community that increasing numbers of very young children are manifesting behavior problems. The Center for Mental Health in Schools (2005) reports evidence for clinically significant emotional and behavioral disabilities among young children, with estimates in the general population ranging from 4 to 10%; these prevalence estimates are significantly higher for low-income children. Outcomes for young children who exhibit serious challenging behaviors that go without intervention are significantly compromised (National Scientific Council on the Developing Child, 2008). Early appearing behavior problems are associated with adolescent delinquency, school failure and drop out, and adult incarceration. Without appropriate identification and intervention by third grade, a large percentage of these children will continue to require costly, ongoing services (Dodge, 2003).

In very young children these behaviors can be severe enough to warrant removal from their preschool programs, setting into motion a cascade of negative experiences. While much of this concern was initially fueled by anecdotal evidence from parents and ECE providers, Gilliam (2005) released the first data documenting the extent of this problem nationwide. Surprisingly, most states were expelling preschool-aged children at rates that exceeded school-aged populations. One promising statistic was that access to mental health consultation was found to be associated with lower rates of preschool expulsion (Gilliam & Shahrar, 2006). State-funded pre-kindergarten programs that reported onsite access to a psychologist or social worker expelled 5.7 children per 1,000; occasional access to a mental health consultant was associated with a somewhat higher expulsion rate; and programs that lacked consultation expelled children in the highest rates (10.8 per 1,000).

The Georgetown University Center for Child and Human Development (GUCCHD) has long been interested in exploring the supportive intervention of early childhood mental health consultation, and in May 1998, with funding from the Substance Abuse and Mental Health Services Administration, (SAMHSA), convened a Roundtable on Mental Health Consultation Approaches for Programs/Systems Working with Infants, Toddlers, and Preschoolers and their Families. Twenty-five public and private program administrators, practitioners, family members, and evaluators came together to share their state-of-the-art thinking and direct experience on promoting healthy development among our youngest members of society in early childhood settings by means of mental

health consultation. A monograph, *Early Childhood Mental Health Consultation* (Cohen & Kaufmann, 2000) summarized the presentations, discussions and background materials from the Roundtable. It also set forth the following definition of ECMHC:

“Mental health consultation in early childhood settings is a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more [caregivers, typically an early care and education provider and/or family member]. Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age 6 and their families”
(Cohen & Kaufmann, 2000, p. 4).

This widely disseminated document and follow-up training guide (Hepburn & Kaufmann, 2005) has been used by states, programs and communities as a blueprint for developing mental health consultation initiatives across the country.

As considerable investments of public and private funds were being used to develop mental health consultation programs across the country, GUCCHD and others became concerned about a lack of evaluation and research data available to inform the field. As states and communities expand their capacity to meet the mental health needs of young children and their caregivers, the need for accurate, data-driven information about effective strategies to deliver mental health consultation is growing.

Motivated by a desire to assess the level of evidence for the effectiveness of mental health consultation, Eileen Brennan, Portland State University, Deborah Perry, GUCCHD, and their colleagues (Brennan et al., 2008, Perry et al., 2009) completed an extensive review of published and unpublished literature. They concluded that while there is a growing body of evidence to suggest that mental health consultation is effective in building behavior and classroom management skills of ECE staff and reducing the levels of problematic behavior in young children, there are gaps in the knowledge base. These gaps are fueled by a lack of consensus about:

- the essential components of effective mental health consultation;
- the skills, competencies, and credentials of effective consultants;
- the training, supervision and support needs of consultants;
- the level of intervention intensity (i.e., frequency and duration) needed to produce good outcomes; and
- which outcomes should be targeted and how should they be measured.

With funding from the Annie E. Casey Foundation and the A.L. Mailman Family Foundation, GUCCHD embarked on this study to address the knowledge gaps listed above and provide data-driven guidance to states and communities investing (or planning

to invest) in this up-and-coming intervention. This document summarizes the findings of this study and, specifically, describes the core elements of effective ECMHC programs. It also provides a snapshot of the status of consultation efforts nationally.

Study Design and Methodology

Overview of Study Components

As stated above, the primary goals of this study are to:

- address lingering questions in the field regarding the essential components of effective mental health consultation, particularly with respect to consultant training and qualifications, intervention intensity, and evaluation; and
- offer guidance around consultation program design.

To achieve these goals, this study closely examined a small sample of consultation programs that have demonstrated positive child, family, ECE staff and/or ECE program outcomes to learn about their program designs and practices and analyze commonalities. By keeping the sample size small (six), the study team was able to conduct two-day site visits to each program and comprehensively investigate each model. In addition to exploring the questions listed above, the study also examined several topics of special interest to the study funders (i.e., cultural and linguistic competence and consultation to children in foster care, children with special needs, and kith and kin providers).

Further, to gain a better understanding of the extent to which consultation efforts are occurring nationally, the study incorporated a brief online scan to *all* states' and territories' Children's Mental Health Directors and Early Childhood Comprehensive System Coordinators to learn of their local ECMHC activities. Finally, to ensure thorough consideration of the implications of the study findings and generate a diverse array of recommendations, the study team convened a meeting of experts in the field that included researchers, state administrators, consultation program administrators/providers and other mental health professionals. Each of these study components will be described in detail below.

The three major components of this study are:

1. **site visits** to six ECMHC programs that demonstrated achievement of positive child, family, ECE staff and/or ECE program outcomes;
2. a brief **online scan** to *all* states' and territories' Children's Mental Health Directors and Early Childhood Comprehensive System Coordinators to learn of their local ECMHC activities; and
3. a **meeting of experts** to discuss implications of findings from the site visits and scan and generate recommendations for policymakers/funders, ECMHC providers, ECE program administrators and researchers/evaluators.

Site Visits

Data for this study were primarily collected through site visits to six ECMHC programs. The sample size was limited to six programs given funding parameters. The goal of site selection was to assemble a diverse mixture of *effective* early childhood consultation models. For purposes of this study, effective programs are defined as those that have demonstrated positive outcomes on one or more indicators of interest:

- decreases in expulsion from early care and education programs;
- decreases in children’s social/emotional problems;
- increases in children’s positive social/emotional behaviors;
- increases in parent or ECE provider ability to support children’s social/emotional well-being; and
- increases in the quality of ECE programs.

Thus, the core criterion for site selection was demonstration of positive evaluation outcomes.

To begin the site selection process, the study team solicited recommendations from experts in the field and reviewed Brennan et al.’s (2008) and Perry et al.’s (2009) syntheses of research to date on child, family, staff and program outcomes achieved through early childhood mental health consultation. In addition to reviewing written materials and evaluation reports, study team members also had telephone conversations with the lead evaluator(s) for each ECMHC program under consideration for inclusion to gather further detail on their evaluation efforts and methodologies.

Sites with demonstrated results were further examined for diversity across various domains, including:

- service population (e.g., child ages, cultural backgrounds, socio-economic status);
- service settings (e.g., Early Head Start/Head Start, center-based, family child care, informal child care/kith and kin);
- geography (e.g., program location and urban, rural and/or suburban service areas);
- program scope (e.g., statewide, county-wide, community-wide); and
- evaluation efforts (e.g., methodologies and research areas).

Final criteria were that the program must still be in operation and have a clearly articulated model. After this multi-level selection process, the sites selected for inclusion in this study were:

- **Child Care Expulsion Prevention** (Michigan);
- **Early Childhood Consultation Partnership** (Connecticut);
- **Early Intervention Program/Instituto Familiar de la Raza** (San Francisco, CA);
- **Early Intervention Project** (Baltimore City, MD);
- **Kid Connects** (Boulder, CO); and
- **Together for Kids** (Central Massachusetts).

It is important to note that although the six sites selected for this study represent a diverse mix of consultation programs, they are not nationally representative of all consultation programs/models. Thus, while this study provides in-depth information about the elements and practices of these six effective programs, it does not offer an exhaustive list of consultation practices across the country. Since this study was limited to the selection of six sites, several other exemplary programs that illustrate the diversity in efforts occurring nationally around ECMHC are highlighted throughout this report and brief descriptions of their models can be found in the Appendix.

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Once the six sites were notified of their selection and agreed to participate, study team members (two per site) began working with each of the six ECMHC program directors to plan the two-day site visits. These site visits included:

- 1) in-person interviews with key stakeholders;
- 2) dissemination of two standardized data collection tools to consultants in the six study sites to examine consultant activities and consultant education, skills and experience (see Appendix); and
- 3) collection of various materials to support greater understanding of each ECMHC program model (e.g., logic models, training curricula, consultant job descriptions, sample contracts, sample individualized service plans).

Each ECMHC program director received a planning guide that was designed to:

- clarify the purpose of the study and what program participants can expect;
- provide resources to help the program director communicate information about the study to key stakeholders;
- outline GUCCHD's role and the program's role, during and after the site visit; and
- facilitate information-gathering about the program and coordination of logistics for the visit.

ECMHC program directors were specifically asked to schedule the following array of interviewees during the site visits:

1. **Consultation program administrator and/or director** (i.e., themselves)
2. **Mental health consultants** (at least 2), who implement the consultation model with good fidelity
3. **Early care and education (ECE) staff** with whom the identified consultants work
Note: ECE staff include, but are not limited to, center-based director(s), teacher(s) and assistant teacher(s), and licensed family/home-based child care providers.

4. **Informal providers** (i.e., kith and kin) with whom the identified consultants work (*if applicable*)
5. **Parents/caregivers** (at least 2) with whom the identified consultants work and who are representative of the diversity of families the program serves.
Note: If the program served children in foster care or children with special needs, GUCCHD expressed particular interest in speaking with those families.
6. **Program/system partners** (e.g., state, local and community partners including agency and organization representatives and funders)
7. **Lead evaluator(s)**
Note: In several sites, conversations with lead evaluators took place via telephone.

In addition, program directors were asked to identify any other individuals who might help the study team gain a better understanding of the consultation program.

Using a uniform interview protocol for each respondent type², study team members conducted primarily in-person interviews between October 2008 and January 2009 with multiple stakeholders from the six study sites. Respondents included ECMHC program directors/administrators (N=11), program partners (N=47), consultants (N=13), early childhood providers (center-based and family child care) (N=27), parents/caregivers (N=14), program evaluators (N=8), and other ECMHC program staff (N=3). The protocols, which were approved by Georgetown University's Institutional Review Board (IRB), explored questions regarding program background, service array, consultant qualifications/training/supervision, evaluation, lessons learned and challenges, as well as perceptions of what made each program successful. Special topics related to serving unique settings (i.e., family child care, kith and kin care) and populations (i.e., children in foster care, children with special needs) were also incorporated into the protocols. Each interview lasted between one and one-and-a-half hours. Most interviews took place with one respondent at a time, although in some instances, groups of respondents were interviewed at once. Family members were offered a \$50 gift card to a local store (e.g., Walmart) for meeting with study team members on their "own time."

After each site visit, study team members' notes from each interview were typed up and imported into Atlas.ti software. In some cases, audio recordings of interviews were used to supplement interviewer notes and ensure clarity. For the analysis, the study team developed a set of codes to organize the notes by themes. The coding list evolved as the analysis moved forward and new themes began to emerge. Once the coding process was complete, coded notes were then sorted by themes and analyzed for cross-site findings.

²Interview questionnaires are available in the online Resource Compendium to this report, available at <http://gucchd.georgetown.edu>.

In addition to interview participation, interviewed consultants were asked to complete the Mental Health Consultant Education, Skills and Experience Inventory³, a tool designed by GUCCHD to assess consultant qualifications and perceived strengths in various competency areas (N=12). Further, all consultants (whether interviewed or not) were asked to complete the Service Array and Frequency Checklist, another measure developed by GUCCHD, which assesses the type of activities consultants are engaged in and with what degree of frequency (N=82). (Both tools are available in the Appendix.) Analysis of these standardized tools was completed using a combination of Excel and SPSS software programs.

National Scan

In order to update the current status of ECMHC and understand the range of approaches to funding, designing and implementing mental health consultation across states and territories, this study collected national data through an online survey tool. An electronic invitation was emailed to both the State Children’s Mental Health Director (SCMHD) and the Early Childhood Comprehensive System (ECCS) Coordinator in each state and United States territory. These individuals were chosen for their leadership roles in the planning, delivery and coordination of early childhood mental health services and supports for children birth to age six and their families and GUCCHD’s existing relationships with these local leaders. Respondents were asked to confirm whether ECMHC efforts are present in their state or territory and, as appropriate, to provide details on scope, service populations, lead agencies, funding sources, required competencies for consultants, coordinated support networks for consultants, and evaluation efforts. In addition, respondents were asked to share lessons learned and challenges. Thirty-five (35) states and territories responded to the National Scan (65% response rate). Twenty-nine respondents (29) indicated that ECMHC services were available in their states. Findings from these states with current ECMHC efforts will be described in more detail later in this report. (See the Appendix for the National Scan Questionnaire.)

Expert Panel

In addition to the GUCCHD study team, a small group of experts in the field of early childhood mental health consultation were engaged in this project (for a roster, see the Appendix). This advisory group was comprised of a mixture of researchers, state administrators, consultation program administrators/providers and other mental health professionals. Specifically, this study tapped their expertise to:

- recommend notable ECMHC programs for site visit consideration;
- review and provide feedback on the final draft of the study; and
- convene once as an advisory group to discuss policy, programmatic and research implications of this study.

³This tool was adapted from “Qualifications and Skills of Mental Health Consultant,” in *Early Childhood Mental Health Consultation: An Evaluation Toolkit* by Hepburn et al. (2007). See Appendix.

How to Use This Document

This document is primarily designed to describe the central features and practices of six ECMHC programs that have demonstrated positive child, family, ECE staff and/or ECE program outcomes. These descriptions are based on in-depth interviews with various respondents, as well as analysis of quantitative data on consultant activities and characteristics and review of written materials. Although much data was gleaned from these sources and the six sites are a diverse group, this report may not capture *all* of the important features and practices of effective consultation programs. Still, it provides a wealth of information about the six study sites and what those providing and receiving services have learned about effective ECMHC. As such, it offers much-needed guidance for those trying to design consultation programs and improve outcomes for infants and young children.

Findings from the study sites are presented in the following sections of this report:

1. **Study Sites in Brief** (pp. 25-41). This section includes introductory snapshots of each of the six ECMHC programs that were part of this study.
2. **Cross-Site Analysis** (pp. 43-97). This section highlights the main findings of the study and describes the central features and practices that emerged from the analysis of the six study sites.
3. **Detailed Study Site Summaries** (pp. 113-195). This section provides in-depth information about each of the six study sites and how each program model is operationalized.

Throughout the Cross-Site Analysis section, readers will also find shaded boxes that are color-coded to indicate the following supplemental information:

GREEN: Highlighted findings, examples, lessons learned or recommendations from one or more of the study sites.

BLUE: Notable efforts among other ECMHC programs that were not part of the study.

ORANGE: Select resources, definitions or other information relevant to ECMHC.

In addition to findings from the study sites, there is also a section highlighting findings from the National Scan (pp. 99-102) and a section detailing recommendations generated from a meeting of experts on May 20, 2009, as well as overall lessons learned from the study (pp. 103-112). Recommendations are targeted to each of four audiences:

- Policymakers/funders
- Early childhood mental health consultation (ECMHC) providers (e.g., program administrators, consultants)
- Early care and education (ECE) program administrators
- Researchers/evaluators

KEY TERMS USED IN THIS REPORT

Note: When local or site-specific terminology is used, those words will be *italicized*.

Administrative supervision: Supervision in which a supervisor provides supervisees with information and/or guidance regarding administrative or programmatic issues (e.g., program policies and updates, human resources issues).

Challenging/troubling behavior: This term is inclusive of both internalizing (e.g., withdrawn) and externalizing (e.g., physical aggression) behaviors that suggest a need for social and emotional support/intervention.

Child/family-centered consultation: Consultants activities that focus on a particular child with challenging behavior and/or the family of that child (Cohen & Kaufmann, 2000).

Clinical supervision: Supervision in which an experienced clinician supervises another clinician (e.g., consultant) individually or in groups to provide support and knowledge to guide clinical decision making.

Early care and education (ECE): This includes programs and providers in Early Head Start/Head Start and licensed center-based and family child care settings.

ECE providers: This term is inclusive of directors, teachers, assistant teachers/aides and family child care providers.

Individualized service plans: Plans that the mental health consultants develop (collaboratively), which outline strategies/recommendations for children, families and/or ECE providers and programs. Some local ECMHC programs refer to these plans as action plans.

Kith and kin care: Relatives and nonrelatives who are not licensed or regulated by a government agency for the provision of child care, including family members, friends and neighbors. Care may be provided in the caregiver's home or in the child's home (Powell, 2008).

Partnership agreements: Formalized written agreements between the ECMHC program and the ECE provider or program that the consultant(s) will be serving, which outline roles and responsibilities.

Programmatic consultation: Consultation activities that focus on general program or classroom issue(s) that impact the mental health of staff, children and/or families (Cohen & Kaufmann, 2000).

Reflective supervision: A supervisory practice that may encompass clinical and administrative supervision, but specifically has the supervisor:

- offering empathy to help supervisees explore their reactions to the work; and
- helping supervisees manage the stress and intensity of the work (Parlakian, 2002).

Study Sites in Brief

2 SECTION

To familiarize readers with the study sites that formed the basis for the cross-site analysis, this section provides a brief overview of each of the six programs. When site-specific/local terminology is used, terms are italicized. Each snapshot is organized around key programmatic elements, including organizational structure, staff training and qualifications, service array, and funding. In addition, snapshots include highlights of positive evaluation findings that demonstrate the programs' efficacy, as well as a section titled "Notable Program Features," which describes approaches, practices and/or resources that the study team felt are noteworthy.

In these snapshots, service array is presented as succinctly as possible, simply indicating whether sites are providing child/family-centered consultation and/or programmatic consultation, as well as whether sites are offering services above and beyond these consultation services (e.g., direct therapy). Child/family-centered and programmatic consultation both encompass a number of activities including child/classroom/program observation, developing strategies, one-on-one modeling or coaching of strategies, staff training, parent education, and referrals. For those interested in more information on each program, in-depth site summaries are available beginning on page 113 and program contact information is provided in the both the snapshot and detailed summaries in this report.

■ ONLINE RESOURCE COMPENDIUM

To access sample documents from each of the six study sites to assist in designing and evaluating ECMHC programs, visit the online **Resource Compendium** to this report at <http://gucchd.georgetown.edu>

CHILD CARE EXPULSION PREVENTION (CCEP) PROGRAM—MICHIGAN	
Program Type	One model, statewide ⁴
Program Scope	<p>GEOGRAPHIC AREA SERVED 31 of Michigan’s 83 counties, to date, including urban, suburban, and rural communities.</p> <p>SETTINGS SERVED Licensed child day care centers and group day care homes, <i>registered</i> family day care homes, <i>enrolled</i> relative care providers, and <i>enrolled</i> day care aides⁵.</p> <p>AGES SERVED Birth to age 5.</p> <p>ANNUAL NUMBERS SERVED (FY2008) 572 children received child and family-centered consultation; 6,884 children received programmatic consultation in 306 child care settings; 957 parents and providers participated in <i>CORE Training Modules</i>⁶; and 2,151 participated in specialized trainings.</p>
Organizational/Management Structure	The Michigan Department of Community Health (MDCH), Mental Health Services to Children and Families provides state-level administrative and budgetary oversight for 16 CCEP projects that are operated by local Community Mental Health Service Programs (CMHSP). MDCH contracts with three state-level <i>Technical Assistance (TA) Consultants</i> responsible for TA support to local-level CCEP supervisors and consultants and for coordination of intensive state-level collaboration with other early childhood entities.
Staff Composition	CCEP’s State Administrator is responsible for negotiating and managing contracts with local CMHSPs and providing oversight and direction to the three CCEP state-level <i>Technical Assistance (TA) Consultants</i> . The 16 local CCEP project sites employ 30 mental health consultants (16 full-time, 7 half-time, and 7 part-time with a combined total of a 1.6 full-time equivalent [FTE]).
Consultant Qualifications and Training	<p>QUALIFICATIONS</p> <ul style="list-style-type: none"> • Master’s degree in social work, psychology, or a related field • Licensed or license-eligible preferred • <i>Level II Endorsement—Michigan Association for Infant Mental Health</i>⁷ <p>TRAINING Two-day orientation for new staff to review the CCEP model, and ongoing training for all staff to review best practices, and the use of social and emotional assessment tools.</p>

⁴At the time of this report, CCEP was serving 31 of Michigan’s 83 counties.

⁵The terms “registered” and “enrolled” indicate the status of a program or provider with the state Department of Human Services, Bureau of Children and Adult Licensing and eligibility to receive child care payments from the State.

⁶A locally developed, standardized series of 4 training modules

⁷A level of professional development developed and designated by the Michigan Association for Infant Mental Health (MI-AIMH)

CHILD CARE EXPULSION PREVENTION (CCEP) PROGRAM—MICHIGAN

Consultant Supervision and Support	<p>SUPERVISION</p> <ul style="list-style-type: none"> • Administrative and clinical supervision within own agency • Reflective supervision, one-on-one twice a month with a <i>Michigan Association for Infant Mental Health (MI-AMH)</i> qualified professional • Supplemental group reflective supervision <p>SUPPORT</p> <p>Ongoing support by CCEP TA staff: Monthly conference calls, quarterly TA meetings, documents and resources, email listserv, quarterly newsletter, regular onsite visits to programs and phone support.</p>
Consultant Caseload	Caseload of 8-15 children and families at any one time—about 30 cases per year. Caseload of between 15-20 child care programs per year.
Service Array, Frequency and Duration	<ul style="list-style-type: none"> • Child/family-centered consultation, 1-3 hours weekly, duration of 3-6 months with no set number of visits • Programmatic consultation, 1-3 hours weekly, duration of 3-6 months • Standardized <i>CORE Training Modules</i>, two series of four, 3-hour modules for parents, child care providers, and other early childhood services community members
Research/Evaluation Findings	<p>METHODOLOGY</p> <p>Combined internal and external evaluation; longitudinal, quasi-experimental, and qualitative case study methodologies.</p> <p>FINDINGS/OUTCOMES</p> <p>A total of 572 children were served in FY2008. For 133 children served by CCEP for whom complete information was available, 85% of these children had positive outcomes, as follows:</p> <ul style="list-style-type: none"> • 75% stayed in the same child care setting with positive results, “graduated” on to Kindergarten with appropriate support services if needed, or transferred to a more appropriate early care and education setting with agreement from all involved • 3% of the children entered special education services • 7% of children stayed home with parent based on parent decision <p>The other 15% of children had the following outcomes:</p> <ul style="list-style-type: none"> • 3% of children were expelled with no follow-up • 4% of children were expelled but received services at a new site from CCEP • 8% moved or data was not completed for extenuating circumstances
Funding	<p>AMOUNT AND SOURCES (FY2009)</p> <ul style="list-style-type: none"> • Annual program budget: \$1,852,992⁸ • Funds provided by the Department of Human Services, Child Care Development Fund

⁸Funding includes \$125,000 for year three of the evaluation of the program by Michigan State University.

CHILD CARE EXPULSION PREVENTION (CCEP) PROGRAM—MICHIGAN

<p>Notable Program Features</p>	<ul style="list-style-type: none"> • Consultant qualifications, supervision, and <i>MI-AIMH endorsement</i> • <i>CORE Training Modules</i> and training coordination • Technical assistance support to consultants
<p>Program Contact</p>	<p>Mary Mackrain, M.Ed. State Program and Training Director Child Care Expulsion Prevention Initiative Michigan Department of Community Health Mental Health Services to Children and Families 450 Cambridge Street Birmingham, MI 48009 Phone: (248) 739-1414 Email: mackrain@aol.com</p>

For more information on CCEP, see the full program summary on page 113.

EARLY CHILDHOOD CONSULTATION PARTNERSHIP (ECCP)—CONNECTICUT	
Program Type	One model, statewide
Program Scope	<p>GEOGRAPHIC AREA SERVED Statewide; mostly urban (51%), but also suburban and rural areas.</p> <p>SETTINGS SERVED Public and private child care centers/preschool programs; Early Head Start and Head Start programs; licensed family child care homes; foster care settings and intermediate safe homes; kinship care homes (for those raising children of their kin); substance abuse residential facilities; community resource centers.</p> <p>AGES SERVED Birth to 5.</p> <p>ANNUAL NUMBERS SERVED (FY2008) 2,301 individual children, 224 ECE centers, 1,869 teaching staff members trained.</p>
Organizational/Management Structure	ECCP is centrally managed at Advanced Behavioral Health (ABH) in Middletown, CT; program management staff are employed by ABH. ABH subcontracts with 10 non-profit community-based child behavioral health agencies, which employ the consultants delivering ECCP services across the state.
Staff Composition	ECCP's staff is comprised of a full-time Program Manager, Assistant Program Manager and Administrative Assistant (i.e., program management team), as well as 20 full-time <i>Early Childhood Consultants</i> (i.e., mental health consultants) who are assigned to work in specific regions of the state.
Consultant Qualifications and Training	<p>QUALIFICATIONS</p> <ul style="list-style-type: none"> • Master's degree in a human services related field (e.g., psychology, social work, education, marriage and family counseling) • Extensive knowledge of key issues such as early childhood development, emotional and behavioral health, family systems, and children with physical and developmental disabilities • Demonstrated expertise in the field <p>TRAINING Standardized training curriculum that includes:</p> <ul style="list-style-type: none"> • Program orientation • Key programmatic components (e.g., MIS, evaluation tools) • Key early childhood, mental health and consultation topics • Community resources overview

EARLY CHILDHOOD CONSULTATION PARTNERSHIP (ECCP)—CONNECTICUT

<p>Consultant Supervision and Support</p>	<p>SUPERVISION With ABH Program Management</p> <ul style="list-style-type: none"> • Monthly individual reflective clinical and administrative supervision meetings (administrative elements focus on overall ECCP program issues; intensity of clinical supervision depends on hiring agency supervisor’s clinical expertise) • Biweekly group reflective clinical and administrative supervision/staff meetings—half the team at a time • Quarterly staff meetings attended by all staff for administrative updates, team-building activities and joint trainings <p>With Hiring/Subcontracting Agency</p> <ul style="list-style-type: none"> • Individual reflective clinical and administrative supervision occurs at least once a month (administrative elements focus on agency-specific issues); exact frequency and duration is according to agency discretion, but meetings occur at least monthly. <p>SUPPORT In addition to group staff meetings, consultants receive support through monthly peer support/action plan support meetings and informal contacts with peers.</p>
<p>Consultant Caseload</p>	<p>On average, consultants balance 4 to 5 child-focused cases with program/classroom-wide consultation to three child care settings at any given time.</p>
<p>Service Array, Frequency and Duration</p>	<p>ECCP offers both child/family-centered and programmatic consultation across three levels of services that build upon each other in a stepwise fashion (i.e., Child-Specific Consultation is a component of <i>Core Classroom Consultation</i> and both are components of <i>Intensive Site Consultation</i>).</p> <ul style="list-style-type: none"> • <i>Child-Specific Consultation</i>, up to 9 hours of consultation, lasts approximately one month • <i>Core Classroom Consultation</i> (i.e., classroom-focused), 4 to 6 hours a week for up to 14 weeks • <i>Intensive Site Consultation</i> (i.e., program-wide focus), up to 6 hours a week for up to 5 months
	<p>METHODOLOGY External randomized-control evaluation using empirically validated tools; one of the most rigorous evaluations of an ECMHC program to date.</p> <p>FINDINGS/OUTCOMES Children in classrooms benefiting from ECCP consultation showed significant reductions in behavior problems, compared to children in classes that did not receive services. Impacts were greatest with respect to decreases in oppositional behaviors and hyperactivity.</p>

EARLY CHILDHOOD CONSULTATION PARTNERSHIP (ECCP)—CONNECTICUT

Funding	<p>AMOUNTS AND SOURCES (FY2009)</p> <ul style="list-style-type: none"> • Annual program budget: \$2.1M • Funds provided primarily by the Connecticut Department of Children and Families, Early Intervention Prevention Unit with supplementary funding by the State Department of Education
Notable Program Features	<ul style="list-style-type: none"> • Strong public/private partnerships • Centralized management information system • Detailed program manual
Program Contact	<p>Liz Bicio, LCSW Program Manager Early Childhood Consultation Partnership Advanced Behavioral Health, Inc. 213 Court St, 8th floor Middletown, CT 06457 Phone: (860) 704-6198 Email: ebicio@abhct.com</p>

For more information on ECCP, see the full program summary on page 129.

EARLY INTERVENTION PROGRAM (EIP) INSTITUTO FAMILIAR DE LA RAZA (IFR)—SAN FRANCISCO, CA	
Program Type	One of multiple models within a county-wide ECMHC effort
Program Scope	<p>GEOGRAPHIC AREA SERVED Urban; primarily San Francisco’s Mission District and Excelsior District, as well as the Outer Mission area that is on the south edge of the city.</p> <p>SETTINGS SERVED Overall, EIP serves settings that have a high percentage of at-risk Latino children and low-income families. These settings include Early Head Start and Head Start programs; a private non-profit early care and education program (only one, which serves a number of homeless children); public-funded early care and education programs that are part of the San Francisco Unified School District; licensed family child care providers; and family resource centers.</p> <p>AGES SERVED Birth through 5.</p> <p>ANNUAL NUMBERS SERVED (FY2008) 20 family child care homes, 31 classrooms at 15 early childhood centers, over 740 children.</p>
Organizational/ Management Structure	EIP is organizationally and physically located within Instituto Familiar de la Raza, a non-profit, community-based mental health and social services agency in San Francisco’s Mission District. All EIP staff are full-time and employed by IFR, although funding for their positions comes from various sources.
Staff Composition	EIP’s staff is comprised of an <i>Early Intervention Coordinator</i> , three <i>Senior Mental Health Specialists</i> , and six <i>Mental Health Specialists</i> (i.e., mental health consultants).
Consultant Qualifications and Training	<p>QUALIFICATIONS</p> <ul style="list-style-type: none"> • Master’s degree or higher in social work, psychology or related field • Bilingual in Spanish • Preferred bicultural background • Other preferred qualifications include mental health licensure and experience in early childhood mental health, mental health consultation, direct mental health services and in working with low-income and multi-cultural communities <p>TRAINING Newly hired consultants must complete an intensive, standardized training that is organized into four sessions around three topics:</p> <ul style="list-style-type: none"> • Introduction/Overview • Initiating Consultation • Child Observation and Developmental Norms (covers 2 sessions) <p>In addition, new consultants are required to read <i>Mental Health Consultation in Child Care</i> (Johnston & Brinamen, 2006) and <i>Enhancing Relationships Between Children and Teachers</i> (Pianta, 1999). Further, consultants take part in monthly agency-wide meetings where trainings on an array of topics relevant to mental health and cultural competence are provided.</p>

EARLY INTERVENTION PROGRAM (EIP)/INSTITUTO FAMILIAR DE LA RAZA (IFR)—SAN FRANCISCO, CA

Consultant Supervision and Support	<p>SUPERVISION</p> <ul style="list-style-type: none"> • Weekly one-hour individual reflective clinical and administrative supervision meetings • Weekly two-hour team group reflective clinical and administrative supervision meetings <p>SUPPORT</p> <p>The primary vehicle for support and professional development is the weekly two-hour team meetings.</p>
Consultant Caseload	<p>On average, three sites per consultant (approximately 44 children per site), although the ratio is higher if one or more of the sites is a family child care home, which averages only six children per program.</p>
Service Array, Frequency and Duration	<ul style="list-style-type: none"> • Child/family-centered and programmatic consultation • Direct therapy services to children and families (e.g., therapeutic play groups, counseling) <p>Consultants spend approximately 6-8 hours per week at each center-based program—up to 16 hours for large centers—and two hours a week for family child care homes; frequency and duration varies with need; there is no time limitation.</p>
Research/Evaluation Findings	<p>METHODOLOGY</p> <p>External evaluation that aggregates data from 13 consultation programs that are funded through a county-wide consultation initiative, of which EIP is one; the evaluation incorporates empirically validated tools, using a pre/post design and comparison group.</p> <p>FINDINGS/OUTCOMES</p> <p>Disaggregated data from the county-wide evaluation effort demonstrated that children receiving EIP services showed:</p> <ul style="list-style-type: none"> • Greater improvements in social skills than children not receiving services • Significant reductions in externalizing problem behaviors • Greater improvements in age-appropriate play than children not receiving services
Funding	<p>AMOUNTS AND SOURCES (FY2009)</p> <ul style="list-style-type: none"> • Annual program budget: \$556,047 • Overall allocation for county-wide initiative: \$4.6M • Funds provided primarily by the San Francisco Departments of Public Health and Children, Youth & Families, and First Five⁹. • Additional program funding comes from the Preschool for All¹⁰ initiative and Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT)¹¹ program

⁹First Five California, also known as the California Children and Families Commission, is a statewide initiative funded by cigarette taxes and designed to improve the lives of California's young children and their families through a comprehensive system of education, health services, child care and other key programs.

¹⁰Preschool for All (PFA) is a city-funded initiative providing universal access to free, high-quality, part-day preschool programs for all San Francisco four-year-olds.

¹¹EPSDT is Medicaid's comprehensive and preventive child health program for individuals under 21 years of age.

EARLY INTERVENTION PROGRAM (EIP)/INSTITUTO FAMILIAR DE LA RAZA (IFR)—SAN FRANCISCO, CA

<p>Notable Program Features</p>	<ul style="list-style-type: none"> • Promoting and personifying cultural and linguistic competence • Engaging family child care providers • Nurturing staff personally and professionally
<p>Program Contact</p>	<p>Cassandra Coe, LCSW Early Intervention Coordinator Instituto Familiar de la Raza 2919 Mission Street San Francisco, CA 94110 Phone: (415) 229-0500 ext 207 Email: ccoe@IFRSF.org</p>

For more information on EIP, see the full program summary on page 145.

EARLY INTERVENTION PROJECT (EIP)—BALTIMORE CITY, MD	
Program Type	One of multiple models within a statewide ECMHC effort
Program Scope	<p>GEOGRAPHIC AREA SERVED Urban; Baltimore City.</p> <p>SETTINGS SERVED Early Head Start and Head Start programs, licensed child care centers, public pre-kindergarten programs, and family child care homes in Baltimore City; majority of services (70%) are provided to center-based programs.</p> <p>AGES SERVED Birth to age 6.</p> <p>ANNUAL NUMBERS SERVED (CY2008) Individual children: 50; early childhood programs: 25.</p>
Organizational/ Management Structure	EIP is housed within the Baltimore City Child Care Resource Center (BCCCRC), a private, non-profit community organization that provides a myriad of services to the local child care community, including trainings for providers and child care locator services for parents. All EIP staff are centrally located at BCCCRC and employed by its parent non-profit organization, the Maryland Committee for Children, with the exception of the Clinical Supervisor, who is on staff at the University of Maryland Medical Center.
Staff Composition	EIP has a small team comprised of a full-time Program Director, part-time Clinical Supervisor, two full-time <i>Early Interventionists</i> (i.e., mental health consultants), and a full-time Intake Coordinator.
Consultant Qualifications and Training	<p>QUALIFICATIONS Consultants must have at least a bachelor's degree in child development, psychology, early childhood education, or special education with a concentration in early childhood, plus previous experience in the field.</p> <p>TRAINING Consultants are encouraged, but not required, to complete trainings provided by the Maryland Committee for Children on how to be an effective trainer, as well as the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) training on the Teaching Pyramid¹² model and various statewide trainings offered through the consultation grant.</p>
Consultant Supervision and Support	<p>SUPERVISION</p> <ul style="list-style-type: none"> • Weekly 1½ hour group clinical and administrative supervision meetings <p>SUPPORT</p> <ul style="list-style-type: none"> • Monthly peer group meeting with all consultants in the statewide consultation initiative • Ongoing informal peer support among the two EIP consultants

¹²See <http://www.vanderbilt.edu/csefel/>.

EARLY INTERVENTION PROJECT (EIP)—BALTIMORE CITY, MD

Consultant Caseload	Caseload sizes vary from 8 to 18 child-focused cases, plus 2 program-level cases.
Service Array, Frequency and Duration	EIP provides both child/family-centered and programmatic consultation services. Consultants visit each classroom/program for 2 hours each week, although this varies with the number and complexity of child-specific cases. Duration is typically 3 to 6 months, although there is no limitation.
Research/Evaluation Findings	<p>METHODOLOGY External evaluation conducted during the pilot phase; incorporated empirically validated measures, as well as locally-developed tools.</p> <p>FINDINGS/OUTCOMES As measured by the Preschool Kindergarten Behavior Scales (PKBS; Merrell, 2002):</p> <ul style="list-style-type: none"> • Decreases in problem behaviors: 69% improved • Decreases in internalizing behaviors: 67% improved • Decreases in externalizing behaviors: 71% improved • Improvements in social skills: 76% improved <p>EIP services also led to enhanced classroom/program environments, as indicated by improvements from intake to discharge on all items included in a locally-developed classroom environment measure.</p>
Funding	<p>AMOUNTS AND SOURCES (CY2008)</p> <ul style="list-style-type: none"> • Annual program budget: \$150,000 • Overall allocation for statewide initiative: \$1.87M • Funds provided by the Maryland State Department of Education, Division of Early Childhood Development, Office of Child Care
Notable Program Features	<ul style="list-style-type: none"> • Community development efforts • Behavioral pediatrician on staff to work with consultants and families • “Cultural broker”¹³
Program Contact	<p>Nancy Pelton, M.Ed. Director of Training and Technical Assistance Baltimore City Child Care Resource Center 1645 Ridgely Street, Suite 200 Baltimore, MD 21230 Phone: (410) 685-5150 Email: npelton@bccrc.org</p>

For more information on EIP, see the full program summary on page 157.

¹³A cultural broker helps ease people into each other’s cultures.

¹⁴Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC: 0-3R). Developed by ZERO TO THREE (www.zerotothree.org).

KID CONNECTS—BOULDER, CO	
Program Type	One model, countywide
Program Scope	<p>GEOGRAPHIC AREA SERVED Boulder County, including the city of Boulder and primarily suburban and rural communities.</p> <p>SETTINGS SERVED Community-based center or home care settings serving at-risk populations and accepting state child subsidy or at-risk preschool subsidy.</p> <p>AGES SERVED Birth through age 5.</p> <p>ANNUAL NUMBERS SERVED (FY2008) 72 children through child/family-centered services; 321 children through programmatic services; 7 child care centers and 5 family child care homes.</p>
Organizational/Management Structure	The Mental Health Center serving Boulder and Broomfield Counties is agency home to the program. The Partnership for Families and Children is the administrative and fiscal home and the central organization for statewide replication efforts. The Kid Connects Advisory Council addresses policy, funding, and plans for replication.
Staff Composition	Staffing includes the Senior Team Leader as director and supervisor, a Research Assistant, and four Mental Health Consultants (three full-time and one is a .75 full-time equivalent [FTE]).
Consultant Qualifications and Training	<p>QUALIFICATIONS</p> <ul style="list-style-type: none"> • Master's degree or higher in social work, psychology or related field • Knowledge of early childhood mental health • Experience in a clinical setting, early care and education, working with young children and families, and working in a collaborative setting • Familiarity with child care field and services • Clinical license preferred <p>TRAINING New consultant training and support protocol includes orientation to the model, guidance on consultation approach, training on DC: 0-3R¹⁴ tools and documents, essential readings, and shadowing an experienced consultant.</p>
Consultant Supervision and Support	<p>SUPERVISION</p> <ul style="list-style-type: none"> • Group reflective administrative and clinical supervision weekly by Senior Team Leader • Peer Supervision, twice a month, led by the Senior Consultant; focused on case conferences and reflective practices <p>SUPPORT Use of JFK Partners checklist (2006) to guide supervision and staff development. Ongoing staff development and training on early childhood development, work in early care and education settings, consultation skills, early childhood diagnosis and intervention, and other topics.</p>

KID CONNECTS—BOULDER, CO

Consultant Caseload	Caseload of 8-12 children and families receiving child/family-centered <i>Intensive Intervention</i> , at any one time, and a program caseload of either 2-3 large centers serving a total of 120-180 children, or 5-7 home providers collectively serving 50-75 children.
Service Array, Frequency and Duration	<ul style="list-style-type: none"> • Integrated health care screenings and follow-up in partnership with the Department of Public Health • Programmatic services, 16-20 hours per week in centers, 4 hours per week per family child care homes • Child/family-centered services: <ul style="list-style-type: none"> – <i>Intensive Intervention</i> services, no fixed number of visits – <i>Prevention Plus</i> services, minimum of 3 service hours
Research/Evaluation Findings	<p>METHODOLOGY Internal evaluation that incorporates qualitative and quantitative data from administrative information and empirically validated tools using a pre/post design.</p> <p>FINDINGS/OUTCOMES A total of 321 children served in FY2008:</p> <ul style="list-style-type: none"> • 40% of children who received <i>Intensive Intervention</i> showed improved behavior • 19 of 20 children at risk of expulsion were maintained in their early care and education settings • Over 96% of children were rated in the typical or strength range for total protective factors at post-test, a 12% increase from the baseline assessment
Funding	<p>AMOUNT AND SOURCES (FY2009)</p> <ul style="list-style-type: none"> • Annual program budget: \$431,346 • Funds provided by Department of Human Services, Early Childhood Services, Department of Human Services—Social Services, TANF reserves, and local foundations
Notable Program Features	<ul style="list-style-type: none"> • Integrated health screening and follow-up • <i>Early Care Site Readiness Assessment</i> tool • Replication manual
Program Contact	Jordana Ash, LCSW Early Childhood Services Team Leader Director, Kid Connects Boulder Irving Harris Fellow in Child Development & Infant Mental Health Phone: (720) 406-3637 Email: Jash@mhcbbc.org

For more information on Kid Connects, see the full program summary on page 168.

¹⁴Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC: 0-3R). Developed by ZERO TO THREE (www.zerotothree.org).

TOGETHER FOR KIDS—CENTRAL MASSACHUSETTS	
Program Type	One of multiple models within a statewide ECMHC effort
Program Scope	<p>GEOGRAPHIC AREA SERVED Central Massachusetts, which includes Worcester County (predominantly urban, with some suburban and rural).</p> <p>SETTINGS SERVED Early care and education centers, preschool programs, family child care programs, and Head Start programs.</p> <p>AGES SERVED Ages 2 to 5.</p> <p>ANNUAL NUMBERS SERVED (FY2008) Over 49 ECE agencies, 85 ECE sites, 180 classrooms, 400 teachers, and 4000 children, through programmatic consultation. TFK consultants provided child/family-centered consultation for approximately 600 children and families.</p>
Organizational/Management Structure	Community Healthlink (CHL) is the lead agency and fiscal agent for the Together for Kids project. In addition to being a TFK service provider, CHL subcontracts with four mental health agencies that employ the TFK consultants. The TFK Coalition/Steering Committee acts in an advisory role and supports advocacy and policy development.
Staff Composition	TFK's staff is comprised of a full-time Project Director, 13 full/part-time consultants, and 4 interns who are employed by CHL, as well as 13 full/part-time consultants and 4 additional interns, who are employed by local agencies with whom CHL subcontracts. Consultant positions are funded by a combination of state consultation funds and third-party insurance billing.
Consultant Qualifications and Training	<p>QUALIFICATIONS</p> <ul style="list-style-type: none"> • Master's degree in psychology or social work • Experience in a clinical setting working with children and families • License or license-eligible preferred <p>TRAINING Although not a requirement for the consultants hired by subcontracting agencies, it is strongly recommended that consultants regularly attend TFK staff trainings and meetings. Close to 100% of the TFK consultants have participated in a 32-hour clinical seminar on issues in early childhood mental health, titled "When Young Children Need Help: Challenges and Possibilities."¹⁵</p>

¹⁵This seminar is facilitated by Deborah Hirschland, LICSW. Material field tested in the seminar informed the development of the publication, *Collaborative Intervention in Early Childhood: Consulting with Parents and Teachers of 3-to-7-Year-Olds* (Hirschland, 2008).

TOGETHER FOR KIDS—CENTRAL MASSACHUSETTS

<p>Consultant Supervision and Support</p>	<p>SUPERVISION All TFK consultants are required to receive clinical and administrative supervision, the amount of which is based upon level of clinical licensure (i.e., licensed or unlicensed) and the guidelines set forth by their professional organization and credentialing body.</p> <ul style="list-style-type: none"> • Licensed clinicians receive clinical supervision based on the hiring agency’s protocol and clinical need • Unlicensed clinicians¹⁶ are required to have weekly clinical supervision • Clinical and administrative supervision is provided to the consultants by an experienced licensed independent psychologist or clinical social worker at the hiring entity and each agency is responsible for monitoring the implementation of the TFK program model <p>SUPPORT</p> <ul style="list-style-type: none"> • All consultants participate in weekly clinical team meetings • Interagency meetings are regularly scheduled for administrators/ supervisors and clinical teams that provide <i>embedded</i> services
<p>Consultant Caseload</p>	<p>TFK recommends approximately 1 full-time equivalent (FTE) consultant per 200 children in state subsidized care. Currently, they are staffed at 1 FTE per 250 children per state funding requirement.</p>
<p>Service Array, Frequency and Duration</p>	<p>On average, the consultant spends 16-20 hours per week providing child/family-centered and programmatic consultation services. TFK offers two main levels of services, which vary in intensity and duration:</p> <ul style="list-style-type: none"> • For <i>embedded</i> services, the consultant typically works with the center for the entire year on an ongoing basis, providing a full array of child/family-centered and programmatic services, as well as direct child and family therapy • For <i>non-embedded</i> services, the consultant typically conducts one to four visits per referral, including child or classroom observation(s), consultation with ECE providers/parents, development of a written report, and optional follow-up visit(s)
<p>Research/Evaluation Findings</p>	<p>METHODOLOGY External evaluation including qualitative and quantitative data, using a pre/post design and empirically validated instruments.</p> <p>FINDINGS/OUTCOMES</p> <ul style="list-style-type: none"> • On average, children’s scores for aggressive behavior decreased 23%; for maladaptive behavior they decreased 21%; and for adaptive behavior, they increased 12% • Over 90% of parents felt that TFK services had taught them better ways to handle their child’s behavior • Suspension rates dropped drastically, and the expulsion of children from preschools was all but eliminated (less than 1%)

¹⁶Unlicensed consultants are those clinicians with a master’s degree, but without requisite clinical hours and the subsequent passing of a professional test for “independent level” state licensure.

TOGETHER FOR KIDS—CENTRAL MASSACHUSETTS

Funding	<p>AMOUNTS AND SOURCES (FY2009)</p> <ul style="list-style-type: none"> • Annual program budget: \$861,343¹⁷ • Funds provided by MA Department of Early Education and Care, The Health Foundation of Central Massachusetts¹⁸, United Way of Central Massachusetts, Head Start, Community Partnership for Children programs¹⁹, and third-party billing to public and private insurance companies for direct therapy services
Notable Program Features	<ul style="list-style-type: none"> • Successful public policy efforts • Use of third-party insurance billing • Diverse evaluation and research studies
Program Contact	<p>Lynn Hennigan, MSW, M.Ed., LICSW Director of Services for Young Children Together For Kids Project Director 275 Belmont Street Worcester, MA 01604 Phone: (508) 421-4453 Email: lhennigan@communityhealthlink.org</p>

For more information on Together for Kids, see the full program summary on page 182.

¹⁷Due to tough economic times, the state drastically reduced its budget for statewide ECMHC in FY2010. As a result, TFK's FY2010 budget is approximately \$500,000.

¹⁸The Health Foundation of Central Massachusetts provided funding from 2001-2009. Funding ended as of June 30, 2009.

¹⁹Community Partnership for Children programs help income-eligible families pay for preschool programs for their children.

Contextual Factors that Support ECMHC

Before discussing the specific components that comprise an effective ECMHC program, it is important to consider the contextual factors that support the emergence of ECMHC programs in states and communities. Certainly, *funding is an essential ingredient*, but something must compel funders to invest in this particular intervention. Across the six study sites, a number of contextual factors were mentioned. This section will explore these key factors that inspired funders and other key stakeholders to lend their support to local consultation efforts.

1. **Data.** Research showing high rates of preschool expulsion (see Gilliam, 2005) was a strong catalyst for state and local public and/or private investment in early childhood mental health consultation across the six study sites. State rankings on expulsion rates were particularly compelling to policymakers and funders residing in states with poor rankings. Research linking ECMHC to reductions in expulsion rates (see Gilliam & Shahar, 2006) also lent strong support for initiating (and later, sustaining) consultation efforts.
2. **National experts.** A number of program leaders mentioned finding inspiration to pursue early childhood mental health consultation in their state or community because of a stirring presentation by a nationally renowned expert. For example, compelling presentations on the need for and benefits of ECMHC by Kadija Johnston from the Infant-Parent Program in San Francisco and Jane Knitzer from the National Center for Children in Poverty helped convince Michigan's leadership that ECMHC was the right choice to help address growing concerns about child care expulsions.
3. **Champions.** A significant factor underlying the emergence of consultation services across the study sites was the presence of a champion or group of champions. These individuals may have been situated at the state, county and/or community level, but they helped create opportunities for ECMHC through strategic collaborations, compelling marketing to key stakeholders and, in some cases, provision of funding.

"I became more enthusiastic when I saw [the evaluator's] data that started to show that you can attribute this program to decreasing the number of suspensions and expulsions. And so I promoted it among my colleagues at work and talked to them about focusing some more of our efforts on early childhood."—PROGRAM PARTNER

4. **Local context.** All study sites articulated a unique “local” context that led to financial and stakeholder support for consultation efforts in their states and communities. This included a mixture of political agendas (e.g., improving mental health services, bolstering school readiness, prevention/early intervention), existing state/community grant awards (e.g., Early Childhood Comprehensive Services, System of Care, Mental Health Transformation) and specific issues that had generated a lot of local concern (e.g., increases in children exhibiting challenging behavior, staff turnover in ECE settings). In addition to data demonstrating consultation’s efficacy in addressing some of these issues, the preventative and capacity-building nature of this intervention was also effective in garnering support.

■ CROSS-SITE HIGHLIGHT: LEGISLATIVE ACTION

In Connecticut, a Governor’s Blue Ribbon Commission Report on Mental Health that highlighted significant gaps in the state’s mental health service system was a catalyst for ECMHC services. As a result of this report, the Connecticut State Legislature established the Mental Health Strategic Investment Fund to seed initiatives designed to improve access to and availability of quality mental health services. Concurrently, the legislature created a broad-based Community Mental Health Strategy Board to guide funding allocation by recommending targeted community-based efforts that would collectively lead to an improved service delivery system. A leader in the local early childhood community was appointed to the Board’s subcommittee on children and strongly advocated for funding early childhood mental health consultation, given that it focused on young children, was innovative, and had data indicating that it significantly decreased preschool expulsion rates. In the end, the Board recommended and the legislature approved funding for five children’s initiatives, one of which was early childhood mental health consultation.

5. **Starting small.** The majority of sites included in this study started as pilot efforts. Conducting pilots provided the opportunity to test out and evaluate consultation models on a small scale. Through outcome data and stakeholder input, pilot efforts can shape stronger program models going forward and, ideally, expansion of ECMHC services, as was the case in Baltimore City, MD (see box below).

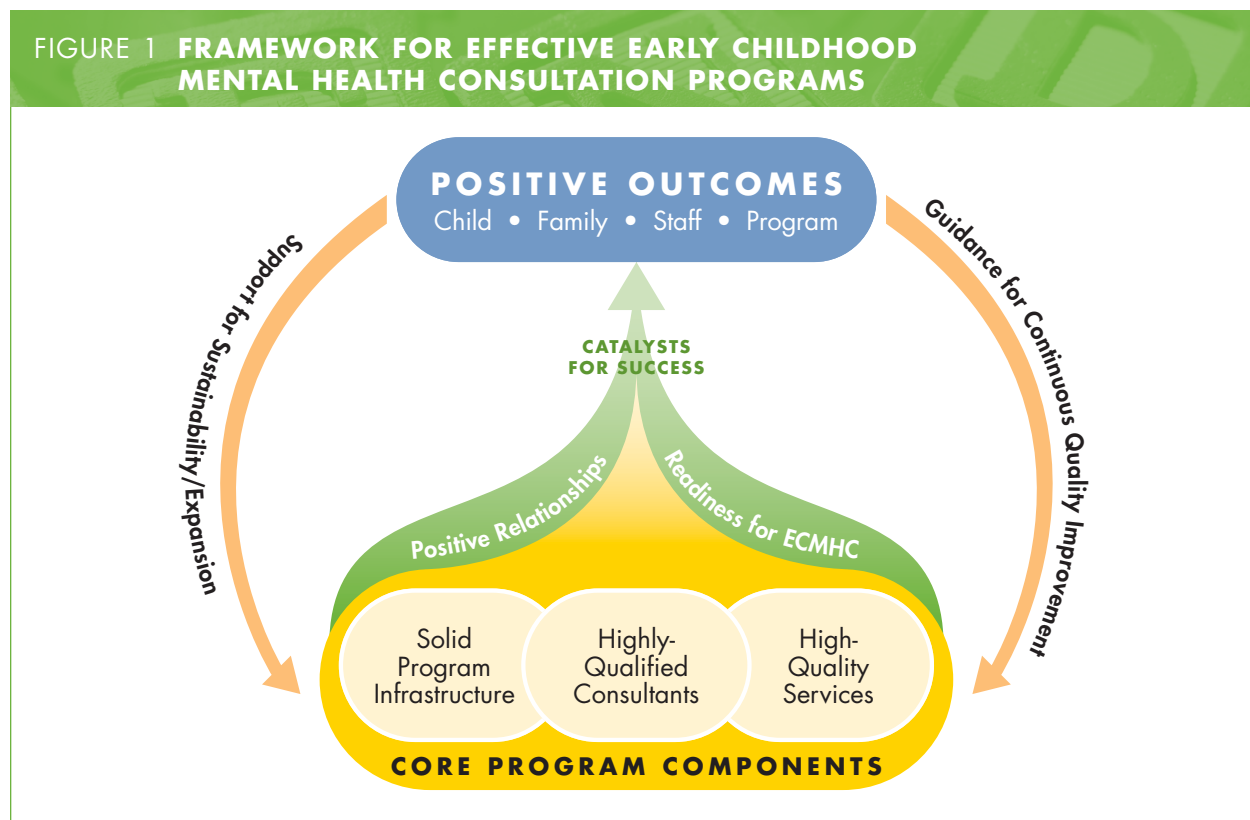
■ CROSS-SITE HIGHLIGHT: PILOT EVALUATION LED TO STATEWIDE EXPANSION

In Maryland, a pilot effort ultimately led to statewide expansion of consultation services. Building on momentum from promising consultation outcomes in Anne Arundel County, the Maryland State Department of Education spearheaded a pilot project in two other counties using quality set-aside funds from the Child Care Development Fund. Funding was also provided for an independent evaluation, and legislation was passed to mandate that evaluation results be shared with the executive and legislative branches. Promising evaluation findings from both pilot sites led to the state’s decision to expand consultation to all regions of the state beginning in 2006. Currently, Baltimore City’s Early Intervention Project (EIP) is one of twelve consultation programs statewide that comprise the Maryland Early Childhood Mental Health Project, a program funded by a new state allocation of nearly \$2 million. The Project is directed by the Division of Early Childhood Development within the Maryland State Department of Education.

Central Features of Effective ECMHC Programs

This section highlights common elements and practices across the six study sites and provides specific examples of how these components are operationalized. It also infuses lessons learned and recommendations from those who are managing and providing consultation services, as well as those who are receiving services.

The framework for effective early childhood mental health consultation that emerged from this cross-site analysis is depicted in Figure 1 below.



This framework suggests that there are five factors that are important in the design of an effective ECMHC program (i.e., a program that achieves positive outcomes). First, **three core program components** must be in place:

- 1) solid program infrastructure (e.g., strong leadership, clear model design, strategic partnerships, evaluation, etc.);
- 2) highly-qualified mental health consultants; and
- 3) high-quality services.

These core program components are hypothesized to be strongly associated with positive outcomes of consultation, measured at multiple levels (e.g., changes in child behavior, teacher behaviors, and ECE environments). Yet, these components alone are not sufficient to produce the desired outcomes.

This study uncovered two other elements that are essential to achieving positive outcomes and, in fact, serve as **catalysts for success** (i.e., as yeast is to other ingredients in making bread). These elements are:

- 1) the quality of the relationships between and among consultants and consultees; and
- 2) the readiness of families and ECE providers/programs for ECMHC (e.g., openness to gaining new skills and knowledge, opportunities for collaboration).

It is important to note the dynamic interaction between these two catalysts, as well as the ongoing developmental processes inherent within these two elements. For example, consultants can help consultees enhance their readiness for consultation through building and strengthening relationships. It is also important to underscore that readiness or presence of an existing, positive relationship does not (or should not) precede consultation services. In fact, consultants constantly develop new relationships and work with ECE providers and families who are at varying levels of readiness for consultation. Building relationships and facilitating the journey to readiness are cornerstones of consultation.

In addition to the relationships between the factors listed above, this diagram also illustrates the importance of using evaluation findings/outcome data to guide program enhancements (i.e., a continuous quality improvement process) and to educate funders and other key stakeholders about the program's impact in order to promote sustainability and/or expansion.

Each element of this framework will be described in greater detail in the following narrative.

CORE PROGRAM COMPONENT 1: Solid Program Infrastructure

An essential component of an effective ECMHC model is a strong infrastructure that supports success. This includes numerous facets, each of which will be discussed in turn below.

Strong Leadership

Strong leadership is a critical asset of any consultation program. Respondents noted that consultation program leaders (e.g., directors, managers, administrators) served a variety of functions that laid the groundwork for successful consultation and helped to maintain a thriving program. Several of the key leadership functions and characteristics discussed include:

- being an advocate for the program and ECMHC (at all levels);
- thinking systemically and acting strategically;
- sitting at the “right tables” (i.e., tables where one can take part in key conversations, decisions and opportunities regarding policy and funding);
- engaging partners and maintaining their commitment to the program’s success;
- gathering and utilizing data/feedback to improve services;
- making staff feel appreciated;
- providing meaningful support to staff (e.g., clinical, emotional); and
- promoting a positive attitude and organizational culture.

“[The key to success] is leadership and commitment to relationships and really thinking about all of the pieces that are needed. So, not just the practice piece that of course is core, but also the research and the advocacy and the training pieces.”—PROGRAM PARTNER

CROSS-SITE HIGHLIGHT: LEADING THE WAY FOR POLICY CHANGE

Under the leadership of the ECMHC program director and a strong local coalition, Central Massachusetts’ Together for Kids (TFK) program successfully advocated for expansion of early childhood mental health consultation in Massachusetts. By strategically using positive evaluation findings from their program that demonstrate the efficacy of consultation as an intervention, TFK Coalition members succeeded in influencing state-level policy. Specifically, Coalition members secured the inclusion of early childhood mental health language in the enabling statute for the then-new Department of Early Education and Care, as well as a line item in the state budget for statewide ECMHC services (which increased from \$1.4M in FY2008 to \$2.4M in FY2009). Although tough economic times led to a significant decrease in the FY2010 allocation in the state budget for consultation (\$1.0M), the line item was preserved and local advocates are poised to champion reinstatement of prior funding levels when the time is right.

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

Clear Model Design

Across all six sites, there is consensus that it is essential to have a clearly defined program model as well as materials and processes that support articulation of that model. Model clarity is a cornerstone of effective programs, helping to prevent role confusion among consultants and consultees, support consistency in service delivery, and create a necessary foundation for evaluation efforts. It is very important that all program staff and partners are well-versed in the model through trainings or other mechanisms, and receive ongoing feedback/guidance to ensure implementation fidelity.

Several key components to address in developing a consultation model are the:

- philosophy or theoretical approach to consultation;
- guiding principles (e.g., cultural competency, family involvement, strengths-based);
- purpose of the consultation;
- service population (e.g., ages, settings, geographic areas to be served);
- roles and responsibilities of the consultant and consultees;
- caseload parameters; and
- methodology or protocol for service delivery (including referral, case closure and follow-up procedures).

CROSS-SITE HIGHLIGHT: THEORETICAL APPROACHES TO CONSULTATION

Each of the six study sites indicated that their consultation models were anchored in one or more theoretical approaches. Predominantly, programs cited a relationship-based orientation (e.g., infant mental health) to consultation that emphasized strengthening relationships among ECE providers, parents and children. Other guiding theories that were mentioned include a public health approach (i.e., comprehensive focus on promotion, prevention and intervention) and systems theory (i.e., a framework that acknowledges the interconnectedness of various parts of a system). These theoretical underpinnings helped shape programs' model designs (e.g., service array, service duration) and influenced how consultants approached the work.

Several practices to support model clarity and transparency that were mentioned across the six study sites are listed below.

- Develop marketing materials such as fact sheets or brochures that describe the ECMHC program and establish accurate expectations.
- Enter into written contracts with ECE providers/programs so that each party understands and commits to their roles and responsibilities.
- Communicate early and often with consultees about what services will be provided and what to expect. At the beginning ask consultees, “what are your expectations?” and clarify issues as needed.
- Develop a service delivery flowchart and create/integrate tools and forms (e.g., referral forms, observation tools, service plan templates) that support service implementation with fidelity to the program model.

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

Clear Organizational Structure

In addition to clearly defining the model, it is important to establish a clear organizational structure that specifies the interactions and lines of accountability among ECMHC program staff and partners (including advisory boards and/or committees). This is particularly important when operating large programs that engage subcontractors for service delivery. For example, Connecticut’s statewide consultation program subcontracts with 10 community-based agencies that employ consultants across the state, but each agency is clearly accountable to the program’s central management team. Further, each consultant is jointly supervised by their respective subcontracting (i.e., hiring) agency and a member of the program’s central management team.

CROSS-SITE HIGHLIGHT: PROGRAM/REPLICATION MANUAL

To ensure model clarity and support fidelity, Connecticut developed *Solid Ground: A Resource for Early Childhood Mental Health Consultation* (Bicio, Moy, & Starkey, 2007) a program manual for consultants and other stakeholders interested in detailed guidance on ECCP’s consultation model. The manual provides a summary of how the program evolved and evaluation findings, as well as descriptions of ECCP services and detailed instructions on the tools and procedures that are components of this model. In addition, *Solid Ground* includes a variety of resource materials including staff job descriptions, training outlines, sample reports, and a listing of relevant websites, books and publications. It is also designed to help readers understand:

- key elements involved in developing and implementing an early childhood mental health consultation program; and
- the importance of a data driven system in implementing and monitoring a quality program that remains consistent across large geographic areas.

Hiring and Training Program Staff

Respondents from the study sites unanimously agreed that a key determinant of a program’s success is the caliber of staff, underscoring the importance of a thorough and thoughtful hiring and training process. Respondents pointed to the importance of having an ECMHC program director with strong leadership and management skills, as well as highly-qualified mental health consultants (which will be described in greater detail later in this report). In addition, they emphasized the importance of stability in staffing because of the negative impact of disruptions in consultant/consultee relationships. However, some ECMHC program directors noted that recruiting and retaining staff can be challenging because consultant salaries are not as competitive as salaries for other mental health professions. Lower salaries also make it harder to secure bilingual or bicultural consultants that “match” the cultural backgrounds of service recipients, as these added skills/characteristics are often in demand.

“I think that you really can’t underestimate the amount of training that goes into increasing [consultants’] level of expertise.”—PROGRAM PARTNER

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

To assist in hiring highly-qualified mental health consultants, most programs operate with a standardized consultant job description, although one site gave subcontractors some flexibility in the composition of the job description. All but one site required consultants to have a master’s degree in mental health or a related field, with most also requiring some level of early care and education experience.

TABLE 1 CROSS-SITE SNAPSHOT OF REQUIRED/PREFERRED CONSULTANT QUALIFICATIONS

	DEGREE REQUIREMENT	OTHER QUALIFICATIONS
Child Care Expulsion Prevention (Michigan)	Master’s degree in social work, psychology or a related field	<ul style="list-style-type: none"> • License or license-eligible preferred • Level II Endorsement—Michigan Association for Infant Mental Health
Early Childhood Consultation Partnership (Connecticut)	Master’s degree in a human services related field (e.g., psychology, social work, education, marriage and family counseling)	<ul style="list-style-type: none"> • Extensive knowledge of key issues such as early childhood development, emotional and behavioral health, family systems, and children with physical and developmental disabilities • Demonstrated expertise in the field • Familiarity with early care and education programs and systems
Early Intervention Program/Instituto Familiar de la Raza (San Francisco, CA)	Master’s degree in social work, psychology or related field	<ul style="list-style-type: none"> • Bilingual in Spanish • Bicultural background preferred • Mental health licensure and experience in early childhood mental health, mental health consultation, direct mental health services and in working with low-income and multi-cultural communities preferred
Early Intervention Project (Baltimore City, MD)	Bachelor’s degree in child development, psychology, early childhood education, or special education with a concentration in early childhood	<ul style="list-style-type: none"> • Demonstrated experience in the field
Kid Connects (Boulder, CO)	Master’s degree in social work, psychology or related field	<ul style="list-style-type: none"> • Knowledge of early childhood mental health • Experience in a clinical setting, early care and education, working with young children and families, and working in a collaborative setting • Familiarity with the early care and education field and services • Clinical license preferred
Together for Kids (Central Massachusetts)	Master’s degree in psychology or social work	<ul style="list-style-type: none"> • Experience in a clinical setting working with children and families • License or license-eligible preferred

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

CROSS-SITE HIGHLIGHTS:**AN INTERVIEW STRATEGY FOR CONSIDERATION**

In San Francisco's Early Intervention Program (EIP) model, being self-reflective is a critical skill for consultants. To gauge a candidate's tendency and ability to self-reflect, as well as his/her alignment with other important program values, the ECMHC program director asks interviewees to react to a vignette that illustrates a situation a consultant might encounter in the field.

INFANT MENTAL HEALTH ENDORSEMENT

In Michigan, both current and newly-hired consultants must attain a Level II Michigan Association for Infant Mental Health (MI-AIMH) endorsement. This endorsement verifies that a consultant has attained a level of education as specified by the MI-AIMH, participated in specialized in-service trainings, worked with guidance from mentors or supervisors, and acquired knowledge to promote the delivery of high quality, culturally sensitive, relationship-focused services to infants, toddlers, parents, other caregivers and families. For more information, visit <http://www.mi-aimh.org>.

ECMHC program directors reported that it is challenging to find candidates that have all of the necessary or desirable ECMHC skills, so they anticipate the need to train new hires and provide ongoing professional development to maintain a strong, skilled team. In fact, Central Massachusetts embraces the notion that in the field of early childhood mental health consultation, you have to "grow your own." Still, ECMHC program directors from all of the sites agreed that candidates must have strong relationship-building skills to be considered for a consultant position. Another consideration in hiring that some sites mentioned was assembling a mix of consultants with diverse backgrounds (e.g., cultural backgrounds) and experiences. Among the 13 consultants that were interviewed for this study, the overwhelming majority (12) was female and 10 were Caucasian, non-Hispanic.

OTHER NOTABLE PROGRAMS' PRACTICES: WORKFORCE DEVELOPMENT

San Francisco's Daycare Consultants Program offers a practice-based program for mental health clinicians who wish to become consultants. The training integrates infant and early childhood mental health principles and knowledge of early childhood education and development, and is comprised of four key elements: a didactic training seminar; a clinical conference; clinical supervision; and direct consultation experience (Johnston & Brinamen, 2005). For more information on Daycare Consultants, see Appendix.

Clearly, a strong consultant training component is essential to establishing a strong foundation for high-quality consultation work. Although there is a good deal of variability across study sites with regard to the length of training and who facilitates the training (e.g., internal program staff, external partners or experts, or both) there is much commonality in the topic areas addressed:

- Orientation to the ECMHC program model—from principles to procedures
- Key early childhood topics, such as developmental norms, attachment, trauma

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- Key consultancy topics, such as the “consultative stance” (see shaded box), conducting and interpreting observations, becoming an effective trainer
- Working within early care and education settings
- Administering specific observation/assessment/evaluation tools
- Cultural and linguistic competency

■ THE “CONSULTATIVE STANCE”

Johnston and Brinamen (2006) describe the consultative stance as a consultant’s “way of being.” This way of being is essential to developing strong consultation relationships and can be characterized by the following 10 elements:

- Mutuality of endeavor
- Avoiding the position of expert
- Wondering instead of knowing
- Understanding another’s subjective experience
- Considering all levels of influence
- Hearing and representing all voices—especially the child
- The centrality of relationships
- Parallel process as an organizing principle
- Patience
- Holding hope

In addition to general topical areas, several programs also integrate trainings on evidence-based practices and/or manualized interventions such as the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) Teaching Pyramid model (Fox, Dunlap, Hemmeter, Joseph & Strain, 2003) and/or SECOND STEP, a violence prevention curriculum with a strong social and emotional component (Committee for Children, 2003).

■ CROSS-SITE HIGHLIGHT: COMBINING ECMHC AND EVIDENCE-BASED CURRICULA

In Central Massachusetts, Together for Kids evaluators have received a National Institute of Mental Health Intervention Development Grant (funded through Spring 2010) to develop and evaluate a primary prevention curriculum in four randomly assigned Worcester early care and education centers that are receiving TFK consultation services. The project is adapting SECOND STEP, a violence prevention curriculum (Committee for Children, 2003), for use as a primary prevention strategy for all children enrolled in preschool classrooms. Child behavior outcomes and classroom impacts are being measured, and curriculum adaptations and feasibility are being reviewed. The overall goal is to develop a transportable “real world” intervention model to decrease the number of children in preschool who require intensive behavioral intervention services and provide a sustainable mechanism for identifying and appropriately intervening with those who do.

Similarly, Project Mastery in North Carolina and the Chicago School Readiness Project both incorporated The Incredible Years Parent and Teacher Training Series (Webster-Stratton, 1999a, 1999b), an evidence-based social emotional curriculum, into consultation services and evaluated outcomes. For more information on these efforts, see Appendix.

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It is worth noting that in two sites, trainings are not mandatory but strongly recommended. Consultants interviewed from both those sites indicated that they had completed the trainings, as had most (if not all) of their colleagues. In other sites, some modules are only offered as the need is identified. Most sites also mentioned providing ongoing professional development opportunities for consultants through local, state and national trainings on relevant topics.

■ CROSS-SITE HIGHLIGHT: INFRASTRUCTURE CHALLENGES IN RURAL AREAS

ECMHC program administrators and consultants serving rural areas noted the following unique challenges:

- Building a “team” feel when consultants and program staff are often spread out over long distances
- Attending program trainings or meetings in “central” locations, which are often many miles from where the consultant is located
- Traveling long distances between each consultee site, which limits the number of cases a consultant can accommodate, as well as how frequently he/she can visit each consultee

In addition to training sessions, a couple of sites also give consultants required reading, a mixture of national resources (e.g., *Mental Health Consultation in Child Care* by Johnston & Brinamen, 2006; *Enhancing Relationships Between Children and Teachers* by Pianta, 1999) and program-specific materials. Further, several sites have new hires shadow veteran consultants to illustrate the consultation model in practice and help sharpen their skills. Consultants and ECMHC program directors from these sites underscored the value of these mentoring opportunities for new consultants. Another important role that a veteran consultant can play when a new hire replaces him/her at a particular ECE program, is to help transfer the relationships that have been established so that the new consultant can build upon those relational foundations. Of course, this practice is useful whenever there is a change in consultants, regardless of whether they are new hires or not.

Supervision and Support Mechanisms for Mental Health Consultants

All study sites strongly agreed that high-quality supervision and support for mental health consultants is a critical element of any successful consultation program. Given the roving and intensive nature of consultation, consultants can easily get overwhelmed and feel isolated without regular, ongoing clinical and emotional support by well-trained supervisors and peers. Furthermore, a lack of supervision and support can lead to “model drift” (i.e., deviance from the program model). In addition to clinical supervision, consultants also benefit from administrative supervision, which helps them stay updated with agency or program policies, procedures and plans.

“[Reflective supervision and peer support]—these were the two components that made me want to stay and [that] make the program successful.”—MENTAL HEALTH CONSULTANT

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

In most sites, individual and group supervision is offered from weekly to twice a month to monthly. For larger programs, team meetings typically do not include the entire consultant staff, just those from the same local hiring agency or in the same geographic area. However, in Connecticut, quarterly all-staff meetings are held to provide administrative updates, team-building opportunities, and joint trainings for consultants.

The majority of the sites utilize reflective supervision as a significant part of their approach. This supervisory practice helps build consultant competencies in a nurturing and supportive way and supports a parallel process that will enhance consultants’ ability to meet the needs of those they are serving. In Michigan, reflective supervision must be provided by someone trained in this approach. Thus, while general clinical and administrative supervision is always provided within the agency where the consultant is employed, reflective supervision might be provided by someone outside of the agency if there is not a supervisor at the home agency with the necessary training.

In addition to reflective supervision, there is consensus that consultants need opportunities to meet with their peers to share challenges and strategies and provide emotional support. Most of the consultants mentioned the value of having both face-to-face time with peers, as well as informal networking opportunities through phone conversations and email exchanges.

TABLE 2 CROSS-SITE SNAPSHOT OF SUPERVISION & SUPPORT TO CONSULTANTS		
	SUPERVISION	SUPPORT
Child Care Expulsion Prevention (Michigan)	<ul style="list-style-type: none"> Administrative and/or clinical supervision within own agency Reflective supervision one-on-one twice a month Supplemental group reflective supervision	Ongoing support by CCEP TA staff includes monthly conference calls, quarterly TA meetings, documents and resources, email listserv, and a quarterly newsletter.
Early Childhood Consultation Partnership (Connecticut)	<p><u>With program management staff:</u></p> <ul style="list-style-type: none"> Monthly, two-hour individual reflective clinical and administrative supervision Biweekly group reflective administrative and clinical supervision—half the team at a time Quarterly staff meetings attended by all staff with administrative updates, team building activities and training <p><u>With hiring/subcontracting agency:</u> Individual clinical and administrative supervision occurs at least once a month; exact frequency and duration is according to agency discretion.</p>	In addition to biweekly and quarterly group staff meetings, consultants receive support through monthly peer support/action plan support meetings and informal contacts with peers.

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

TABLE 2 CROSS-SITE SNAPSHOT OF SUPERVISION & SUPPORT TO CONSULTANTS

	SUPERVISION	SUPPORT
Early Intervention Program/Instituto Familiar de la Raza (San Francisco, CA)	<ul style="list-style-type: none"> Weekly one-hour individual reflective clinical and administrative supervision Weekly two-hour group reflective supervision meetings <p>The team also participates in monthly agency-wide meetings where trainings occur on an array of topics relevant to mental health and cultural competence.</p>	<p>The primary vehicle for support and professional development is the weekly two-hour group meetings.</p>
Early Intervention Project (Baltimore City, MD)	<ul style="list-style-type: none"> Weekly 1½ hour group clinical and administrative supervision meetings 	<p>Monthly peer group meeting with all consultants in the statewide consultation initiative as well as ongoing informal peer support among the two EIP consultants.</p>
Kid Connects (Boulder, CO)	<ul style="list-style-type: none"> Weekly group reflective administrative and clinical supervision by Senior Team Leader; also incorporates specialized trainings Peer Supervision, two times a month, led by Senior Consultant focused on case conferences and reflective practices 	<p>Use of JFK Partners checklist to guide supervision and staff development. Ongoing staff development and training on early childhood development, work in early care and education settings, consultation skills, early childhood diagnosis and intervention, and other topics.</p>
Together for Kids (Central Massachusetts)	<p>Administrative and clinical supervision is provided by a supervisor at the hiring agency. Format, frequency and duration are at the agency's discretion.</p> <ul style="list-style-type: none"> Licensed clinicians receive clinical supervision based on the hiring agency's protocol and clinical need Unlicensed clinicians receive 1-2 hours of weekly supervision with access to additional supervision as needed <p>Each agency is responsible for monitoring implementation of the TFK program model.</p>	<p>Weekly clinical team meetings at each hiring agency. Interagency meetings are also scheduled on a regular basis for administrators, supervisors and clinicians who provide clinical intervention services.</p>

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

■ CROSS-SITE HIGHLIGHT: FOSTERING STAFF GROWTH AND PROVIDING SUPPORT

An integral part of staff development and model fidelity in San Francisco’s Early Intervention Program (EIP) is the weekly Early Intervention team meetings. These meetings create a safe, supportive space for consultants to discuss challenging cases with their peers and clinical supervisor and “wonder” with them to formulate next steps. Through a parallel process, these sessions actively provide consultants with an opportunity to learn first-hand how to integrate and assimilate the reflective, consultative stance. The regular meetings cultivate a positive group dynamic and help to establish trust among team members. They also give the program manager an opportunity to help foster staff growth and adherence to program goals and values. Furthermore, it provides consultants much-needed time for reflection and emotional support. Often it is challenging for consultants to make the shift from a more traditional, individual service model to a consultation model. These reflective and instructional sessions help facilitate that transition.

Strategic Partnerships

The need for strong partners was a common theme that emerged across the study sites. Partners were defined broadly, encompassing community leaders, early childhood providers, funders, legislators, researchers and other service providers. Partners played various pivotal roles, including:

- laying the groundwork for the consultation program to emerge;
- championing the program to support sustainability and/or expansion;
- providing funding for program implementation/sustainability;
- contracting with the program to provide consultation services;
- collaborating with the program by making referrals and/or providing complementary services;
- conducting evaluations to assess model fidelity and program efficacy; and
- offering guidance to ensure ongoing program quality.

“One of the reasons that [the consultation program received increased funding was that] people around the state realized how beneficial [consultation] was. It wasn’t just the department, it wasn’t [program staff] going and saying this is a good thing—we need more, but it was other people in the state, other constituents in the state that talked to legislators.”—PROGRAM PARTNER

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

CROSS-SITE HIGHLIGHT: STATE AND LOCAL LEVEL PARTNERSHIPS

Michigan’s Child Care Expulsion Prevention (CCEP) program has key collaborative partners at the state level. Those partners’ local representatives are also engaged, participating as members on local advisory teams for each local CCEP program. Having leadership roles and regular presence at meetings among state agencies has enabled CCEP to inform, advise, and influence state level partners so that attention is focused on the social emotional development of young children and their families in a comprehensive way at both the state and local levels. These partnership activities have impacted policy, practice, and system change, providing a foundation for early childhood mental health promotion, prevention, and intervention across service systems and increasing access to early childhood mental health consultation to benefit all young children and families.

For example:

- CCEP’s State Administrator co-chairs the Social-Emotional Health External Board Advisory Committee for the Early Childhood Investment Corporation, the public/private partnership leading the development of Michigan’s comprehensive early childhood system.
- CCEP’s TA staff helped to forge an 8-member CCEP State Partners Social and Emotional Training Committee to discuss and coordinate social and emotional training offered by all state partners, including Part C, Head Start T/TA Network and State Collaborative Office, and the Michigan Association for Infant Mental Health.

Respondents acknowledged that they “could not do it alone” and with regards to service delivery, expressed that they had no interest in duplicating efforts. On the contrary, several ECMHC program directors mentioned concerted efforts to identify opportunities to leverage resources through collaboration with partners who shared similar goals and for whom the partnership would be mutually beneficial. For example, in Boulder, Kid Connects partners with the Boulder County Public Health Department to complement ECMHC services with health screenings (i.e., vision, hearing, dental and developmental), which help consultants better meet the needs of children and families (see box below). Further, in Central Massachusetts, Together for Kids receives some program funding from Head Start programs as consultation services help the centers meet their federally-required mental health goals.



“I’m all about sharing the dollars.”

—ECMHC PROGRAM DIRECTOR

CROSS-SITE HIGHLIGHT: HEALTH/MENTAL HEALTH PARTNERSHIPS

Colorado’s Kid Connects program has a partnership with Boulder County Public Health that supports the integration of health care screenings into the consultation model. The public health nurses and consultants work together to educate providers on the interplay of primary health and mental health, and encourage parents to have their children participate in health screenings. The nurses complete the health screenings (vision, hearing and dental) and share screening results and recommendations with the consultant. The consultant then integrates this information with developmental/mental health findings to support families in making follow-up appointments and seeking further assessment and/or treatment as needed. The results of this partnership are high participation in health screenings, early identification and eligibility for Early Intervention services, high follow through on referrals, healthier children, and improved school readiness.

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

Community Outreach and Engagement

Building community trust and raising awareness of ECMHC services is a critical infrastructure component. The study sites succeeded in building community trust through a variety of strategies. Several consultation programs were housed within or affiliated with local agencies that had existing strong community ties and solid reputations from their work over the years. For example, San Francisco’s consultation program is centrally located at Instituto Familiar de la Raza, a community mental health agency that has been known and respected in the Mission District for over thirty years.

To establish a community presence despite their statewide scope, Connecticut and Michigan subcontract with community-based agencies throughout each state to serve as local homes for services. Still, one challenge that remains when consultation services are placed within community mental health agencies is stigma. Despite the fact that services are provided in homes and/or ECE settings, some respondents expressed that the association with a mental health agency can create resistance for some families. Mostly, this resistance was overcome by building relationships and trust over time.

CROSS-SITE HIGHLIGHT: CULTURAL BROKER

A key component of the success of outreach efforts in Baltimore City’s Early Intervention Project (EIP) has been the important yet unofficial role that the program’s Intake Coordinator plays—that of a “cultural broker.” Cultural brokers help ease people into each other’s cultures. The Intake Coordinator is typically the first person that individuals meet when initiating services with the program. The Intake Coordinator has deep roots in the Baltimore community and, at the time of this report, was the only staff member of the same cultural background as the majority of providers seeking and receiving services through EIP (i.e., African American). In addition, through her twenty years of experience in family child care, she has firmly established relationships in the local child care community. Thus, her involvement from the beginning goes a long way in establishing the program’s credibility and paving the way for a positive working relationship between the EIP consultant and provider.

Other effective strategies employed by study sites that served dual purposes of community relationship-building and marketing to generate awareness and program referrals include:

- building relationships with key community leaders who could “vouch” for the consultant/consultation program (this strategy was particularly useful in rural communities, where it can be challenging to build relationships if you are viewed as an “outsider”);
- attending and/or presenting at local meetings, forums and trainings for ECE providers and other key stakeholders;
- participating in community events, such as fairs, that families and ECE providers attend;
- “cold calls” or drop-ins to local child care centers or family child care homes to introduce the consultation program; and
- mailings to ECE providers, pediatricians, family members or other stakeholders who might benefit from consultation services.

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In Baltimore City, extensive outreach efforts using many of the strategies listed above has helped the program to become better established in the community and generated a good volume of referrals. As a result, word of mouth has also become an effective outreach tool.

■ CROSS-SITE HIGHLIGHT: LESSONS LEARNED REGARDING COMMUNITY OUTREACH

Study sites had the following recommendations regarding community outreach:

- Recognize that the most effective outreach strategies vary from community to community
- In developing marketing materials, consider how the language and imagery portray the consultation program (e.g., Are you using photos of happy children or sad/angry looking children? Are you using language that is sensitive to stigma concerns in the community you are serving? Would ECE providers be comfortable sharing these materials with families in their programs?)
- Consider the needs of those for whom English is not the first language (i.e., translating written materials, offering presentations in other languages)

Clear Communication

Regular communication among ECMHC program staff and between ECMHC program staff and their funders, program partners and service recipients should be incorporated into any program infrastructure. Establishing ongoing channels of communication can help clarify roles and responsibilities, identify and address problems before they escalate, ensure that all parties are working towards the same goals, and provide a feedback loop to inform program improvements. As previously discussed, communication among ECMHC program staff is essential and should be infused into the supervision and support structures.

In communicating with subcontractors or stakeholders outside of the ECMHC program, the six study sites used a variety of communication strategies to foster understanding and collaboration—some formal and others informal. In Michigan, CCEP’s Technical Assistance (TA) staff, which are part of the program’s “central office,” communicate regularly with local consultation service providers via monthly conference calls, TA resource documents, quarterly reports from the local program sites, and periodic site visits. Another communications vehicle widely used across the six study sites is written contracts or agreements. Larger sites that partner with local subcontracting agencies/organizations to help deliver consultation services (i.e., Michigan, Connecticut and Central Massachusetts) enter into formal contracts or Memoranda of Understanding (MOU) that clearly outline tasks and areas of accountability. These agreements not only help communicate expectations, but are a mechanism to support fidelity to the consultation model. Similarly, all six study sites employ partnership agreements (i.e., written agreements between the consultation program and the ECE program/provider receiving services) that communicate what services are to be provided and for how long, as well as the roles that all involved parties are expected to play. Although these partnership agreements are not mandatory in all study sites, ECMHC program directors and consultants indicated that they are a very useful communications tool and help to avoid confusion about the consultant’s role and the purpose of consultation.

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

Collaborative meetings between ECMHC program staff and ECE providers/programs are another strategy employed by the study sites. For example, in San Francisco’s Early Intervention Program (EIP), the consultation program management meets regularly with local Head Start management to go over critical cases and address issues as they arise. These meetings are not only productive, but foster collaboration and maintain positive relationships. In Connecticut, ECMHC program management also communicates regularly with their primary funder, either in person or over the phone, to provide updates on the program’s activities and discuss future directions.

In addition to clear communication with program partners and ECE programs/providers, it is essential that consultation programs integrate mechanisms for communicating effectively with families. Some communications strategies or vehicles employed across the six study sites include:

- letters or brochures describing the ECMHC program and the consultant’s role in family-friendly language, to be distributed by the ECE program/provider and/or the consultant;
- personal contact with families by having the consultant available to introduce him/herself and the consultation program during pick-up and/or drop-off times, parent nights or other social activities associated with the ECE program; and
- consent forms that clearly articulate the services the consultant will provide to the son and/or daughter.

Regardless of the audience, ECMHC programs also expressed the need to foster an open communications policy, such that any stakeholder—program partner, ECE provider or parent—feels comfortable contacting ECMHC program staff to ask questions or raise issues of concern.

■ CROSS-SITE HIGHLIGHT: SUPPORTING CULTURAL AND LINGUISTIC COMPETENCE THROUGHOUT PROGRAM INFRASTRUCTURE

Study site respondents mentioned a number of strategies to support cultural and linguistic competence that cut across various facets of program infrastructure, which are presented below.

- Hire staff that are bilingual and, if possible, bicultural
- Enlist interpretation services as needed
- Provide flexible scheduling (i.e., to accommodate religious holidays, parents that do shift-work)
- Read communications aloud for those with low reading levels or limited English proficiency
- Translate materials into different languages
- Provide provider/family trainings in different languages
- Integrate cultural competence into consultant trainings and provide ongoing support and supervision on relevant topics (e.g., how to examine various traditions and beliefs, how to discuss “culturally difficult questions” with consultees)

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

Evaluation

Another critical piece of any program infrastructure is collecting and analyzing data to support program monitoring, reporting, quality improvement and sustainability efforts. All six study sites engaged in evaluation activities, although there was variability in the extent to which data was infused into program functioning and the sophistication of data management systems. The primary function for data collection across the sites is monitoring program outcomes, particularly child outcomes. Some programs predominantly use the data to meet funders' requirements, while others used it extensively as a tool to promote program sustainability and inform continuous quality improvement efforts. Additional uses for demographic, activity tracking and outcome data that were mentioned by study sites include monitoring program fidelity, assessing staff professional development needs, and informing action plan development. For further discussion of evaluation issues and a listing of standardized measures used for assessing outcomes, see page 88.

CROSS-SITE HIGHLIGHT: STRONG MANAGEMENT INFORMATION SYSTEM

As a statewide consultation model, Connecticut's Early Childhood Consultation Partnership (ECCP) program must balance the need for individualized services with the required level of infrastructure necessary to maintain model fidelity. Part of this infrastructure is the ECCP Management Information System, which was designed to support program monitoring and continuous quality improvement. Through this system, the program manager can track consultant activities and provide support as needed when services fall short of program expectations with respect to quantity and/or quality. In addition, the system generates a number of reports (at both the program and consultant level) that help to guide services, meet funders' reporting requirements, and inform policymakers and other stakeholders.

Financing

The majority of the study sites originated as pilot efforts, with seed money to implement and evaluate the efficacy of the consultation program. Promising evaluation findings led to sustainability beyond the pilot effort and, in some cases, also led to significant expansion. For example, after successful pilot efforts in Baltimore City and the Eastern Shore, Maryland extended consultation statewide and the state Department of Education currently appropriates \$1.87M to this effort. Further, in Central Massachusetts, positive evaluation findings of Together for Kids coupled with significant and ongoing legislator outreach and education efforts resulted in the state Department of Early Education and Care financing a statewide expansion of ECMHC. A line item in the state budget was created in 2007, and funding increased for statewide consultation from \$1.4M to \$2.4M between FY2008 and FY2009²⁰.

²⁰Despite the governor's recommendation to increase funding in FY2010 to \$2.9M, tough economic times led to a final budget appropriation of \$1.0M for statewide ECMHC services, of which Together for Kids will receive the largest portion: approximately \$285,000 (a 56% decrease from their FY2009 allocation).

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

TABLE 3 CROSS-SITE ANALYSIS OF FUNDING SOURCES AND AMOUNTS

	SOURCE(S)	AMOUNT (Fiscal Year/FY or Calendar Year/CY)
Child Care Expulsion Prevention (Michigan)	State Department of Human Services, using Child Care Development Fund dollars	FY09 budget: \$1.85M
Early Childhood Consultation Partnership (Connecticut)	Primarily funded through the CT Department of Children and Families' Early Intervention Prevention Unit, with supplemental funding from the State Department of Education.	FY09 budget: \$2.1M
Early Intervention Program/Instituto Familiar de la Raza (San Francisco, CA)	Primarily funded through San Francisco's Early Childhood Mental Health Initiative, which is funded by the San Francisco Departments of Public Health and Children, Youth & Families, and the First Five initiative. ²¹ Additional program funding comes from the Preschool for All initiative ²² and through billing Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) ²³ program for direct therapy services.	FY09 budget: \$556,047
Early Intervention Project (Baltimore City, MD)	State Department of Education, Division of Early Childhood Development, Office of Child Care	CY2008 budget: \$150,000
Kid Connects (Boulder, CO)	Primarily funded by the state Department of Human Services—Social Services/TANF reserves. Additional funding provided by the state Department of Human Services—Early Childhood Services and local foundations.	FY09 budget: \$431,346
Together for Kids (Central Massachusetts)	Primarily funded by the state Department of Early Education and Care. Additional funding provided by The Health Foundation of Central Massachusetts ²⁴ , the United Way of Central Massachusetts, Worcester Community Partnership for Children ²⁵ , and Worcester Head Start, as well as billing through public and private insurers for direct therapy services.	FY09 budget: \$1.1M ²⁶

²¹First Five California, also known as the California Children and Families Commission, is a statewide initiative funded by cigarette taxes and designed to improve the lives of California's young children and their families through a comprehensive system of education, health services, child care and other key programs.

²²Preschool for All (PFA) is a city-funded initiative providing universal access to free, high-quality, part-day preschool programs for all San Francisco four-year-olds.

²³EPSDT is Medicaid's comprehensive and preventive child health program for individuals under 21 years of age.

²⁴Funding from The Health Foundation of Central Massachusetts ended on June 30, 2009.

²⁵The Worcester Community Partnership for Children is a program that helps Worcester families pay for preschool programs for their children.

²⁶Tough economic times (see footnote 20) led to a marked decrease in TFK's FY2010 budget—from \$1.1M to \$500,000.

CORE PROGRAM COMPONENT 1: SOLID PROGRAM INFRASTRUCTURE

Current funding across the study sites varies significantly, reflective of the variability in scope of these programs. In Connecticut and Michigan, the two statewide programs, annual funding is \$2.1M and \$1.85M respectively. For the sites with more targeted geographic areas, funding ranged from \$150,000 (Baltimore City/EIP) to \$431,346 (Boulder/Kid Connects) to \$556,047 (San Francisco/EIP) to \$1.1M (Central Massachusetts/TFK).

Funding sources were primarily state or local/county child welfare, education/early care and education, public health, and/or human services agencies. Some sites also receive (or have received) funding from private foundations or local initiatives (e.g., San Francisco's First Five initiative). Two sites (San Francisco and Central Massachusetts) also bill to private insurance and/or Medicaid for eligible children who receive direct therapy services.

CROSS-SITE HIGHLIGHT: THIRD-PARTY BILLING

Central Massachusetts' Together for Kids (TFK) program uses third-party billing to insurance companies/programs when services shift from consultation to direct, individualized therapy. This financing mechanism has allowed TFK to provide individualized therapy onsite at the early care and education center, which allows for ease and consistency of service delivery. In addition, Head Start programs served by TFK provide some funding, as the consultants help the programs meet their required mental health goals.

Recommendations/lessons learned regarding securing funding include:

- Link the program to goals that are important to funders (e.g., school readiness, reductions in preschool expulsion)
- Invest in evaluation; it is critical to demonstrate the efficacy of the program and the merit of funding it
- In approaching potential funders, augment data findings with real stories and/or testimonials to give them a greater sense of the program's impact

OTHER NOTABLE PROGRAMS' PRACTICES: LINKING ECMHC TO ECE QUALITY RATINGS

In Louisiana, a statewide ECMHC project is being implemented as an integral part of their Quality Rating System. This effort is funded through their federal Child Care and Development Fund dollars and has three main goals: 1) to promote the social and emotional health of young children; 2) to support teachers' promotion of healthy child development within the classroom setting, and 3) to refer for treatment and/or design interventions for young children exhibiting behavioral problems. For more information on this initiative, see Appendix.

CORE PROGRAM COMPONENT 2: Highly-Qualified Mental Health Consultants

In addition to a solid program infrastructure, an effective consultation program requires highly-qualified mental health consultants. Overwhelmingly, respondents noted that the quality of the consultants is one of the most essential elements of a program's success.

"She [the mental health consultant] is a huge wealth of knowledge and I always have questions, so it's nice to have someone to ask."

—FAMILY CHILD CARE PROVIDER

While this report already briefly discussed guidance on hiring and training consultants, this section will explore the needed attributes, skills and content knowledge of consultants in greater depth. Cross-site findings represent a compilation of core consultant qualifications, skills and characteristics noted by ECMHC program directors, consultants, ECE providers and family members.

CROSS-SITE HIGHLIGHT: SNAPSHOT OF INTERVIEWED CONSULTANTS

Below is a snapshot of the qualifications of the mental health consultants (MHCs) interviewed for this study who completed the Mental Health Consultant Education, Skills and Experience Inventory, a self-administered tool (N=12; see Appendix). Key findings include:

- the majority of MHCs (9) attained a master's degree;
- all but one have a degree(s) in mental health—the most common mental health degree is psychology (7), followed by marriage & family therapy, social work, and counseling, each with 2 responses (note: some MHCs had more than one area of specialty);
- few (3) held a degree, license or certification in early childhood education; and
- the majority (9) had 10 years or less of early childhood mental health experience.

Education and Content Knowledge

ECMHC program directors, ECE providers and families mentioned several core areas of knowledge that are essential to providing effective consultation because they provide a foundation for identifying needs and developing appropriate strategies, which, in turn, fosters trust and confidence in the consultants' abilities. These core areas include knowledge of:

- infant and early childhood mental health, including underlying causes of and interventions for challenging behavior;
- child development (particularly infancy to preschool), including typical versus atypical development, recognition of "red flags" and symptoms of disorders;
- best practices, evidence-based practices and other resources related to early childhood mental health;
- cultural and linguistic competence; and
- child/family/ECE service systems and community resources.

CORE PROGRAM COMPONENT 2: HIGHLY-QUALIFIED MENTAL HEALTH CONSULTANTS

In addition, respondents felt strongly that consultants must have an **understanding of the realities of working in early childhood settings**, so they can put themselves in the providers' shoes. While some of the consultants interviewed had prior experience working as early childhood providers, others gained this perspective through interactions with providers.

CROSS-SITE HIGHLIGHT: UNDERSTANDING ORGANIZATIONAL CULTURES

In addition to understanding the general realities of working in ECE settings, study respondents expressed that consultants must also understand the unique organizational cultures of each ECE program with which they work. For example, when working with Early Head Start/Head Start programs, consultants must have a firm grasp of the programs' federal and local regulations, policies and procedures as well as a clear sense of the roles of each staff member (e.g., Disabilities Services Coordinator, Family Services Coordinator) to avoid duplication or fragmentation of services.

Skills

Respondents also identified key skills for consultants. These include the ability to:

- build relationships—with and among providers, children and parents;
- communicate effectively (i.e., clearly and in a non-threatening way);
- conduct screenings and observations and using findings appropriately;
- develop individualized strategies/interventions that reflect the culture (e.g., personal values, center philosophies and regulations), skills, strengths, needs and preferences of those they are serving;
- motivate parents and providers to try different strategies and approaches;
- build parent/provider capacity to meet the social and emotional needs of young children;
- work effectively with children of all ages in group settings; and
- link children/families/providers to other services and systems as needed.

"She [the mental health consultant] has a way of telling you how to do things differently without making you feel like she's telling you you've done something wrong."—CENTER-BASED TEACHER

CROSS-SITE HIGHLIGHT: CONSULTANT COMPETENCIES

The consultants interviewed for this study were also asked to report their perceived level of competency in a variety of areas specified in the Mental Health Consultant Education, Skills and Experience Inventory (see Appendix). Using a scale of 1 to 5, with 5 indicating the highest level of competency and 1 indicating minimal competency, consultants reported that on average, they felt pretty competent on most items outlined in the Inventory. Rankings ranged between 3.6 and 4.5 in most areas. A complete list of perceived competency levels is presented in Table 4, ranked from lowest to highest.

CORE PROGRAM COMPONENT 2: HIGHLY-QUALIFIED MENTAL HEALTH CONSULTANTS

TABLE 4 CONSULTANTS' REPORTED AREAS OF COMPETENCY (Lowest to Highest)
(N=12; means reported based on a scale of 1 to 5)

UNDER 3	3 TO 3.49	3.5 TO 3.99	4 TO 4.49	4.5 AND ABOVE
Experience working with children in foster care	Experience providing direct therapy to children birth through five	Experience working in child care settings (prior to job as a consultant)	Care management/ care coordination skills Crisis intervention skills	Ability to collaborate with child care directors/teachers/providers
	Knowledge of early intervention systems	Knowledge of family support and adult service systems	Ability to integrate mental health activities into group care settings	Communication skills
		Understanding of diverse cultures	Experience observing/ screening/assessing children in classroom, home or other natural settings	Ability to collaborate with families
		Knowledge of community resources	Ability to integrate a "wellness approach" to mental health that includes activities focused on promotion and prevention	
		Experience providing training/education to adults	Experience working with children with challenging behavior	
		Knowledge of diverse mental health treatment/intervention approaches	Knowledge of infant and early childhood mental health/social-emotional development	
			Knowledge of typical and atypical early childhood development Ability to develop and support implementation of individualized intervention plans	
			Ability to facilitate team meetings/manage diverse perspectives	

CORE PROGRAM COMPONENT 2: HIGHLY-QUALIFIED MENTAL HEALTH CONSULTANTS

■ OTHER NOTABLE PROGRAMS' PRACTICES: ENHANCING THE CONSULTANT WORKFORCE THROUGH COLLABORATION WITH HIGHER EDUCATION

In Arkansas, consultation efforts support workforce development through collaboration with local colleges and universities to offer training opportunities to students interested in early childhood mental health. For more information on Arkansas' model, see Appendix.

Attributes/Characteristics

At least equally as important as skills and knowledge is the consultant's approach to delivering consultation. In fact, the consultant's approach can significantly impact his/her ability to build strong relationships with consultees and, consequently, the consultees' willingness to partner with the consultant and embrace new ideas and strategies. Further, the consultant's approach can also facilitate a parallel process, in which the consultee begins to mirror the consultant's interactions with children, parents and/or ECE providers.

The list below provides some key consultant attributes identified by ECMHC staff, ECE providers and family members.

- Respectful—values others' opinions
- Open-minded/non-judgmental—accepts people for who they are
- Reflective
- Flexible—will adjust schedule and modify strategies as needed
- Approachable/easy to talk to
- Good listener
- Trustworthy
- Compassionate/empathetic
- Team player
- Willing to be hands-on and not just stand in the corner
- Reliable, dependable
- Self-motivated
- Positive/upbeat
- Patient—recognizes that change takes time
- Persistent—does not give up if there is resistance to change
- Loves children—shares the “children come first” mentality
- Warm/people person

It is important to note the complexity in what constitutes a highly-qualified mental health consultant; some things can be learned through education, training and/or experience, while others seem to be personality traits. Again, when selecting candidates to fill this important position, it is critical to consider the individual's existing skill set and the extent to which training and/or experience might fill any gaps.

CORE PROGRAM COMPONENT 3: High-Quality Services

An important area of exploration in this study was assessing the types of services provided by the six consultation programs and assembling lessons learned and recommendations for delivering high-quality services, which are an essential element of effective consultation. This section will discuss both service array and recommended practices, informed by both qualitative (i.e., site visit interviews) and quantitative data (i.e., the Service Array and Frequency Checklist, see Appendix).

All study sites indicated that they provide both child- or family-centered consultation and programmatic consultation. These types of consultation are defined as follows:

- **child- or family-centered consultation:** consultation focuses on a particular child with challenging behavior and/or the family of that child; and
- **programmatic consultation:** consultation focuses on a general program or classroom issue that impacts the mental health of staff, children and/or families (Cohen & Kaufmann, 2000).

Study sites reported that one type of consultation often segues into the other. For example, an ECE program may engage a consultant to help address a particular child's behavior and later ask for assistance with overall program enhancements (e.g., updating the program's behavior management policy, improving staff/parent communication). Services may also begin with programmatic consultation and then lead to a child-specific referral as the ECE providers become better able to recognize social/emotional issues in infants and young children.

Most of the study sites also offer levels of service intensity such that providers and parents have different options to meet their needs. For example, in Connecticut, providers can elect to receive child/family-centered consultation services only or to augment these services with programmatic consultation of varying intensity (i.e., one classroom or the entire program). Further, in Central Massachusetts, providers can opt to have regular, onsite visits by a consultant or services that are short-term and less intensive. Respondents indicated that having levels of services is beneficial because it allows consultees to tailor services to their needs and provides an opportunity to “test drive” services before committing to more involvement.

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

CROSS-SITE HIGHLIGHT: MOTIVATIONS FOR PROGRAMMATIC REFERRALS

Although less frequent than referrals for child- or family-centered consultation, referrals for programmatic consultation stem from a variety of needs, often identified by the ECE program director. Some common reasons for programmatic referral include a desire to:

- enhance program/classroom environment to better support healthy social/emotional development;
- improve staff/family communication;
- establish or improve a program's behavior management policy;
- strengthen co-worker relationships;
- strengthen partnerships with families and increase family involvement; and
- train staff on specific behavior/mental health topics (e.g., biting, attachment).

In 2007-2008, 17% of child care sites served by Michigan's CCEP program requested programmatic consultation, apart from child/family-centered consultation.

Consultants reported spending the majority of their time working with ECE providers and families to address the needs of children identified with concerns, although much of the intervention is focused on the classroom. In providing child/family-centered consultation, consultants typically develop individualized service plans that blend targeted interventions specific to a particular child (e.g., a weighted blanket for naptime for a toddler with sensory issues, singing a favorite song to help soothe an upset infant) and environmental improvement strategies that support that child as well as other children (e.g., rearranging the classroom, improving transition practices, implementing positive behavior reinforcement techniques, restructuring circle time). This bolsters parent/caregiver and provider ability to meet not only the needs of the individual child, but others in their homes and classrooms. Thus, programmatic and child/family-centered consultation are often intertwined.

It is important to note that half of study sites provide an array of services that extend beyond consultation. That is, in addition to providing services that build the capacity of ECE programs/providers and families to address infants and young children's social/emotional well-being, a number of ECMHC programs are complementing these services with other activities, such as direct therapy to children with more intensive intervention needs. This will be discussed in greater detail below.

Service Array

Consultants in the six study sites employed various strategies and activities in their work with families and ECE programs/providers (see shaded box on page 70). Although some activities extended beyond provider/family capacity-building, all study sites agreed that the primary

"I think that one of the things that impresses me and continues to impress me about this program is the amount of support that teachers get...that they [the teachers] can continue to use the strategies that [consultants] gave for one or two or three children and...they can begin to use them with other children, so it's an ongoing kind of process."—PROGRAM PARTNER

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

goal of ECMHC is improving child well-being by enhancing provider and parent/caregiver ability to meet the social and emotional needs of infants and young children. The array of services and activities was influenced by several factors, particularly the program model, financial resources and the size and complexity of the consultants' caseloads.

■ CROSS-SITE HIGHLIGHT: TOP CONSULTANT ACTIVITIES

The following information was collected via the Service Array and Frequency Checklist (see Appendix), which study sites were asked to distribute to all their consultants (including, but not limited to, those that were interviewed). This checklist examined whether consultants engaged in specified activities and the frequency with which each activity occurred (i.e., from "never" to "weekly or more"). Eighty-two consultants representing all six sites submitted checklists. The top three activities for each category are listed. Percentages indicate the percent of consultants reporting that they do this activity at least monthly.

CHILD/FAMILY-CENTERED CONSULTATION

With ECE providers/in the classroom:

- Observe/assess individual children (95%)
- Support/guide (e.g., coaching) classroom strategy implementation (95%)
- Develop classroom strategies (93%)

With families/in the home:

- Support/guide home strategy implementation (81%)
- Develop home-based strategies (77%)
- Provide informal education (77%)

PROGRAMMATIC CONSULTATION

- Support/guide (e.g., coaching) implementation of classroom/program-wide strategies (85%)
- Develop classroom/program-wide strategies (73%)
- Model strategies in the classroom (73%)

Beyond classifications of child/family-centered and programmatic consultation, consultant activities fell into six overarching categories:

1. Information Gathering
2. Individualized Service Plan Development
3. Individualized Service Plan Implementation Support
4. ECE Provider/Family Education
5. ECE Provider/Family Emotional Support
6. Linkages to/Provision of Services Beyond Consultation

Each of these activity categories will be discussed in turn.

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

1. Information Gathering

Typically a consultant's first service activity, whether providing child/family-centered, programmatic consultation or both, is gathering information about the needs of the child, family and/or ECE provider/program. This is often accomplished by conducting an observation or assessment. Child-specific observations/assessments require parent/guardian consent. According to a survey of all consultants across the six study sites (i.e., Service Array and Frequency Checklist), consultants most frequently conduct observations of individual children identified with concerns (63% do it weekly or more), while classroom-wide observations of all children and assessments of the overall classroom/program environment occur much less often (22% and 27%, respectively, do these weekly or more). While a few sites use locally-developed tools to guide these observations, most use standardized instruments, such as the Ages and Stages Questionnaire: Social Emotional (ASQ:SE; Squires, Bricker, & Twombly, 2002), the Home Observation for Measurement of the Environment (HOME; Caldwell & Bradley, 1984) or the Classroom Assessment Scoring System (CLASS; Pianta, La Paro, & Hamre, 2008).

Often, the consultant will also ask providers and/or family members to complete screening/assessment tools as part of the service planning process. In several programs, consultants offer both classroom and home observations when providing child-specific services. A number of respondents, including family members, indicated that a home observation or visit was an important step in the service delivery process, affording the consultant an opportunity to examine the child's behavior in both settings and setting a positive tone with families. Consultants indicated that after the initial information-gathering process is complete, they take time to review the results with the providers and families, often jointly, and collaboratively determine the best course of action.

■ CROSS-SITE HIGHLIGHT: A WORD ABOUT HOME VISITING

Respondents—particularly family members—from several sites noted the importance of incorporating home visiting into the service delivery model and making it available to families who are amenable. In particular, respondents recommended at least one home visit to conduct an observation of the child, with the option for additional home visits as needed and desired. Home visiting not only helps to provide a more holistic context for intervention, but also sets a positive tone for family engagement. Still, among consultants in the six study sites, 52% of consultants reported that they never or rarely conduct home visits.

2. Individualized Service Plan Development

After conducting a thorough information gathering process, consultants typically move into the service planning phase. Although not a mandatory practice in all study sites, consultants typically put the service plans in writing to help facilitate communication and ensure that all involved parties are on the same page.

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

■ CROSS-SITE HIGHLIGHT: ACTION PLANS

In Connecticut, the Early Childhood Consultation Partnership (ECCP) Information System generates *Action Plans* (i.e., individualized service plans), which organize the goals, objectives and hands-on, strengths-based strategies to be implemented for consultees. ECE providers, family members, and consultants alike indicate that these plans are a valuable communication and service-planning tool. Further, from a program management perspective, the *Action Plans* support model fidelity by creating a consistency in approach, communication and intervention on a statewide basis, while also allowing for the individualized needs of the child, family, and/or ECE classroom/program.

Across the six study sites, the plan development process is highly collaborative and engages ECE providers and family members, although there is variability in how this is accomplished. For child/family-centered consultation, consultants from all sites have regular contact with both parties, either through joint consultant/ECE provider/family meetings, individual meetings/contacts with the ECE provider and family, or a combination of both. A common practice is having all parties meet together initially to develop the service plan, followed by one-on-one support to the provider and family member, unless the need to reconvene and significantly modify the plan arises. In programmatic consultation, the collaboration might be between a child care center director, classroom teacher(s) and the consultant.

Tables 5 and 6 provide some specific examples of strategies that consultants might incorporate into individualized service plans. These examples were derived from information provided via the Service Array and Frequency Checklist (see Appendix) by consultants across all six study sites, including those who were interviewed as well as their colleagues (N=82).

■ ECMHC RESOURCES: CSEFEL AND ZERO TO THREE

The Center on the Social and Emotional Foundation for Early Learning (CSEFEL) developed a number of activities and tip sheets designed to promote the social and emotional well-being of infants and young children in early care and education classrooms and at home. For example, reproducible feelings charts, problem-solving cue cards, and tip sheets on creating supportive environments. Consultants can download these free, ready-to-use activity guides and materials to support strategy development from the CSEFEL website: <http://vanderbilt.edu/csefel>.

Likewise, on the ZERO TO THREE website (<http://www.zerotothree.org>), consultants will find a variety of free resources to help ECE providers and caregivers support infants' and toddlers' social and emotional health, including tip sheets on helping infants and toddlers learn to communicate and build relationships with others.

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

TABLE 5 CHILD-CENTERED AND PROGRAMMATIC CLASSROOM-BASED STRATEGY EXAMPLES

STRATEGY	SPECIFIC EXAMPLE
Support self-calming	<ul style="list-style-type: none"> • Establish a cozy corner/safe place/be-by-myself space • Make/provide stress bottles • Teach children various relaxation techniques, when and where to use them with the group and with individuals
Improve classroom functionality	<ul style="list-style-type: none"> • Rearrange furniture to get rid of “run ways” and create better flow • Declutter the classroom to cut down on overstimulation
Implement routines and schedules to promote consistency	<ul style="list-style-type: none"> • Introduce sticker charts • Use visual charts/schedules
Improve transitions	<ul style="list-style-type: none"> • Introduce “5-minute warnings” before switching to a new activity • Use a transitional object to help a child move from one activity to another • Create transition booklets to help ease transitions
Promote social skills	<ul style="list-style-type: none"> • Teach social/emotional concepts and skills (e.g., through social stories, “feelings books” or music) • Provide opportunities to practice role play of social skills (e.g., through dollhouse play and puppets) • Provide opportunities for friendship development into a daily routine (e.g., through circle time, cooperative games and activities) • Provide opportunities for self-expression and make-believe play (e.g., through a dress-up corner/box)
Strengthen problem-solving skills	<ul style="list-style-type: none"> • Create a solution kit to help a child work through problem situations
Enhance circle time	<ul style="list-style-type: none"> • Begin with a short activity to expend excess energy and help children settle down (e.g., yoga, song with movement, “shake your sillies” exercise) • Make accommodations for specific children, such as seating them close to teacher • Have children sit on individual rugs as a visual reminder to stay within their own space
Enhance naptime	<ul style="list-style-type: none"> • Use transitional objects, such as a stuffed toy from home for the child to cuddle with • Make accommodations for specific children, such as placing their cots near teachers

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

TABLE 6 CHILD/FAMILY-CENTERED HOME-BASED STRATEGY EXAMPLES

STRATEGY	SPECIFIC EXAMPLE
Support parent needs for more effective discipline and positive behavior support practices	<ul style="list-style-type: none"> • Explore setting limits and establishing boundaries • Introduce positive “time out” techniques • Implement behavior charts • Post visual reminders around the home • Create a “time in” space for child to calm him or herself
Establish/enhance routines and schedules	<ul style="list-style-type: none"> • Develop a picture schedule • Establish routines and expectations for meal time, bedtime, etc. • Explore ways to integrate nurturing rituals into the daily routine
Encourage increased parent/child interaction time	<ul style="list-style-type: none"> • Suggest family fun activities • Provide or raise awareness of social-emotional stories or books that parents/caregivers can read to their children
Help parents/caregivers meet specific social and emotional needs of their children	<ul style="list-style-type: none"> • Promote children’s understanding of the permanence of caregivers through games like peek-a-boo or hiding a toy under a blanket • Create photo books to help children with attachment issues (e.g., due to a recent divorce)

3. Individualized Service Plan Implementation Support

Once the initial service plan is in place, consultants provide an array of support to assist ECE providers and family members in implementing the recommended strategies. This includes training, coaching—in person, over the phone and/or via email—and modeling, which typically takes place in the classroom. As mentioned above, ongoing communication with ECE providers and family members to assess the

“[I]nstead of giving us the solution she—whatever it is—I don’t know how this happens, like magic, we end up with a solution when we walk out the door. And everyone feels supported and like we won.”—ECE DIRECTOR

“She [the consultant] listens to me and then gets me to think the complete opposite. She just totally changed my mind and gets me to think in different ways. She does not say ‘you’re wrong,’ instead she’ll ask ‘have you ever noticed this?’ or ‘have you ever thought about it this way?’”—FAMILY MEMBER

efficacy of certain strategies and inform strategy modifications along the way is essential. Further, as with any aspect of consultation, the manner in which the consultant approaches strategy implementation is important. For example, several recipients of consultation indicated that exemplary consultants use an approach of “suggesting” strategies and never make the providers or families feel like they are being critiqued or corrected. Ideally, the entire team feels vested and engaged in the service plan.

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

4. **ECE Provider/Family Education**

Although a less frequent occurrence than development and implementation of classroom- and home-based strategies, consultants also provide group educational sessions for both ECE providers and families. In fact, one-third of consultants indicated that they engage in these activities for providers and families at least monthly (33% and 32%, respectively). More frequent was informal, one-on-one education to families, which 77% of consultants reported doing at least monthly. A sampling of training and education topics covered by consultants across the six study sites includes:

- recognizing red flags;
- managing stress;
- understanding underlying causes for behavior;
- guiding behaviors of infants and toddlers;
- embracing diversity;
- communicating with parents about children’s behavior; and
- encouraging family involvement.

Some consultants indicated that their ability to conduct group training sessions fluctuates depending upon the number of child-centered cases in their caseload and the complexity of the needs of those children and families. If child-centered consultation efforts are particularly time-intensive, then there may not be time in the consultant’s schedule to provide group trainings.

In addition to trainings that consultants conduct with consultees, consultants from a couple of study sites also provide group trainings to the broader early childhood community on topics relevant to social/emotional well-being in infants and young children. For example, to promote social and emotional quality in early care and education, Michigan’s CCEP consultants must offer a standardized four-part training series in their local communities for ECE providers, families, and other early childhood professionals. These four training modules, based on best practice and research, are each three hours in length and include the topics below:

- Foundations of Social and Emotional Development
- Preventing and Working with Challenging Behavior
- Conflict Resolution
- Caring for the Caregiver

In addition to providing valuable information, these trainings help Michigan ECE providers with professional development, licensing and programmatic goals. For example, the trainings 1) support competency areas for those working toward a Child Development Associate (CDA), 2) count toward licensing requirements for training hours for child care centers, and 3) count toward the 16 training hours required of relative care providers and day care aides to earn monetary incentives.

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

5. ECE Provider/Family Emotional Support

Another important activity or function that consultants provide is lending emotional support to ECE providers and family members and helping them cope with the

“It’s very hard. You beat yourself up and blame yourself when your child is having difficulties and not the way you think he should be. It’s helpful to know that there are kids out there that are this hard.”—FAMILY MEMBER

stresses of dealing with children who have extremely challenging behaviors. Respondents indicated that it was important to have someone to turn to who would validate their frustrations and affirm that the difficulties they encountered were not due to a lack of ability or hard work. Further, they expressed that having this support mechanism helped reduce stress.

6. Linkages to/Provision of Services Beyond Consultation

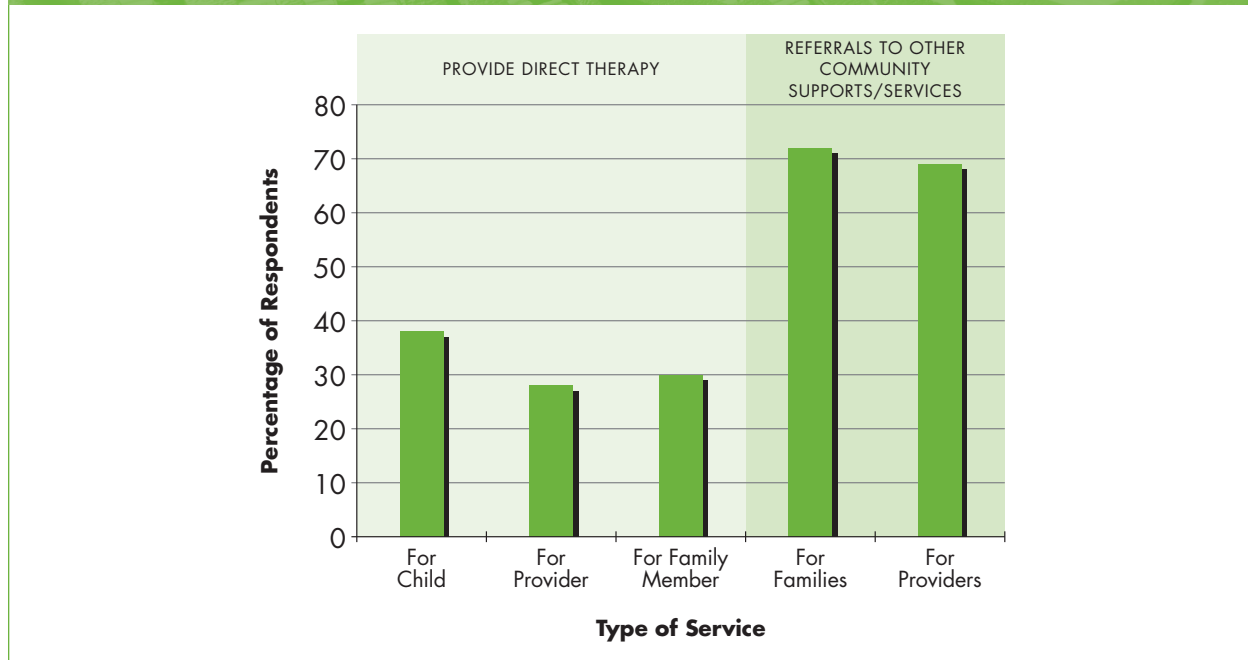
Making referrals and linking providers and families to services beyond mental health consultation is a common occurrence. In fact, the majority of consultants across the six study sites reported that they make referrals to other community supports and services at least monthly for ECE providers (69%) and families (72%). Common referrals include the Early Intervention system (e.g., for occupational therapy, speech and language therapy) and local social services agency (e.g., for food stamps, Medicaid and other family supports). Referrals are typically made in writing and, often, the consultant will assist the ECE provider or family in following through with the referral. For example, after obtaining a release, the consultant might call make the call to a specialist on behalf of the parents or join the family at an Individualized Family Service Plan²⁷ (IFSP) meeting.

For some consultation programs (e.g., Baltimore City, Connecticut, Michigan), a child whose needs require direct therapeutic intervention warrants a referral because they are beyond the scope of services offered. In other programs, direct therapy is within that scope and might be conducted by the consultant who is also providing consultation services (e.g., Central Massachusetts, Boulder) or by another consultant who is part of the same consultation program, but not the same individual providing consultation services to that particular child and family (e.g., San Francisco). In these instances, therapy—either one-on-one or play therapy—is typically provided at the early childhood setting. Clearly, these various scenarios for addressing therapeutic needs have implications for consultant qualifications (i.e., licensed mental health clinician). Across the six study sites, 55% of consultants reported that they never provide child-focused direct therapeutic intervention, while 30% indicated that they provide this service weekly or more, reflecting the variation in program models.

²⁷The Individualized Family Service Plan (IFSP) is required under Part C of the Individuals with Disabilities Education Act (IDEA) to facilitate service planning for young children with disabilities and their families. The IFSP contains information about the services necessary to foster a child’s healthy development and guides the early intervention process.

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

FIGURE 2 CONSULTANTS CONDUCTING REFERRALS OR DIRECT THERAPY AT LEAST MONTHLY (N=82)



Frequency and Duration of Services

Across the six sites there was notable variability with regard to both the frequency (i.e., consultant visits) and duration of services. This diversity seems to be reflective of a recognition of the individualized nature of ECMHC as well as variations in program models. For example, consultants serving rural areas in Michigan made less frequent visits than consultants serving urban/suburban areas, and consultants in Connecticut tended to have shorter service durations than consultants from the other five study sites, indicating fidelity to their consultation model.

Several sites indicated that services tend to last for three to six months, but noted that duration for child-specific services is largely a function of the complexity of the case. This variability reflects program efforts to be flexible in order to meet children's needs effectively. A number of respondents also noted that flexibility in duration is important because it can take time to develop positive relationships with providers and families, and this element is foundational to effective consultation.

Anticipated length of service duration is typically outlined in partnership agreements or contracts between the ECMHC program and ECE programs/providers. These agreements establish what services will be offered and how long the consultation program will work with the early childhood program/provider. For example, in Baltimore City, EIP

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

establishes *Partnership Agreements* of three to six-months' duration with individual programs/providers. San Francisco and Central Massachusetts employ similar agreements that establish renewable year-long working relationships with providers and programs that they serve. Boulder agrees to a two-year long working relationship and a transition plan when leaving a program, reflecting their intent to build provider capacity as well as the time it can take to achieve this goal. However, for those ECE providers that do not want to enter into longer-term relationships, most consultation programs indicated offering a less time-intensive option.

With regard to frequency, most consultants make at least weekly visits. In Colorado, consultants typically make twice-weekly visits. The amount of time consultants spend onsite each week varies based on the setting (i.e., center or family child care home), the size of the early childhood program, the type of service being provided (i.e., child/family-specific, programmatic or both) and the number of child/family-specific cases at each program. Consultants may spend from two hours a week up to 16-20 hours a week onsite.

Consultant caseloads also vary, but half of the sites reported that consultants handled at least eight child-specific cases and up to 12, 15 or 18 at highest volume. In most sites, the balance between child/family-specific and classroom/program-wide cases shifted based upon demand for the former. A few consultants noted that once caseloads exceed 10 child/family-specific cases, it is challenging to do group trainings or other programmatic activities that cannot be infused into their work with providers through child/family-specific consultation services. Of course, in certain programs, like Connecticut's, child/family-specific caseloads are lower because intensive classroom and program-wide services are consistently a significant percentage of the overall caseload.

Caseload parameters by site are listed in the table below. It is important to note that these are guidelines and that all programs make adjustments based on the intensity of needs among those they are serving. At the time of this report, programs indicated that wait lists for services were infrequent and short-term, if necessary at all. In Michigan, if a waitlist is in effect, consultants still tend to make contact with the provider and family requesting services and try to send along resources in the interim (e.g., handouts on biting, if that is the issue at hand).

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

TABLE 7 CROSS-SITE SNAPSHOT ON CASELOAD GUIDELINES

CONSULTATION PROGRAM NAME	CASELOAD GUIDELINES
Child Care Expulsion Prevention (Michigan)	8-15 child-centered cases
Early Childhood Consultation Partnership (Connecticut)	4-5 child-centered cases and 3 program/classroom cases
Early Intervention Program/Instituto Familiar de la Raza (San Francisco, CA)	3 ECE programs per FTE consultant, although the ratio is higher if one or more programs is a family child care home
Early Intervention Project (Baltimore City, MD)	8-18 child-centered cases
Kid Connects (Boulder, CO)	2-3 large centers and one family child care home; 120-180 children total, of which 8-12 are child-centered cases
Together for Kids (Central Massachusetts)	One FTE consultant per 250 children (although 200 is recommended)

Serving Unique Settings and Populations

Collectively, the six study sites served a variety of settings and populations, including family child care, kith and kin care, children in foster care, and children with special needs. Although overall these groups were served less frequently than young children in center-based care without these special living or developmental circumstances, the study sites had a number of lessons learned regarding serving these settings and populations. Below are some tips and challenges generated by providers and recipients of consultation. Given that all the study sites embraced the value of *individualizing services*, the guidance is less focused on model adaptations per se, and more about recommended strategies and thoughts for consideration.

Family Child Care

Lessons Learned:

- Since family child care settings typically serve multiple ages in one classroom, consultants need to adapt their classroom-based strategies accordingly to ensure they are developmentally appropriate and effective.
- Many family child care homes are operated by one provider, thus consultants should arrange their visiting schedule around naptime when they need one-on-one time with the provider.
- Consultation is an important source of support and guidance for family child care providers, many of whom express feeling “alone” without the resources available to center-based providers (e.g., supervisors, onsite peers).

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

Challenges:

- It is harder to conduct outreach to family child care providers as they typically rely on informal supports such as neighbors or faith-based communities for assistance.
- Family child care providers may be apprehensive about consultation, as it involves having a consultant come into their home.

■ CROSS-SITE HIGHLIGHT: SERVING FAMILY CHILD CARE PROVIDERS OF DIVERSE BACKGROUNDS

Instituto Familiar de la Raza (IFR) in San Francisco (the Early Intervention Program's home agency) has a long history of supporting and engaging Latina family child care providers. By attending to the unique culture of family child care as well as the Latino/Chicano culture, IFR has built and maintained strong ties to this community. They have fostered this relationship through genuine collaboration that reinforces mutual expertise and effectively meets the needs of family child care providers in a culturally competent manner. Strategies that have been successful include regular, ongoing consultation that has strengthened relationships over time; a monthly "Charla" or support group; an overnight professional development retreat; regular communication about additional professional development opportunities in the community; assistance, as needed, in identifying ways to cover the expense of local trainings; and providing all services in Spanish by bilingual and bicultural professionals.

Kith and Kin Care (i.e., family, friends and neighbor care)

Only one study site (Michigan) included kith and kin providers as a priority population of focus. The following strategies were found to be successful in outreaching to and engaging these informal providers:

- hosting informal gatherings such as play groups or "coffee clubs;" and
- creating opportunities for kith and kin providers to talk and network, such as meetings at a local public library.

Children in Foster Care

Lessons Learned:

- It is typically not a good idea to initiate services while a child/family is engaged in an open investigation (e.g., of abuse and/or neglect), as this is a time of acute crisis and turmoil.
- At the onset of services, it is critical to establish who has legal guardianship of the child and what stakeholders should be engaged in service planning and implementation (e.g., foster parents, caseworker, biological parents).
- Given that many children in foster care have experienced trauma, consultants should be well-trained on this issue and help to educate providers and foster families on how to identify trauma symptoms and support children affected by trauma.
- Consultants working with children in foster may need to take on a greater case management role, as there are often more services to coordinate and more stakeholders with whom to collaborate (e.g., case workers).

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- Consultants may need to provide significant in-home support to foster parents to help them facilitate the child's adjustment to his/her new placement.
- Consultants may also need to take extra time to help providers understand the child's family system and history, as appropriate per consent of the legal guardian.
- ECMHC programs may need to consider extending service duration and age eligibility criteria to meet the complex needs of children in foster care (e.g., provide services to ages 6 or 7 instead of ending at 5 years of age).

Challenges

- It can be hard to engage foster parents, given the transient nature of foster placements and the fact that foster parents are often inundated with service referrals when a new child enters their care.

■ CROSS-SITE HIGHLIGHTS:

ECMHC AND CHILD WELFARE PARTNERSHIP

In Boulder, CO, Kid Connects collaborates with the child welfare system to serve children in foster care. For example, child welfare workers are aware of the ECE settings receiving Kid Connects services and will sometimes ensure that a child in their care is placed in one of those ECE settings. Further, Kid Connects conducts community trainings specifically for foster care workers.

AN ACTIVITY TO SUPPORT CHILDREN IN FOSTER CARE

One strategy that consultants in San Francisco's Early Intervention Program (EIP) employ is working with providers and foster families to create a scrapbook for the young children in their care that will catalog the child's history and give them something to take with them if/when they move to another placement.

Children with Special Needs

Lessons Learned:

- Consultants should familiarize themselves with community resources for infants and young children with special needs (e.g., early intervention services).
- As children approach kindergarten age, consultants should consider offering workshops on special education services and/or providing families with assistance in pursuing an Individualized Education Plan (IEP)²⁸ for their children with special needs.

■ CROSS-SITE HIGHLIGHT: SERVING YOUNG CHILDREN WITH DISABILITIES

In partnership the State Department of Education (SDE), Connecticut's Early Childhood Consultation Partnership (ECCP) program has a specialized component designed to serve children with disabilities who are receiving special education and related services. This program subcomponent, titled Early Childhood Behavioral Consultation (ECBC), offers intensive onsite consultation, training and technical assistance to six urban child care centers a year that serve children ages three and four.

²⁸Under the Individuals with Disabilities Act (IDEA), public schools are required to develop an Individualized Education Plan (IEP) for every student who is found to meet the federal and state requirements for special education. The IEP outlines goals set for a child during the school year, as well as any special support needed to help them achieve them.

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

Recommendations for High-Quality Service Delivery

Across the six study sites, respondents offered a number of recommendations and lessons learned regarding provision of high-quality services and a strong service delivery process. These recommended principles and practices are described below.

- **Strong service initiation process.** Respondents noted several practices that helped get consultation services off to a good start. First, is setting the right tone and approaching consultees in a way that will foster healthy relationships. Another important component is clear communication between all involved parties about what the consultation program provides, individual roles and responsibilities, and what will happen as part of the consultation process. An initial communication strategy often used is disseminating informational materials to all providers and parents/caregivers in the settings where the consultant will be offering services. In Boulder, consultants post a picture and personal introduction of themselves in a prominent location in the center or family child care home, in addition to sending an introductory letter home with parents and personal introductions with the ECE program director and staff.

CROSS-SITE HIGHLIGHT: TIPS FOR SETTING THE RIGHT TONE AT THE ONSET OF SERVICES

Study respondents shared the following guidance regarding service initiation:

- Be respectful and recognize that you are “entering their space.”
- Convey an attitude of “I’m here to help.”
- Avoid an “expert stance”—value everyone’s opinions equally.
- Listen to their needs and respond accordingly.
- Establish that you are working towards the same goal (e.g., helping a child).
- Demonstrate commitment to collaboration.

- **Collaboration.** Collaboration among consultants and recipients of consultation services (e.g., families and/or ECE providers) is a foundational component of high-quality services and is particularly critical to service plan development, implementation and modification over time. Through collaboration and open channels of communication, consultants gain a better understanding of which strategies to recommend and what the child, family, ECE provider and program needs are over time.
- **Family involvement.** Engaging families is essential if consultation—particularly child/family-centered consultation—is to be effective. At the most fundamental level, consultants must obtain parent/guardian consent before initiating any child-focused services. More importantly, parents know their children best and can provide valuable insight into a child’s behavior as well as the situations or circumstances that might be affecting that behavior. Furthermore, without family involvement to guide service planning and support implementation of strategies at home, the impact of consultation

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

will likely fall short of desired outcomes. To facilitate family involvement in Michigan’s ECMHC program, consultants distribute two helpful resources to ECE providers at the onset of consultation services: 1) *Introducing CCEP Services to All Families with Children in Your Care*, and 2) *Encouraging Parents to Accept a CCEP Referral: Tips for Child Care Providers*. These resources provide sample text to

include in a letter to parents/caregivers as well as guidance on language to use when verbally communicating with families about consultation services.

“...It’s not rocket science. We would see these situations developing over time. We would see these systems that didn’t tend to appreciate the importance of engaging families, and the earlier you do that, the better.”—PROGRAM PARTNER

- **Cultural and linguistic competence.** Respondents indicated the interconnectedness of relationships, high quality services, and cultural and linguistic competence. In order to establish a relationship and deliver effective services, consultants must first explore the consultee’s culture and gain a firm understanding of his/her reality. Further, given the collaborative nature of consultation, consultants should reflect on the collective cultures of those who will be involved in the intervention. Respondents noted a broad array of cultural variations to be considered including ethnic, racial, socioeconomic, educational and religious diversity.

■ CROSS-SITE HIGHLIGHT: CULTURAL SELF-REFLECTION

San Francisco’s Early Intervention Program (EIP)—and all of the programs within its home agency, Instituto Familiar de la Raza—strive to provide services in a manner that reflects and is respectful of the collective culture being served. Through their work, EIP staff seek to help others apply this same approach to service delivery. Often, the first step is cultural self-reflection and consideration of how culture affects one’s worldview. This introspection, coupled with a heightened awareness and understanding of the cultures of the community being served, helps lead to more appropriate and effective services. Given that most of EIP’s service population is Latino/Chicano, most staff are both bilingual and bicultural, with a firm grasp of the cultural norms and traditions within this community.

- **Individualize services/strategies.** Respondents agreed that a “cookie cutter” approach does not work. Services and strategies must evolve from and reflect an understanding of the unique needs, strengths and values of the provider, child and family. One family member lauded the individualized approach her consultant would take: “This is the way the book says to do this strategy—now, how can we make this work for you?” Another parent described how the consultant integrated her child’s interest in cooking into the strategies that were recommended. Individualizing service referrals is also important. Several factors consultants consider when making referrals are how the provider/family will react to a particular referral (e.g., adult therapy), the number of recommended referrals (i.e., will it be overwhelming?), and the affordability of services to which the provider/family is being referred.

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- **Consistency across home and classroom settings.** To maximize the impact, service plans should support families and ECE providers in implementing the same or similar strategies and addressing issues consistently across settings. This underscores the need for collaboration on and individualization of service plans to ensure both parties are willing and able to follow through with the chosen strategies.

“We’ve got to bring the home, the school, the parent and teacher together with the consultant.”—PROGRAM PARTNER

- **Utilization of hands-on, practical materials.** Respondents, particularly ECE providers and family members, mentioned the value in consultants providing materials that were ready-to-use and easy to incorporate into daily routines (e.g., visual charts and cue cards, scripted social stories, “stomping pads” to help children appropriately vent their frustrations).
- **Consistency in consultants.** According to respondents, a major factor of consultation success is consistency with a consultant. Consistency includes minimal consultant turnover and regular, timely consultation visits. With respect to the “timeliness” of visits, respondents indicated that visits should occur with sufficient frequency to maintain strong relationships and provide the consultant opportunity to observe changes over time and make modifications to strategies in a responsive manner. In some cases, respondents felt this required weekly visits, but others seemed content with less frequency, particularly after the action plan is in maintenance mode.

■ CROSS-SITE HIGHLIGHT: A WORD ABOUT TURNOVER

Clearly, some degree of consultant turnover is unavoidable, whether due to resignation, temporary absence or a need to reassign consultants. To ease this transition, programs mentioned strategies to help “transfer the relationship” such as having the new consultant shadow or be introduced by the former consultant or another consultation program staff member with whom the consultee has a relationship.

- **Availability of consultants.** One of the most frequently cited attributes of an effective consultant was availability. Providers and parents/caregivers alike underscored the importance of having a consultant that is willing to be flexible in scheduling (e.g., during naptime, pick-up/drop-off times) and available by phone or email when coming onsite is not feasible. This is particularly important because of the need for assistance in handling crisis situations. Across the six sites, 53% of consultants said that at least once a month they are engaged to help providers manage classroom crises.

CORE PROGRAM COMPONENT 3: HIGH-QUALITY SERVICES

- **Integration of the consultant into program routines and operations.** A number of strategies are employed to help integrate the consultant into the early childhood program and promote positive relationships with providers, parents and children. These include attending program staff meetings, participating in open houses and other program activities (e.g., recreational activities, plays), and actively engaging in classroom activities, such as circle time and playground time. Across the six sites, 80% of consultants reported that they attend program staff meetings with some frequency.
- **Facilitation of ECE program requirements and goals.** Consultants find a variety of ways to help provide consultation while meeting early childhood program requirements and provider professional development goals. For example, consultants offer trainings and activities (e.g., screenings/assessments) that align with requirements set forth by Head Start, state-funded programs (e.g., School Readiness in Connecticut), and accrediting or credentialing entities (e.g., National Association for the Education of Young Children). These activities not only alleviate burdens for programs and providers, but can lead to added benefits such as accumulation of Continuing Education Units (CEUs), assistance in meeting Child Development Associate (CDA) requirements, or, in Connecticut, movement along a state early childhood career ladder. Further, in Michigan, registered day care aides and relative providers who attend the standardized social-emotional trainings provided by CCEP consultants can use the hours towards eligibility for a monetary provider incentive from the Department of Human Services.

The three core program components discussed above (i.e., solid program infrastructure, highly-qualified consultants, and high quality services) are cornerstones of effective consultation programs. Yet, without the added ingredients of positive relationships and readiness for consultation, ECMHC programs will almost certainly fall short of achieving the positive outcomes they desire. These ingredients, which this report describes as “catalysts for success,” interact with the three core program components and dynamically affect the trajectory for achieving positive outcomes.

CATALYST FOR SUCCESS 1: Positive Relationships

Overwhelmingly, respondents indicated that positive relationships between the consultant and consultees are central to successful consultation efforts. It is essential that consultants establish trust and are able to “make a connection” with providers, family members and children. Respondents discussed many factors that influence a consultant’s ability to develop strong, positive relationships. A number of these have to do with the consultant’s personality, demeanor, and professional knowledge, which were discussed earlier in this report.

■ CROSS-SITE HIGHLIGHT: TIPS ON BUILDING POSITIVE RELATIONSHIPS

Specific recommendations made by ECMHC program directors, consultants, ECE providers and family members across the six study sites regarding how to build relationships are presented below.

- Accept people for who they are and where they are at.
- Do not project a “better than” attitude or come across as “the authority.”
- Share some personal experiences.
- Find “common ground” (e.g., we all want what is best for the child).
- Do not make people feel like just another number—show genuine interest and caring.
- Be visible—spend face time at early childhood programs so that providers, children and parents/caregivers get to know you.
- Foster trust and confidence in your abilities by responding to needs promptly and effectively.

In addition to consultant characteristics, another factor that impacts one’s ability to form positive relationships is time. Building relationships does not occur on a set schedule and consultants need flexibility to extend service duration as needed to accommodate each situation. In several sites, the consultation programs enter into long-term relationships with an ECE provider or program via annually renewable partnership agreements. As a result, some consultants have worked consistently with the same ECE programs/providers for years, responding to new programmatic and child/family-centered needs as they arise. In Colorado, although the partnership agreements are not renewable, they span a two-year timeframe, affording similar opportunity for relationships to develop over the long term.

■ CROSS-SITE HIGHLIGHT: RELATIONSHIPS AND CULTURAL AND LINGUISTIC COMPETENCY

Building a relationship with individuals of any culture begins with respect. Establishing respect includes demonstrating understanding of and sensitivity to where someone is coming from, which is clearly shaped by various cultural influences. Some recommendations for building relationships and high quality services in the context of culture that were highlighted by study respondents are listed below.

- Learn about the degree of importance different constructs have in certain cultures (i.e., obedience or discipline).
- Understand how mental health is perceived in different cultures (i.e., how comfortable is a parent engaging someone outside of the family to address mental health issues).
- Learn about different cultural timetables for developmental practices such as toileting or feeding.
- When home visiting, be attentive to customs and cultural expectations (i.e., taking shoes off upon entry, accepting refreshments that are offered).
- Acknowledge that the consultant’s culture plays a role in shaping perceptions and reflect on how to ensure that these perceptions do not negatively impact service quality.

CATALYST FOR SUCCESS 2:

Readiness for Early Childhood Mental Health Consultation

Clearly, consultation is a very dynamic process and requires active participation from all parties involved for maximum impact. Consequently, the “readiness” of an ECE program, provider or parent/caregiver to enter into a consultative partnership is a major determinant of the consultation’s efficacy. Although stakeholders may be at various stages of readiness when consultation services begin, it is important for a consultant to understand a consultee’s readiness so he/she can work towards helping that individual reach a state of readiness where consultation can be most effective. Respondents discussed a number of indicators that suggest readiness, which are described below.

- Indicators of ECE program readiness:
 - Presence of a supportive early childhood program administrator/director
 - Flexibility to incorporate consultation into the ECE program
 - Embraces a “mental health perspective” (i.e., a recognition that infant and young children’s behavior must be understood within the context of development, relationships and how environment impacts relationships; Cohen & Kaufmann, 2000).

CROSS-SITE HIGHLIGHT: EARLY CARE SITE READINESS ASSESSMENT TOOL

Kid Connects in Boulder, CO completes a “readiness” assessment for centers who are interested in mental health consultation. The *Kid Connects Early Care Site Readiness Assessment* tool (Ash, 2009) helps to evaluate areas of readiness and areas that may need to be addressed in preparing an ECE program to benefit from consultation. A program’s level of readiness is assessed through an interview process and rating by an interviewer affiliated with Kid Connects. Assessment areas include demonstration of need, interactions, environment, parent/home connections, expulsion and at-risk protocols, interest in/expectations of mental health consultation services, and readiness to partner.

Although each of the readiness indicators above is important, having an early childhood program administrator/director that is supportive of consultation and his/her staff is particularly significant. Supportive administrators bolster consultation efforts in a number of ways, including providing time for staff to engage in consultation activities (e.g., by arranging for a floater to cover the classroom), ensuring that consultant involvement is not perceived as punitive to staff, and positively presenting/marketing consultation services to staff and families.

- Indicators of ECE provider readiness:
 - Openness to gaining more knowledge
 - Willingness/desire to try something new
 - Willingness to collaborate
 - Not threatened by consultant’s involvement

- Indicators of parent/caregiver readiness:
 - Acceptance that there are issues that are having a negative impact on the child that need to be addressed
 - Willingness/desire to try something new
 - Willingness to collaborate (beyond signing the consent form)
 - Resolution of stigma concerns associated with consultation

■ CROSS-SITE HIGHLIGHT: A WORD ABOUT STIGMA

Stigma can be a barrier to effective consultation in a number of ways and should be assessed and factored into decisions regarding how a consultation program is structured and implemented. For example, some respondents voiced resistance to accessing consultation services because the program was associated with a mental health agency. On the contrary, others felt that because consultation services were provided onsite at an early childhood setting, it diffused stigma concerns.

Consultation program terminology can also trigger stigma issues. For example, all study sites noted that they purposely avoided using “mental health consultant” language and instead developed more family-friendly staff titles that omitted the words mental health (e.g., *Early Interventionists*, *Child Development Associates*).

Finally, respondents indicated that the way in which consultation services are presented also has implications for stigma-related barriers. A couple of approaches mentioned were normalizing challenging behaviors and reframing consultation as help or support as opposed to mental health intervention.

Outcomes/Evaluation

Putting the three core program components in place (solid program infrastructure, highly-qualified consultants, high-quality services), along with building strong relationships and enhancing consultees’ readiness for consultation is an ongoing process. Evaluation is a critical tool in this process, helping ECMHC programs assess whether the current consultation model is working or not and how it can be improved to heighten the program’s positive impact.

As mentioned earlier in this report, setting the stage for an ongoing evaluation process is part of a solid program infrastructure (e.g., incorporating data collection into the program model, establishing an information system). This section provides greater detail about how to structure evaluations of consultation programs, including what to measure and how to

measure it, as well as important issues to consider when conducting these evaluations. Recommendations are derived from interviews with ECMHC staff, ECE providers, families and experienced evaluators, including members of this study’s expert panel.

“At the end of the day, it’s all about the data.”—ECMHC PROGRAM DIRECTOR

Key Indicators and Constructs to Measure

In selecting outcomes to measure, it is important to engage key stakeholders in the decision-making process to make sure that data can demonstrate impact in areas that are meaningful to various audiences (e.g., families, ECE program administrators/providers, funders, policymakers and system partners). For example, if there is a lot of concern regarding preschool expulsion rates, it would be a good strategic decision to assess the program's impact in this area.

Child Outcomes

- Decreased expulsion rates
- Increased numbers of children in placements that meet their needs (i.e., if a child needs a more developmentally appropriate placement, that change is made voluntarily)
- Decreased problematic behavior (externalizing and internalizing)
- Increased pro-social behavior
- Improved school readiness

Family and ECE Provider Outcomes

(Note: most of the outcomes listed below apply to both family members and providers)

- Implementation of techniques and strategies recommended by the consultant
- Enhanced sense of self-efficacy
- Increased knowledge (e.g., greater understanding of the underlying reasons for certain behaviors)
- Reduced stress
- Improved interaction with child
- Strong provider, parent/caregiver and consultant collaboration
- Satisfaction with services

Family

- More positive attitude toward mental health services (i.e., less stigma association)
- Follow-through with referrals

ECE Provider

- Application of learned strategies to other children (e.g., children in future classes)
- Improved communication with parents/caregivers
- Increased ability to identify and address social and emotional concerns early

ECE Program Outcomes

- Increased quality of early childhood settings
- Decreased job turnover
- Improved linkages with community resources

Other evaluation areas for consideration, which will help guide programmatic enhancements and provide valuable contributions to the field, are 1) the cost efficiency of the program, 2) fidelity to the model, 3) the “dosage” of services needed to produce positive outcomes, 4) the longitudinal impact of consultation services (e.g., into kindergarten) and 5) the capacity of the system to meet infant and young children’s social and emotional needs.

CROSS-SITE HIGHLIGHT: LONGITUDINAL AND COST-BENEFIT STUDIES

Since the inception of Together for Kids (TFK) in Central Massachusetts, evaluation has been a core component of the program. Some notable evaluation efforts include:

- The TFK Kindergarten Follow-Up Study, which was initiated to determine if the improved outcomes demonstrated for children during the preschool years had lasting effects. The follow-up study was designed to follow a small cohort of children (n=15) served by TFK during the 2005-2006 school year into their kindergarten years to determine if the children maintained gains in behavior and development achieved in preschool with TFK services, how many of the children received special services or Individual Education Plans (IEPs), if there was evidence that the provision of TFK services in preschool reduced the special education services in kindergarten, and that parents continued to see improvements in behavior at home (Upshur, Davis & Friderici, 2007).
- Economic Evaluation of the Together for Kids Project: Using the findings from the TFK program evaluation in combination with data from related research and demonstration studies, evaluators estimated the costs and benefits of a statewide implementation of the TFK model in state subsidized licensed preschool centers (Warfield, 2006).

For more information on findings from these studies, see page 191.

Outcome Measurement Tools

The following table presents a compilation of standardized measurement tools used by the six study sites as part of their service planning and/or evaluation efforts, which examine many of the constructs listed above. One important consideration in selecting tools is who will complete the measure. If a parent or teacher will self-administer the tool, one should be attentive to length, intended administrator (i.e., clinician or non-clinician), and language/literacy issues.

TABLE 8 OUTCOME MEASURES USED BY STUDY SITES

MAIN ECMHC OUTCOMES	MEASURES	AUTHOR(S) & DATE	USED BY
<i>Changes In...</i>			
...Teacher Behaviors	Arnett Caregiver Interaction Scale (CIS)	Arnett, 1989	Baltimore City** Connecticut* San Francisco*
	Pre-K Survey of Beliefs and Practices (BP)	Marcon, 1999	Connecticut*
	Student Teacher Relationship Scale (STRS)	Pianta, 2001	San Francisco*
...Teacher Attitudes	Goal Achievement Scale (GAS)	Alkon, Ramler, & MacLennan, 2003	Michigan**
	Parental Modernity Scale of Child-Rearing and Education Beliefs (PMS)	Schaefer & Edgerton, 1985	Connecticut*
	Teacher Opinion Survey (TOS)–Revised	Geller & Lynch, 2000	San Francisco* Michigan** Boulder**
...Job Stress	Child Care Worker Job Stress Inventory (JSI)	Curbow, Spratt, Ungaretti, McDonnell, & Breckler, 2000	Connecticut*
	Maslach Burnout Inventory	Maslach, Jackson, & Leiter, 1996	Central Massachusetts*
...Parenting Behavior	Parenting Scale	Arnold, O’Leary, Wolff, & Ackler, 1993	Central Massachusetts*
	Parenting Stress Index–Short Form (PSI)	Abidin, 1995	Michigan** Connecticut** Boulder** Central Massachusetts*
...Depression	Center for Epidemiological Studies Depression Scale (CES-D)	Radloff, 1977	Connecticut*
...Home Environment	Family Resource Scale	Dunst & Leet, 1985	Central Massachusetts*
	Home Observation for Measurement of the Environment (HOME-EC or HOME-IT)	Caldwell & Bradley, 1984	Connecticut** Central Massachusetts*

*Used in completed/published evaluations

**Used in current service planning/evaluation efforts

***Used in both past and present efforts

TABLE 8 OUTCOME MEASURES USED BY STUDY SITES

MAIN ECMHC OUTCOMES	MEASURES	AUTHOR(S) & DATE	USED BY
<i>Changes In...</i>			
...Classroom Environment	Classroom Assessment Scoring System (CLASS)	Pianta, La Paro, & Hamre, 2008	Connecticut**
	Early Childhood Environmental Rating Scale (ECERS)—Revised	Harms, Clifford & Cryer, 1998	San Francisco* Connecticut***
	Infant-Toddler Environmental Rating Scale (ITERS) - Revised	Harms, Clifford, & Cryer, 2006	Connecticut**
	National Association for the Education of Young Children (NAEYC) Family Questionnaire	NAEYC, n.d.	Central Massachusetts**
	Preschool Mental Health Climate Scale (PMHCS)	Gilliam, 2008	Connecticut**
	Teaching Pyramid Observation Tool (TPOT)	Hemmeter & Fox, 2006	Baltimore City**
...Children’s Social Skills	Ages and Stages Questionnaires: Social Emotional (ASQ:SE)	Squires, Bricker, & Twombly, 2002	Baltimore City** Connecticut**
	Devereux Early Childhood Assessment (DECA)	LeBuffe & Naglieri, 1999	Baltimore City** Michigan**
	Devereux Early Childhood Assessment—Clinical (DECA-C)	LeBuffe & Naglieri, 1999	San Francisco** Boulder***
	Devereux Early Childhood Assessment—Infant/Toddler (DECA-IT)	Mackrain, LeBuffe, & Powell, 2007	Michigan**
	Preschool and Kindergarten Behavior Scales (PKBS)	Merrell, 2002	Baltimore City* San Francisco*
	Social Skills Rating System (SSRS)	Gresham & Elliott, 1990	Connecticut*
	Vineland Adaptive Behavior Scales	Sparrow, Balla, & Cicchetti, 1995	San Francisco*

*Used in completed/published evaluations

**Used in current service planning/evaluation efforts

***Used in both past and present efforts

TABLE 8 OUTCOME MEASURES USED BY STUDY SITES

MAIN ECMHC OUTCOMES	MEASURES	AUTHOR(S) & DATE	USED BY
<i>Changes In...</i>			
...Children's Behavior Problems	Behavioral and Emotional Screening System (BASC)	Reynolds & Kamphaus, 1992	Central Massachusetts**
	Behavioral and Emotional Screening System-2 (BASC-2)	Reynolds & Kamphaus, 2002	Michigan**
	Caregiver-Teacher Report Form (C-TRF)/1 1/2-5	Achenbach & Rescorla, 2000	San Francisco* Connecticut**
	Child Behavior Checklist (CBCL)/1 1/2 to 5 years	Achenbach & Rescorla, 2000	Connecticut**
	Conners' Teacher Rating Scale-Revised (CTRS-R)	Conners, 1997	Connecticut*
	Early Screening Project	Walker, Severson, & Feil, 1995	Central Massachusetts*
	Preschool and Kindergarten Behavior Scales (PKBS)	Merrell, 2002	Baltimore City* San Francisco*
	Sutter-Eyberg Student Behavior Inventory-Revised	Eyberg & Pincus, 1999	Central Massachusetts**
	Treatment Outcome Package (TOP)	Kraus, Seligman, & Jordan, 2005	Central Massachusetts**
...Children's Functioning	Ages and Stages Questionnaires (ASQ)	Bricker & Squires, 1999	Baltimore City** Connecticut**
	Child and Adolescent Needs and Strengths (CANS)	Lyons, 1999	Central Massachusetts**
	Child Services Survey for Families	Bleecker & Sherwood, 2004	San Francisco*
	Developmental Profile II	Alpern, Boll, & Shearer, 2000	Central Massachusetts*
	Sensory Profile (Infant/Toddler and Preschool versions)	Dunn, 1999	Connecticut**

*Used in completed/published evaluations

**Used in current service planning/evaluation efforts

***Used in both past and present efforts

Methodological Considerations

Designing evaluations of ECMHC programs requires much thought and collaboration to ensure meaningful results. Researchers who conducted evaluations of the study sites and/or other consultation programs recommended considering the following questions as this design/development process moves forward.

- What is the appropriate length of time between pre- and post-assessment (i.e., what is the length of time needed to show impact)?
- What outcomes can reasonably be expected from the model (i.e., what is really being expressly targeted)?
- When will the sample be selected? If selection will occur before parent/guardian consent for consultation services is obtained, one needs to factor that in to the sample size as some parents may decline individualized services.
- What is a reasonable amount of tools/data collection to include in the evaluation that will not overburden participants? One site mentioned that they reduced the number of tools because some families cancelled meetings with consultants as they felt overwhelmed by the evaluation component.
- How will comparison groups be designated? Will those children/providers/families have had any exposure to consultation services or serve as a wait list comparison group?
- Will the data collectors be blind to the intervention and if not, how will potential bias issues be addressed?

Challenges

Despite best efforts, challenges exist. Below are some of the overarching challenges that were mentioned across the six study sites. Where available, guidance is given regarding how these programs addressed some of these issues.

Mental Health and Consultation Related Issues

1. **Stigma.** A pervasive challenge that is difficult to address is misgivings about involvement with any “mental health” program, particularly for parents/caregivers. ECMHC programs try to overcome this barrier in a number of ways, including using non-mental health terminology and explaining that services are designed to help children thrive in early childhood settings and, later, school settings.
2. **Role confusion.** For example, some respondents indicated that initially providers incorrectly thought that the consultation program was tied to child care licensing. For ECMHC programs that do not provide direct therapy, another misconception is that this is part of their service array. Respondents indicated that implementing clear service initiation practices, including written agreements that specify roles and responsibilities, can help avoid these problems.

3. **Behavior change.** Consultants and service recipients alike noted that it is challenging to try something new. Respondents noted that in addition to developing a trusting, respectful relationship, being patient and staying positive can be the best strategy in cases where change is slow to come.
4. **Managing expectations.** Early childhood mental health consultation is a time-intensive approach to service delivery and it can be challenging when expectations do not reflect this. Respondents expressed the need for timeframes and caseload requirements that align with this method of service delivery as opposed to those in place for more traditional mental health services. Again, one of the strategies commonly employed to address this issue is clarifying expectations up front, whether it be with funders or providers who are looking for a “quick fix.”

“It’s really hard to change ways sometimes.”—FAMILY CHILD CARE PROVIDER

Outreach and Engagement Issues

5. **Family engagement.** Engaging parents/caregivers can be difficult because they believe the services are unwarranted, unfamiliar or stigmatizing, or because various factors impede their involvement beyond signing consent forms for their children (e.g., transportation). Certainly, stigma and fear of their child being labeled plays a role in some cases, but it can also be challenging for a parent/caregiver to come to terms with a child’s behavioral issues for the first time. Time constraints can be another impediment to active involvement. Consultants employ a number of different strategies to boost family engagement, most of which revolve around building relationships. Raising awareness that intervening early optimizes child outcomes and increases chances for school and life success has been another compelling approach.

■ CROSS-SITE HIGHLIGHT: BEHAVIORAL PEDIATRICIAN ON STAFF

For some parents/caregivers, it can be very difficult to accept that their infant or young child has social/emotional challenges and/or a mental health diagnosis. Yet, it is clearly an important first step in addressing those issues through consultation or any other intervention method. While the behavioral pediatrician that is part of Baltimore City’s Early Intervention Project (EIP) staff complements the consultation team in a number of ways, one of the areas of greatest impact is around family engagement. For some parents/caregivers, the message regarding the need for intervention has more credibility when delivered by a doctor, leading to greater acceptance and willingness to collaborate on a plan of action.

6. **Provider engagement.** Consultants often meet with some level of resistance when meeting and working with a program or provider for the first time. Providers may have concerns that they are being judged or have reservations about whether a consultant can really help. In some instances, provider resistance is a function of how consultation services were initiated (e.g., did the center director mandate that the teacher participate or give the impression that engaging a consultant was a reflection on the teacher’s performance?). Thus, respondents frequently mentioned the

importance of clarifying any provider misconceptions up front and establishing that the consultant is there as a “helper.”

Evaluation Issues

7. **Data collection concerns.** Evaluators indicated a number of concerns expressed by consultants and/or providers when asked to participate in data collection activities. First is the concern that administering an evaluation tool may compromise relationships between the administrator and respondent. Burden is another frequent complaint, as data collection is often perceived—at least initially—as “one more thing to do.” Carefully and sparingly selecting measures along with communicating regularly about findings helped evaluators ease some of these concerns.
8. **Limited selection of tools.** Another challenge that evaluators face is finding quality measures that are appropriate for assessing consultation services. For example, there are a limited number of measures that are suited for infants and toddlers. Further, it is hard to measure the quality of relationships and other relationship-based elements that are central to consultation.
9. **Obtaining follow-up data.** Despite best efforts, it can be challenging to obtain “post” data after a child or family completes consultation services. Unfortunately, these data are a critical piece of assessing the impact of the intervention. Often these data are missing because a child moves or leaves his/her ECE placement quickly.

Systems Issues

10. **Funding.** A common challenge cited by respondents was funding, including funding for program operations and evaluations, particularly rigorous (i.e., randomized control) evaluations. Financial issues manifested in a number of other challenges, including modest consultant salaries, too few consultants to meet the demand and, consequently, limitations on the number of providers, families and children served. One site mentioned that they temper outreach efforts so as not to generate greater demand than their program can handle.
11. **Consultant workforce.** As mentioned above, the salaries offered for mental health consultants are typically less competitive than for other mental health related positions. Thus, it can be challenging to recruit and retain high quality staff. Many who engage in this work express a clear passion for it, which helps to overcome the financial limitations to some extent. Still, burnout is common and respondents underscored the need for manageable caseload sizes as well as ongoing support and supervision.

12. **Early childhood staff turnover.** It is well known that turnover is common in early childhood settings. It is particularly challenging when a teacher or director leaves during or after consultation services, as the consultant often has to start the process all over again with staff who have never benefited from consultation.
13. **Gaps in referral sources.** Respondents noted several gaps in services that undermined their ability to meet the needs of children, families and providers. For example, several respondents noted an absence of mental health clinicians trained to work with infants and young children. Other gaps in community-based resources included Spanish-speaking services and parenting programs.

National Scan

4 SECTION

National Scan Findings

As previously mentioned, in addition to assessing the core components of effective consultation, this study endeavored to provide a national snapshot of the status of ECMHC. Toward this end, GUCCHD collected data through an online scan to states and territories (for complete methodology, see page 21). This scan provided an update to Georgetown’s 2002-2003 scan of State Children’s Mental Health Directors, which investigated state initiatives in early childhood mental health. Twenty-one (21) states responded to the earlier scan and revealed diverse efforts to address the social and emotional health of children ages birth to eight. Early childhood mental health consultation (ECMHC) ranked third as both a primary focus (6 states) and identified strategy (11 states) of the initiatives described by those states that responded.

Thirty-five (35) states and territories responded to the current scan:

Alaska**	Indiana*	Michigan**	New Mexico**	Puerto Rico
Alabama	Kentucky**	Mississippi*	New York*	South Carolina
Arkansas**	Louisiana**	Montana*	Ohio**	Texas*
Colorado**	Massachusetts**	North	Oklahoma**	Utah*
Connecticut**	Maryland**	Carolina**	Oregon*	Vermont**
Delaware	Maine**	Nebraska**	Pennsylvania**	Wyoming**

Of these 35 states and territories, 29 (83%) confirmed that ECMHC services are available in their state and 6 (17%) indicated that ECMHC services were not currently available, although several provided descriptions of how their state/territory was moving in that direction. For those without ECMHC services, the most common reasons were 1) lack of funding, 2) lack of providers, and/or 3) lack of expertise. For those with ECMHC services, the following factors supported implementation: 1) funding, 2) research/data, 3) leadership, 4) state/community concerns, and 5) early childhood initiatives. Key findings across the 29 states currently offering mental health consultation are provided below.

*States and territories confirming that ECMHC services are currently available

**States and territories with statewide ECMHC efforts

Consultation Models

- Of those 29 respondents indicating the presence of ECMHC services in their state, 21 (72%) reported offering consultation statewide.
- Of those 21 who reported statewide efforts:
 - Eight (38%) indicated that there is **ONE service delivery model** in multiple sites across the state.
 - Eleven (52%) indicated that there are **MULTIPLE service delivery models** in multiple sites across the state.

Partners

- Most states identified the **lead or coordinating agency/agencies** for the ECMHC programs as Mental Health (72%) and/or Early Care and Education (59%).
- Most states indicated having **state level partners** in one or more of the following systems: Early Intervention (86%), Early/Head Start (79%), Education (76%), Child Welfare (72%) and Special Education (69%). These partners helped as referral sources and collaborated on service delivery.

Funding

- Looking **across** federal, state, and local sources of funding, respondents most frequently identified sources of funding for ECMHC services as State General Funds (41%), Child Care Development Funds (34%), Mental Health (32%), and Private Funds (28%).

Populations Eligible/Served

- The majority of respondents indicated that infants, toddlers and preschool aged children are **eligible to receive** ECMHC services, while fewer respondents (45%) indicated that school-age children were eligible for ECMHC services. Correspondingly, the majority of respondents indicated **delivering services** to infants, toddlers, and preschool age children. Fewer respondents indicated serving school-age children.

Settings

- The majority of respondents (66%) identified providing ECMHC services in licensed non-profit and licensed private child care settings. The least frequently identified setting was unlicensed informal child care (including kith and kin)—at 10% of respondents.

Consultation Qualifications/Competencies and Support

- Nine or 31% of respondents indicated that their state **does have** state-level required qualifications and/or competencies for early childhood mental health consultants. Eighteen or 62% of respondents indicated that their state **did not have** state-level requirements.
- Of those nine respondents with state-level requirements, the three most frequently mentioned qualifications and/or competencies were Knowledge of Early Childhood Mental Health (41%), Knowledge of Child Development (including social/emotional) (35%), Advanced Degree (Master's or Doctorate) (35%), and Bachelor's Degree (28%). Twenty-one percent (21%) of these states require licensure for mental health consultants.
- Only one-quarter (25%) of respondents indicated that their state **does have state-level support** mechanisms for early childhood mental health consultants. Of those respondents, the most frequently identified support mechanism was In-service Training (69%). The least frequently identified support mechanism was Pre-service Training (38%).

Evaluation

- Most respondents (61%) indicated that there is a **coordinated evaluation** of ECMHC in their state, although methodologies varied. Of those that indicated there was no coordinated evaluation effort, 17% indicated that none of the programs are evaluating their own services.

Challenges

Respondents described major challenges around ECMHC in their states and territories by themes that broadly included: infrastructure, workforce, funding, awareness, outreach, parent/caregiver/provider involvement, and collaboration. The top four challenges were:

1. Infrastructure to support ECMHC services including program scope/design, program implementation and fidelity, program evaluation, program expansion/"going to scale", and program sustainability.
2. Workforce and professional development challenges related to the lack of qualified consultants, the need to identify core competencies, and the need to focus on cultural responsiveness.
3. Overall lack of funding, limited funding for promotion and prevention activities, diverse funding streams, and challenges in trying to capture Medicaid dollars to support ECMHC.
4. Raising awareness of early childhood mental health and the value of incorporating mental health when building early childhood systems and supports.

Lessons Learned

Respondents described major lessons learned around ECMHC in their states and territories by themes that broadly included: evaluation, collaboration, effective approaches, workforce, infrastructure, early care and education providers, family involvement, and funding. The top five lessons learned were:

1. Evaluation of ECMHC services begins with a clear program plan, benchmarks for program implementation, and measurement of outcomes to ensure fidelity to the model. Data collection, using standardized, norm referenced tools and measures, is essential to project operations and documentation of program effectiveness.
2. Collaboration and cross state-agency cooperation is critical and can bring other state-level stakeholders on board, influence local level stakeholders, and support a comprehensive approach to ECMHC services.
3. An effective approach to ECMHC services includes the public health model (promotion, prevention, intervention), recognizes that consultation is different than direct therapeutic services, incorporates relationship-based practices, and utilizes evidence-based interventions.
4. Infrastructure to support program development should include identifying a lead agency, leader or champion; using community assets mapping or systems change assessment tools to guide systems building activities; and fitting consultation into an identified continuum of support for young children and families.
5. A highly trained workforce, with specialized training and skills, is critical to ECMHC services and their effectiveness. Consultants need reflective supervision, regular technical assistance, and administrators who support the ECMHC program.

Conclusions and Recommendations

5 SECTION

Conclusions

As previously described, the primary goals of this study are to examine key knowledge gaps in the field of ECMHC and provide data-driven guidance around consultation program design. The knowledge gaps explored in this study include:

1. What are the essential components of effective mental health consultation programs?
2. What are the skills, competencies, and credentials of effective consultants?
3. What are the training, supervision and support needs of consultants?
4. What level of intervention intensity (i.e., frequency and duration) is needed to produce good outcomes?
5. Which outcomes should be targeted and how should they be measured?

Through in-depth site visits to six consultation programs that demonstrated positive outcomes, this study was able to address many of the above questions and examine challenges and lessons learned in moving consultation programs from conceptualization to implementation. A summary of findings in each of these areas is provided below.

What are the essential components of effective mental health consultation programs?

Through cross-site analysis of the six study programs, a framework for effective consultation emerged. This framework, which is illustrated in the diagram on page 45, suggests that three core program components must be in place: 1) solid program infrastructure, 2) highly-qualified mental health consultants, and 3) high-quality services. In addition to these program components, two other essential factors or “catalysts for success” are needed to achieve positive outcomes. These catalysts are: 1) the quality of the **relationships** between and among consultants and consultees and 2) the **readiness** of families and ECE providers/programs for ECMHC. They interact with the three core program components and dynamically affect the trajectory for achieving positive outcomes.

What are the skills, competencies, and credentials of effective consultants?

Those providing and receiving consultation services were interviewed to gather their feedback on a number of issues, including the necessary skill set of an effective consultant. This stakeholder feedback, coupled with analysis of the six study sites' requirements around consultant qualifications, led to the following key findings on this topic (for a more detailed description of recommended qualifications, see page 64):

- **Education:** master's degree in a mental health field (e.g., social work, psychology, marriage and family therapy).
- **Core Knowledge:** child development, infant and early childhood mental health, early childhood settings, best/evidence-based practices related to infant and early childhood mental health, child/family/early childhood service systems, and community resources.
- **Key Skills:** relationship-building, communication, able to work with infants/young children in group settings, and able to motivate parents/providers to try new strategies.
- **Key Attributes/Characteristics:** respectful, trustworthy, open-minded/non-judgmental, reflective, approachable, good listener, compassionate, team player, flexible, and patient.

What are the training, supervision and support needs of consultants?

In their interviews, ECMHC program administrators and consultants reiterated the importance of adequate training, supervision and support for consultants to ensure delivery of high-quality services and help consultants manage the demands of the job, which is often stressful and isolating. Cross-site analysis of these interviews, as well as programs' training curricula and supervision/support mechanisms, yielded the following guidance:

- **Training Topics:** detailed overview of consultation program model (e.g., philosophy and processes), early childhood mental health topics (see Core Knowledge above, for examples), and consultation topics (e.g., how to approach the work, how consultation differs from direct therapy).
- **Training Methods:** standardized curriculum, pre-service and in-service training, mentoring and/or shadowing opportunities with a senior consultant, and on-going professional development opportunities through internal and/or external trainings and seminars.
- **Supervision:** clinical and administrative supervision, regular and ongoing, and reflective in nature (i.e., provides support and knowledge to guide decision-making and offers empathy to help supervisees explore their reactions to the work and manage stress; Parlakian, 2002).
- **Support:** in addition to reflective supervision, which is inherently supportive, consultants need formal and informal opportunities to network with peers in order to share resources and discuss challenges.

What level of intervention intensity (i.e., frequency and duration) is needed to produce good outcomes?

This question is one that needs further exploration, as this study's primarily qualitative design could not determine the dosage of consultation that leads to positive outcomes. What findings from this study *did* show is that there is great variability across the study sites regarding frequency and duration of services. This diversity is reflective of the variation in program models (i.e., program guidance regarding service duration/intensity), as well as community characteristics (e.g., rural vs. urban areas). In addition, the variation is indicative of programs' recognition of the individualized nature of ECMHC and the need for flexibility to ensure that the needs of children, families and providers/programs are met.

Which outcomes should be targeted and how should they be measured?

As ECMHC is still a relatively new field and many questions remain about how to develop and implement this intervention, research and evaluation was an area of particular interest in this study. Recommendations regarding what to measure and how to measure it were solicited from ECMHC staff, ECE providers and families, as well as experienced evaluators, including members of this study's expert advisory panel. Overall, there is a need to attend to multiple levels of outcomes, including child, family, ECE staff/providers and ECE programs. Specific recommended indicators at each of these levels are detailed on page 89. Further, Table 8 on page 91 lists an array of measurement tools that have been employed by the study sites' evaluators to assess outcomes at each of these levels and across various constructs (e.g., classroom environment, teacher skills, parenting stress, child functioning).

Other Key Findings

In 2000, Cohen and Kaufmann first posited the following definition of early childhood mental health consultation:

“Mental health consultation in early childhood settings is a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more [caregivers, typically an early care and education provider and/or family member]. Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age 6 and their families” (p. 4).

This conceptualization of ECMHC was strongly embraced by the six study sites, as evidenced by stakeholder interviews and analysis of a variety of program materials. In particular, study sites echoed the emphasis on capacity-building, the centrality of relationships, the need for collaboration, the importance of having consultants with early

childhood mental health expertise, and the adoption of a holistic, promotion/prevention/intervention framework that seeks to improve the mental health of all infants and young children in the early childhood settings that the programs are serving.

In addition, the six programs embraced family involvement and individualization of services as core values. All programs sought to engage families in service planning and implementation and consultants worked diligently to build relationships with families and help foster relationships between providers and families. Programs also placed strong emphasis on individualizing services to meet the unique needs of the children, families, providers and programs they served. In individualizing services, consultants explored specific mental health needs, cultural values and beliefs, and language and literacy needs as well as other areas of strengths and needs.

Other notable findings that emerged centered on how the six study sites developed and operationalized their ECMHC programs. First, half of the study sites augment consultation services with direct therapy, particularly for children. These sites include direct therapy in their programs' service array, as opposed to solely referring consultees to other community resources for these services. Second, although all study sites offered both child/family-centered and programmatic consultation, the lines between these two types of consultation frequently (and purposely) blurred. For example, in responding to the needs of an individual child (child-centered consultation), a consultant would often recommend a number of strategies that not only addressed that child's specific needs, but also helped to improve the overall classroom environment (programmatic consultation).

Moving the Field Forward

In seeking answers to the research questions above and contemplating the implications of those findings, this study identified remaining areas for growth and exploration in the field of early childhood mental health consultation. Mostly broadly, the following needs were recognized:

- **Build consensus** around the core values, principles, and components of early childhood mental health consultation; the competencies and qualifications for mental health consultants; and the important outcomes for children, families, and ECE providers/programs.
- **Engage families and cross-system partners** as stakeholders in the effort to promote early childhood mental health consultation as a strategy to support healthy social and emotional development for infants and young children and their families.
- **Identify key research questions and support efforts to address those questions** to help build the evidence base for effective early childhood mental health consultation.

The key research questions that stakeholders in this study felt would move the field forward include:

- What is the “dosage” of consultation needed for efficacy?
- What is the cost-benefit of ECMHC?
- What are the longitudinal impacts of ECMHC?
- What is the impact of each model component on outcomes (e.g., consultant skills, service array)?
- Which consultation models are most effective for which children, families and/or settings?
- What is the impact of ECMHC on family child care versus center-based care?
- What are the best measurement tools for evaluating ECMHC and where is there need for development of new tools?

Limitations of this Study

This study was able to shed light on a number of lingering questions in the field and provide data-driven guidance to those interested in developing effective ECMHC programs. However, in determining how to apply the findings from this research, states and communities must first understand the study’s limitations.

1. **Sample size.** This study was limited to the examination of six ECMHC programs, thus it is not a fully representative sample of all consultation models.
2. **Causality cannot be determined.** Although the six study sites were chosen in large part because they demonstrated positive outcomes, it is not feasible to determine which aspects of their consultation models caused these sites to be successful.
3. **Information-gathering guided by specific questions.** Although the interview protocol used to gather information on each study program was extensive, it was not exhaustive. Thus, certain topics that may be of interest to some audiences may not be included in this analysis, as they were not one of the areas of exploration within the study protocol.
4. **Qualitative methodology.** This study relied heavily on in-depth qualitative interviews with a variety of key informants in each of the sites. Qualitative data are not appropriate for addressing some questions that might be of interest, such as assessing the strength of the relationship between two variables. Furthermore, resources were not available to transcribe all of the audiotapes, so the study team relied primarily on notes of interviews. Thus, there could be some errors or differences in interpretation of what respondents said.
5. **Definition of ECMHC.** GUCCHD was guided in the selection of sites by the definition of early childhood mental health consultation that has emerged over the past several years (Brennan, et al., 2008; Cohen & Kaufmann, 2000; et al., 2007; Perry, et al., 2009). Thus, there may have been other models of consultation to early care and education sites that were not considered for inclusion in this study.

Recommendations

As previously discussed, this study engaged a small group of experts in the field of early childhood mental health consultation (for a roster, see Appendix) to serve in an advisory capacity and discuss the policy, programmatic and research implications of this study's findings. This advisory group was comprised of a mixture of researchers, state administrators, consultation program administrators/providers and other mental health professionals. They convened on May 20, 2009 with the GUCCHD study team to collectively generate recommendations for four key audiences: policymakers/funders, ECMHC providers, ECE program administrators, and researchers/evaluators. This section summarizes the recommendations for each of these audiences.

For Policymakers/Funders

State and local policymakers (e.g., elected officials, state and local administrators) and funders need accurate information to make good decisions as they seek solutions and supports to promote the healthy social and emotional development of young children and their families through consultation.

- **Encourage data collection.** To help guide decision-making, policymakers and funders should promote data collection among states, communities and/or grantees that documents the need for supports to promote the healthy social and emotional development of young children; the evidence that early childhood mental health consultation “works” (e.g., reduces expulsion rates and prevalence of challenging behaviors in early care and education settings); and the cost-benefit of mental health consultation as an early intervention strategy.
- **Infuse consultation into child-serving systems.** Policymakers and funders should support the integration of mental health consultation in all child serving systems, including child care resource and referral agencies, early care and education programs, special education services, Head Start and Early Head Start. For example, policymakers and funders should influence the early care and education field by integrating early childhood mental health consultation into existing quality rating systems and credentialing processes at the local, state, and/or national levels (e.g. National Association for the Education of Young Children/NAEYC).
- **Support workforce development.** Policymakers and funders should promote efforts that will expand the pool of qualified mental health consultants. For example, policymakers and funders should help to standardize mental health consultant competencies and support adoption of those qualifications across ECMHC programs. Further, policymakers and funders should partner with higher education systems to infuse training and education on early childhood mental health and ECMHC into school curricula.

- **Make diverse funding opportunities available.** Policymakers and funders should support fiscal policies and procedures that make diverse funding opportunities available to support workforce development, establish early childhood mental health consultation programs, and determine strategies to pay for early childhood mental health consultation services. These may include federal earmarks, state budget line-items, and sustainable options such as having mental health consultation defined as a billable service.
- **Have realistic expectations.** Policymakers and funders should understand the nature of consultation services and have realistic expectations of the time and costs involved in delivering these services.

For ECMHC Providers

ECMHC program administrators and mental health consultants need a theoretical foundation and a clearly articulated model to guide their work with children, families, providers and programs. Further, program administrators need a clear vision, commitment, and organizational structure to engage state and community partners, to establish and sustain an early childhood mental health consultation program, and to support consultants and their services.

- **Identify core competencies.** Program administrators and mental health consultants should help inform the development of core competencies, requirements, and the right preparation for providing early childhood mental health consultation. Some clear parameters for prepared mental health consultants identified by the field include 1) knowledge and understanding of normative child development, 2) understanding and strategies to address troubling/challenging behavior, 3) understanding and respect for the context of early care and education, 4) value for and skills in working with families, and 5) understanding the influence of culture on perception, behavior, and relationships. By reflecting on and responding to the question—“What is a high quality mental health consultant?”—effective programs and practicing consultants can help articulate the essential knowledge, skills, and attributes, setting the bar high for prepared staff and identifying approaches for developing those consultants who may need supports for growing into that role.
- **Have an explicit theoretical approach.** Program administrators and mental health consultants should have a sound and explicit theoretical foundation to guide their work, especially one that emphasizes the relationship-based nature of working with young children, families, and early care and education providers that is essential in mental health consultation.
- **Articulate your model.** Program administrators and mental health consultants should be able to articulate the consultation model so that diverse audiences and partners—national, state, and local—can understand the philosophy, approach, and model for early childhood mental health consultation. In addition, both should be able to describe the model in a way that addresses role clarity, the process of consultation, and specific defining constructs or activities involved in this work. Effective ECMHC providers

should be able to respond to the question—“What do consultants do?”—in ways that are meaningful to families, early care and education providers, and others who can influence the field of early childhood services and supports.

- **Establish supervision and supports.** It is essential to build supports for mental health consultants, such as supervision, reflective supervision, peer support, and training and technical assistance. To address the stress involved in their work, mental health consultants must take care of themselves and have supervision and supports that provide opportunity for reflection, guidance, and skill development. Program administrators must recognize the parallel process of supporting consultants who can then support young children and families and early care and education providers in order to sustain successful early childhood mental health consultation.
- **Champion consultation.** ECMHC program administrators should be the knowledgeable “voice” that champions early childhood mental health consultation, engaging others, building partnerships, and promoting consultation as an effective intervention strategy. Mental health consultants should promote consultation through their work as a provider and advocate for early childhood mental health, supported families, and skilled providers.
- **Engage families.** Program administrators play a key leadership role in framing all early childhood mental health consultation services in the context of family involvement and cultural and linguistic competence. Mental health consultants must recognize the essential role that families play in their child’s development and welcome their perspectives, work in partnership, and solicit their feedback to promote the healthy social and emotional development of their children and the family.
- **Build a network.** Program administrators as well as consultants should create opportunities for networking among their peers and key partners (e.g. child care administrators, early intervention providers, etc.) to build interest in early childhood mental health consultation, address mutual concerns and challenges, and share promising strategies and successes.
- **Develop strategic partnerships.** To support consultation efforts and promote sustainability, program administrators should forge partnerships across various systems and stakeholders. For example, partnering with the higher education system to implement pre-service training on early childhood mental health and core consultation competencies can bolster efforts to build a strong consultant workforce.
- **Include evaluation.** Right from the start, program administrators must include evaluation as part of the early childhood mental health consultation model. Management information systems and a clear evaluation plan contribute to setting benchmarks for program implementation, fidelity to the model, and measurement of outcomes. Consultants are essential participants in evaluation efforts and can benefit from feedback on the consultation process and outcomes for children and families. For both, evaluation is critical to program operations, quality improvement, documentation of program effectiveness, and contributions to the evidence base.

For ECE Program Administrators

Early care and education program administrators need a clear vision, commitment, and program supports to promote the healthy social and emotional development of young children and their families, including early childhood mental health consultation.

- **Value early childhood mental health.** ECE administrators have a responsibility to attend to the social and emotional well-being of infants and young children in their programs. As such, ECE administrators should be well-versed in factors that support early childhood mental health, including positive relationships and nurturing environments, and work closely with families and ECE staff to ensure those supports are in place.
- **Address promotion, prevention, and intervention.** ECE administrators should make the most of early childhood mental health consultation by accessing a full array of consultation services from 1) supporting all children through mental health promotion activities to 2) addressing concerns early to prevent the onset of behavioral issues among children at-risk to 3) addressing troubling or challenging behaviors (intervention).
- **Support readiness for consultation.** ECE administrators can greatly influence staff and family readiness to engage in ECMHC. First, administrators can set a positive tone about consultation and the benefits that it provides to children, families, providers and programs. Further, administrators can help consultants integrate into the ECE program by including them in staff meetings and family nights, and making accommodations in program operations that provide staff opportunities to collaborate with the consultant (e.g., arranging for a floater to provide classroom coverage on a regular basis).

For Researchers/Evaluators

Researchers and evaluators should design effective strategies for both research and evaluation by asking the right questions, identifying indicators, using valid measures, establishing data collection processes, and sharing outcomes to help determine features of effective early childhood mental health consultation that will promote the healthy social and emotional development of young children and their families.

- **Establish the evidence-base.** Research and evaluation efforts should be focused on establishing early childhood mental health consultation as an effective, evidence-based intervention.
- **Be realistic about cost.** When planning research and evaluation, be sure to establish a clear and adequate cost for research and evaluation. When seeking funding, consider ways to make research and evaluation a “line-item” (e.g. 15% of a project or program budget).
- **Follow research guidelines.** Research and evaluation should adhere to the following guidelines: 1) employ a participatory process to develop designs and procedures, 2) develop a logic model and theory of change, 3) identify appropriate and valid measures (including those that address fidelity), 4) combine management information

system (MIS) data (e.g. demographic, quantitative process data, etc.) with evaluation data that measures outcomes (e.g. effect of mental health consultation), 5) make research and evaluation processes explicit (e.g. visits—over time, how long, etc.), 6) design strategies and provide supports that will not overburden study participants and that encourage participation, and 7) share research outcomes with all those who participated in the research process for feedback toward quality improvement and to demonstrate effectiveness.

Detailed Study Site Summaries

6 SECTION

Child Care Expulsion Prevention (CCEP) Program—Michigan

PROGRAM BACKGROUND

The State of Michigan was an early innovator in developing early childhood mental health services. The effort began in 1974 when the state legislature appropriated funds for prevention services to the Michigan Department of Community Health (MDCH) Division of Mental Health Services to Children and Families (at that time was called The Michigan Department of Mental Health). The funds were granted to community mental health agencies to pilot, evaluate, and replicate innovative service models designed to prevent mental and emotional disabilities and related negative outcomes. Of the several diverse prevention models developed for children at that time, the infant mental health model became the most replicated and most integrated within the mental health system in Michigan and was the start of early childhood mental health services in the state.

In the late 1990s, the Prevention Services Director, a state-level champion for infant mental health, heard two expert presentations: one by the Program Coordinator of the Daycare Consultants Program, The Infant-Parent Program, University of California—San Francisco²⁹ and the other by the Deputy Director of the National Center for Children in Poverty, Columbia University³⁰. Both presenters described the mental health needs of children birth through five and the effectiveness of a mental health consultation model in early care and education settings. Shortly thereafter, the Prevention Services Director was approached by local Head Start staff that expressed concern about the increasing number of children being expelled from child care settings due to challenging behaviors. It was decided that Michigan would expand early childhood mental health services to include a child care mental health consultation program to address the social and emotional needs of children experiencing challenges in child care.

²⁹Daycare Consultants, a component of the Infant-Parent Program (IPP) at the University of California, San Francisco, provides consultation services to early care and education programs and training for individuals interested in becoming consultants. For more information go to <http://infantparentprogram.org/> or see page 198 of this report.

³⁰The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. For more information go to <http://www.nccp.org>.

CCEP PROGRAM—MICHIGAN: PROGRAM BACKGROUND

In 1998, Prevention Services had unexpended funds and issued a request for proposals to community mental health centers to propose an early childhood mental health consultation pilot project for children ages three to five years. Six agencies were awarded 12-month planning grants from \$10,000 to \$24,000 and agreed to:

- assess and document the number of young children being expelled from child care in their service area, the reasons for expulsion, and the technical assistance needs of child care providers in order to prevent expulsions;
- develop and document a plan to implement a child care mental health consultation model; and
- pilot implementation of their model.

The results of the community needs assessments were quite consistent across projects. By the end of their planning year, all six of the pilot planning projects had documented the need for child care mental health consultation and developed plans for establishing programs in their respective service areas. Five of the six had generated sufficient interest at the local level in order to proceed and were able to use local, state, and federal funds to continue to varying degrees. These pilot projects were the beginning of what has now become the Child Care Expulsion Prevention (CCEP) program.

In 1999, the Department of Human Services (DHS) Bureau of Child Development and Child Care made an interdepartmental agreement with the Michigan Department of Community Health (MDCH), transferring \$40,000 to establish one CCEP project using quality set-aside funds from Michigan's federal Child Care and Development Block Grant (CCDBG; now called the Child Care Development Fund). In 2000, DHS increased CCEP funding for the project using CCDBG targeted funds for improving infant and toddler quality. These additional monies expanded CCEP's service population to children ages birth to five. By 2002, DHS was funding six CCEP projects; three years later, it funded six additional projects; and in 2006, four more projects were added for a total of 16. At the time of this report, there were three CCEP state-level TA staff. This includes a full-time statewide Program and Training Director, a part-time Technical Assistance Consultant (funded by DHS), as well as a part-time State Coordinator supported by the Michigan Department of Community Health. The CCEP staff provides TA support to the 16 projects serving 31 of Michigan's 83 counties.

MODEL DESIGN

Philosophy/Approach to ECMHC

CCEP conceptualizes early childhood mental health consultation (ECMHC) as part of an early childhood system of care that promotes social and emotional well-being; prevents social and emotional problems among at-risk children; and identifies, treats and reduces the mental health problems among children from birth to five years old. ECMHC is a relationship-based, family-centered, service that builds capacity of families and child care providers to successfully nurture the social and emotional health of the infants, toddlers, and preschoolers within their care. Relationship-based practice is the fundamental approach of CCEP, where practitioners facilitate and nurture optimal adult-child interactions by building trust and relationships with adult providers and family caregivers that mirror the attributes that need to be fostered between the adult caregivers and child and between the adult caregivers themselves. The relationship-based approach provides a safe base for growth and change to occur (Parlakian, 2002; Weatherston & Tableman, 2002).

There are seven cornerstones that are essential to the CCEP model of service:

1. Provision of programmatic consultation services
2. Provision of child/family-centered consultation services
3. Qualifications and ongoing professional development required for CCEP consultants
4. Regular and consistent reflective supervision required for CCEP consultants
5. Participation in state-level technical assistance required for CCEP consultants
6. Emphasis on evidence-based tools
7. Collaboration with Community Coordinated Child Care (4C) agencies (child care resource & referral agencies), Michigan State University—Better Kid Care and other early childhood providers

Program Scope

Geographic area served: Statewide, serving 31 of Michigan’s 83 counties. A total of 16 CCEP projects: six of the projects are located in large urban areas, nine are located in counties that have large- to medium-sized cities, as well as rural communities, and one serves the entire Upper Peninsula of Michigan, a vast, extremely rural region.

Settings served: Licensed child day care centers, licensed group day care homes, *registered* family day care homes, *enrolled*³¹ relative care providers, and *enrolled* day care aides serving children receiving Department of Human Service child care subsidy. Consultants cannot serve other federally or state-funded early childhood programs outside of child

³¹The terms “registered” and “enrolled” indicate the status of a program or provider with the state Department of Human Services, Bureau of Children and Adult Licensing and eligibility to receive child care payments from the State.

CCEP PROGRAM—MICHIGAN: MODEL DESIGN

care (e.g., Early/Head Start) due to funding restrictions and possible duplication of services. However, these programs are free to participate in CCEP training events.

Ages served: Children birth to age five receiving Department of Human Service child care subsidy, with a special emphasis on infants and toddlers.

Percent distribution (FY2008)

Infants/Toddlers (through age 3): 59%

Preschoolers (4 to 5): 31%

Annual numbers served (FY2008):

- 572 children received child/family-centered consultation and 6,884 children³² received programmatic consultation. The number of child care providers served is as follows: 360 child care centers; 60 family child care homes; 9 relative providers; 1 day care aide.
- 957 adults participated in *CORE Module Trainings*³³ including:
 - 823 child care providers (centers, group homes and family homes)
 - 38 parents
 - 33 enrolled relative and day care aides
 - 57 other early care and education professionals
- 2,151 adults participated in specialized trainings conducted by CCEP consultants including:
 - 232 parents
 - 2,560 child care providers (centers, group homes and family homes and relative and day care aides)
 - 316 other early care and education professionals

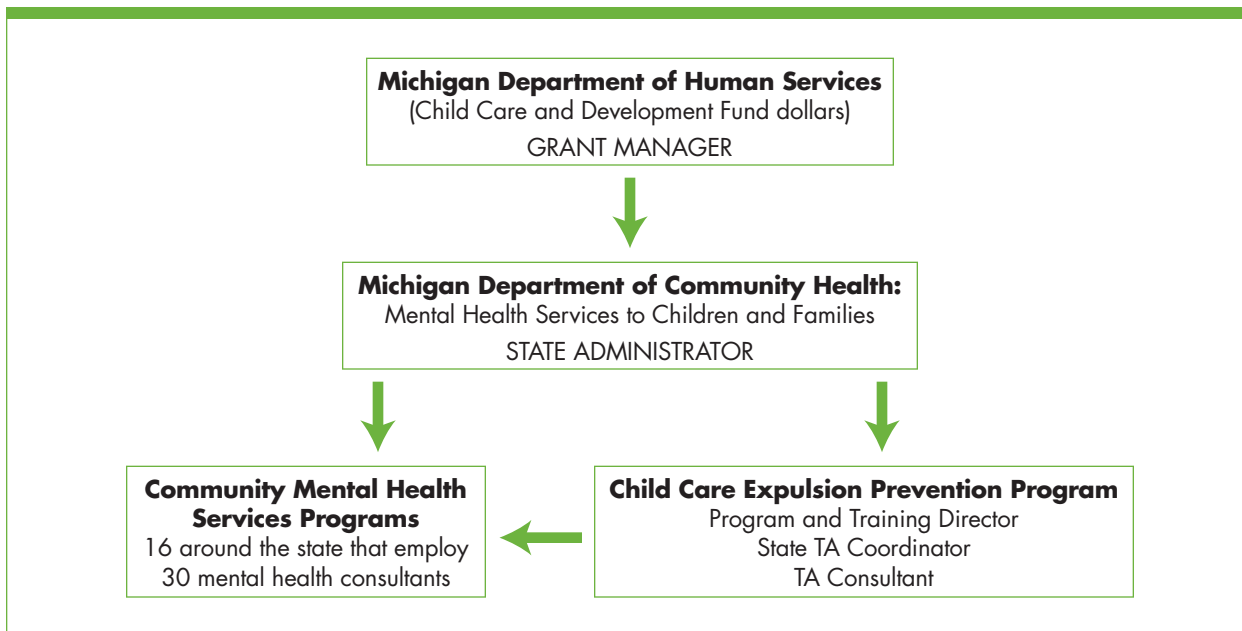
Organizational/Management Structure

The Michigan Department of Community Health (MDCH), Mental Health Services to Children and Families provides state-level administration and contractual and budgetary oversight for the statewide effort. MDCH subcontracts with 16 community mental health services programs that employ a total of 30 consultants who provide CCEP services at the local level. MDCH also contracts with three state-level technical assistance (TA) providers who are responsible for providing TA to the consultants and supervisors in each of the 16 local CCEP projects. CCEP's State Administrator, who is located in MDCH, works closely with the program's TA providers on CCEP activities and future directions.

³²This is a count of *all* children in the enrolled child care sites where a particular child is being served

³³The CORE Module Training is a 12-hour series including 4 modules: 1) Social and Emotional Health, 2) Challenging Behavior, 3) Conflict Resolution, and 4) Caring for the Caregiver.

CCEP PROGRAM—MICHIGAN: MODEL DESIGN



Essential to CCEP’s success are the collaborative partners at the state level and local level. CCEP’s state partners include Michigan’s Department of Human Services (DHS), Department of Community Health, Community Coordinated Child Care (4C) Association, Michigan State University Extension, Better Kid Care, Head Start State Collaboration Office, and the Early Childhood Investment Corporation (ECIC)³⁴ Additionally at the state level, CCEP helped to form an 8 member CCEP State Partners Social and Emotional Training Committee to discuss and coordinate social and emotional training. Partners include: Early On (Part C-IDEA) Training and Technical Assistance, Michigan Association for Infant Mental Health, Michigan Great Start School Readiness Program, Head Start Training and Technical Assistance Network, Head Start-State Collaboration Office, Department of Human Services, Michigan Community Coordinated Child Care (MI4C), and Michigan State University Extension.

CCEP’s State Administrator co-chairs the ECIC Social-Emotional Health External Board Advisory Committee and CCEP’s Program Director and Coordinator are active members. This committee advises the ECIC Executive Committee regarding the development of the social-emotional component of Michigan’s comprehensive early childhood system.

³⁴The Early Childhood Investment Corporation (ECIC), initiated by the Governor’s office, is a public/private partnership to build an early childhood comprehensive system.

CCEP PROGRAM—MICHIGAN: MODEL DESIGN

At the local level, CCEP project staff meet regularly with their early childhood partners to include child care resource and referral agency staff, Michigan State University Extension, Better Kid Care staff and its local Great Start Collaborative members. Most projects also have a local CCEP advisory committee that helps to improve and promote the project. Members typically include child care providers, parents and other early childhood professionals.

Program Staffing

Staff Composition: CCEP’s State Administrator is responsible for negotiating and managing contracts with local Community Mental Health Service Programs (CMHSPs) and providing oversight and direction to the three CCEP state-level technical assistance (TA) consultants, (Program and Training Director, State Coordinator, and Technical Assistance Consultant). Currently, there are 16 projects operated by CMHSPs that provide early childhood mental health consultation in 31 of Michigan’s 83 counties. Program consultants are generally referred to as *CCEP Consultants*, but may have alternative titles related to their local administrative agency. For example, some local CCEP projects are known as KEEP (Keeping Early Education Positive) projects and consultants are called *KEEP Consultants*. When fully staffed, there are 30 consultants across all 16 projects:

- 16 full-time consultants (1 FTE)³⁵
- 7 half-time consultants (.50 FTE)
- 7 part-time consultants with a combined equivalent of 1.6 FTE

Approximately 41% of consultants are CMHSP employees, 31% are employed by subcontracting agencies, and 27% are individual contractors to a local CMHSP

Consultant Caseload: Consultants carry a caseload of 8-15 child/family-centered cases at any one time, with a total of about 30 cases per year. Consultants are expected to be available to all child care providers in their service area who fit the service settings criteria (e.g., age, child care type) and on average serve 15-20 sites per year. For the most part, local programs have been able to respond to demand but a few projects have had to establish wait lists for a short period of time.

³⁵FTE—Full time equivalent

CCEP PROGRAM—MICHIGAN: MODEL DESIGN

Consultant Qualifications and Training

Qualifications for mental health consultants are specified in the contract between the state Department of Community Health and the local Community Mental Health Services Programs and are also reflected in the job description for the Early Childhood Mental Health Consultant. The essential qualifications include:

- master's degree in social work, psychology, or a related field;
- license or license-eligible preferred; and
- Level II—Michigan Association for Infant Mental Health Endorsement³⁶ for culturally-sensitive, relationship-based practice promoting infant mental health or graduate certificate in infant mental health studies.

New consultants participate in a two-day in-service to review the CCEP model, best practices, and the use of social and emotional assessment tools. The training agenda includes overviews of the model and the evaluation plan; defining features and activities related to both child/family-centered and programmatic consultation; resiliency theory and the use of the Devereux Early Childhood Assessment (DECA; LeBuffe & Naglieri, 1999) and DECA for Infants and Toddlers (DECA-I/T; Powell, Mackrain & LeBuffe, 2007) for individualized planning and program strategies; and introduction to adult resiliency and supports.

Consultant Supervision and Support

All consultants have an immediate supervisor within their own agency for administrative and (sometimes, depending on supervisor credentials) clinical supervision. Consultants are also required to participate in one-on-one reflective supervision that is ongoing and supportive for a minimum of 1 hour, twice a month. Someone trained in reflective supervision and who is endorsed by the Michigan Association for Infant Mental Health or meets the eligibility requirements for endorsement must provide this supervision. Currently, in seven of the 16 projects, reflective supervision is provided by a supervisor within the consultant's agency. In the remaining nine projects, the reflective supervision is provided by an outside person with whom the agency contracts. Several agencies, supplement the one-on-one reflective supervision with group reflective supervision using non-CCEP funds.

For any new consultant, the TA staff will host a two-day in-service to review the CCEP model, best practices, and the use of social and emotional assessment tools. New consultants are also encouraged to shadow a seasoned CCEP consultant from other projects.

³⁶MI-AIMH is the Michigan Association for Infant Mental Health, is an organization committed to promoting and supporting nurturing relationships for all infants through education of birth to three and family professionals; diversification of the infant mental health community of providers; advocacy for the social, emotional, and cognitive well-being of all infants and toddlers in the context of their caregiving families; and endorsement of the infant and family workforce.

CCEP PROGRAM—MICHIGAN: MODEL DESIGN

TA staff also provide ongoing support to all CCEP supervisors and consultants, including:

- project specific individualized TA provided onsite and on the phone;
- monthly TA conference calls with participation from staff in all CCEP projects;
- quarterly TA meetings for all project staff;
- TA documents and resources;
- email group support to over 300 ECMH members;
- specialized training; and
- a CCEP quarterly newsletter.

In-service consultation is also available via webinar and one-on-one onsite visitation by the CCEP TA staff.

Accessing Services

CCEP services are publicized at the state and local levels by both the CCEP state-level staff and local consultants. Promotion activities include distributing flyers, brochures and marketing materials; participation on advisory groups and steering committees; facilitation of workshops and trainings locally and at major early childhood conferences. CCEP consultants have two helpful documents they share with local child care providers: a letter, “Introducing CCEP Services to All Families with Children in Your Care,” and a handout, “Encouraging Parents to Accept a CCEP Referral: Tips for Child Care Provider.”

To initiate child/family-centered consultation, early care and education providers or other local agency providers begin by talking with a family about their child and their concerns, filling out a CCEP referral form with the family’s participation and signature, and contacting the consultant about the referral. The consultant will then meet with the provider and schedule an appointment with the family. Families who self-refer can work with their child care provider to contact the consultant. During the initial face-to-face contact, the consultant reviews “How Will CCEP Services Work for My Child?,” and completes an intake interview. As part of the information gathering and intervention planning process, the consultant makes a home visit, works with the family and provider to complete a DECA or DECA-IT, makes observations in the child care setting, and supports a planning process that examines strengths and concerns, identifies goals and strategies, and results in a written *Positive Child Guidance Plan*.

In most instances, programmatic consultation occurs in conjunction with a child-family-centered referral. As relationships are built through child/family-centered consultation, consultants often suggest strategies for programmatic enhancement within the child care setting. Sometimes a child care director or staff member will call to inquire about programmatic consultation separate from a child/family centered referral.

CCEP PROGRAM—MICHIGAN: MODEL DESIGN

After the request for programmatic consultation comes to the CCEP program, the consultant meets with the provider to complete the *CCEP Intake Form for Programmatic Consultation* and collect basic information about the child care program. The consultant then schedules regular onsite observations. During this time, they might ask the child care providers to complete tools such as the DECA or DECA-I/T reflective checklists to gather more information on social and emotional program quality. After information is gathered, the consultant meets with child care providers to complete a *Programmatic Action Plan* and the consultant provides support to help implement the plan.

Service Array, Frequency, and Duration

The service array provided by CCEP consultants includes:

• Programmatic Consultation

- Programmatic consultation within the care setting to improve the social and emotional quality of services and promote child care provider’s skills. Consultation generally includes training and coaching. The steps usually include assessing the situation, developing a *Programmatic Action Plan*, implementing the Plan, and evaluating how well it works.
- Standardized *CORE Training Modules* for parents, child care providers, and other early care and education professionals.
- Specialized social and emotional training as requested by child care providers (e.g. biting, attachment, temperament, etc.).

More often than not, programmatic consultation is provided within the context of a child/family-centered case. In approximately 17% of the child care sites served by CCEP, there is no child referred and the consultants provide programmatic consultation. In these situations, consultants visit the site 1 to 3 hours weekly. Typically, when no child is referred and a consultant engages in just programmatic consultation, consultants visit a particular child care center or program once a week and over time, work with a child care center or program from three to six months (Van Egeren and Zheng, 2008a, 2008b).

• Child/Family-Centered Consultation

- Child/family-centered consultation within the care setting and through home visits, including intake, observation, and assessment; development of a *Positive Child Guidance Plan*; support for parents and providers to implement the plan; and conclusion of services.
- Utilization of evidence-based tools in the provision of consultation, such as the DECA and DECA-I/T, standardized, valid and reliable measures of social and emotional health.
- Referring the child/family to other services as needed.
- CCEP outreach to relative day care providers and day care aides.

CCEP PROGRAM—MICHIGAN: MODEL DESIGN

On average, consultants spend 1-3 hours weekly in child/family-centered consultation. Typically, consultants work with an individual child/family and child care setting for 3-6 months, although depending on the situation, the length of time for services may be much shorter or much longer. There is no fixed number of visits per referral.

As a new priority, CCEP is reaching out to serve informal child care providers through training events, play group opportunities, and “coffee clubs.” Several CCEP projects have started these local informal gatherings (in libraries, local coffee shops, etc.) and offer them on a monthly basis, facilitating discussion on a social and emotional topic, and offering strategies and tips.

Data Collection

Each CCEP site is responsible for gathering both quantitative and qualitative data on a quarterly basis to describe the following:

- Project Status
- DHS Priorities/Strategies
- Collaboration Activities
- Service Delivery: Child and Family Centered
- Service Delivery: Programmatic, Provider Type
- Parent and Caregiver Satisfaction Surveys
- Core Training Delivery
- Specialized Training Delivery
- Closed Case Information
- Staffing
- Professional Development
- Technical Assistance/Support

MDCH uses a web-based survey program so that all CCEP projects can complete their quarterly report online. All of the data is then available to the Program and Training Director, who conducts analyses regularly. The quantitative and qualitative data are used to document project status and service/training delivery and model fidelity, as well as to inform service planning, program improvement, and technical assistance support.

Funding

Funding for CCEP is through the state Department of Human Services using Child Care Development Fund dollars. Funding varies from \$71,400 to \$213,925 per local project, depending on the proposal submitted for funding by each project and the scope of each project. The total state investment in CCEP for fiscal year 2009 is \$1,852,992, including \$125,000 for year three of the evaluation of the program by an interdisciplinary group of investigators at Michigan State University. Funding for technical assistance to CCEP projects is \$92,709.

NOTABLE PROGRAM FEATURES

1. **Consultant qualifications and supervision.** Both current and newly-hired consultants must attain a Level II MI-AIMH endorsement. This endorsement verifies that a consultant has attained a level of education as specified by the Michigan-Association for Infant Mental Health, participated in specialized in-service trainings, worked with guidance from mentors or supervisors, and acquired knowledge to promote the delivery of high quality, culturally sensitive, relationship-focused services to infants, toddlers, parents, other caregivers and families. In addition, consultants are also required to participate in one-on-one reflective supervision that is ongoing and supportive for a minimum of 1 hour, twice a month with someone trained in reflective supervision and who is endorsed by the MI-AIMH or meets the eligibility requirements for endorsement.
2. **CORE training modules and training coordination.** To promote child care social and emotional quality, CCEP consultants must offer a standardized four-part *CORE module training series* (a minimum of two series offered in each county each year) for child care providers, families, and other early childhood professionals. These four training modules, which are based on best practice and research, are each 3 hours in length and include the topics below:
 - Foundations of Social and Emotional Development
 - Preventing and Working with Challenging Behavior
 - Conflict Resolution
 - Caring for the Caregiver

This training helps providers in several ways: 1) it supports competency areas for those working toward a Child Development Associate (CDA), 2) it counts toward licensing requirements for training hours for child care centers, and 3) it counts toward the 16 training hours required of relative care providers and day care aides to earn a DHS incentive of \$150, as well as a small increase in the amount they are paid for caring for infants and toddlers (subsidy).

CCEP consultants also provide specialized social and emotional training upon request, tracking all of these trainings and the types of participants who attend. With the support of the CCEP program staff, a specialized training directory was developed, listing all of the trainings done, by whom, learning objectives, materials used, etc. in order to coordinate and expand training activities. Consultants across community programs can then request all of the materials by training topic from their peers to use across systems and counties.

In addition, CCEP TA staff members are working with state partners to coordinate child care provider training efforts across state programs so that language, training objectives, and learning experiences are consistent and/or support one another in the area of social-emotional development. A formal partnership was established in March 2007.

CCEP PROGRAM—MICHIGAN: NOTABLE PROGRAM FEATURES

3. **Technical assistance support to consultants.** State-level TA staff work very closely with local CCEP supervisors and consultants across all projects to support their work and promote model fidelity. Some key TA activities include:
- Individualized onsite TA and training to CCEP projects
 - Individualized consultation to new program sites
 - In-service trainings (via webinar or onsite) for new consultants to review the CCEP model and best practices and to review use of social and emotional assessment tools
 - Monthly conference calls for all CCEP sites; at least one representative from each site must attend. Typically, these calls include an evaluation “check in”, discussion of “hot topics” or decisions that need to be made.
 - Quarterly TA meetings for all project staff—typically, these meetings are one full day with an agenda that includes state updates, resource sharing, small group reflection activity, and specialized training that counts toward hours needed for MI-AIMH endorsement and professional social work Continuing Education Units (CEUs).
 - TA documents and resources such as the social and emotional specialized training directory, social and emotional booklet for families, one-page handout of birth to five social and emotional milestones, and guidance on social and emotional risk factors for infants and toddlers.
 - CCEP Quarterly Newsletter
 - Coordination of evaluation activities related to the project

State-level TA staff also coordinate state-level connections, take part in many state-level early childhood committees and advisory teams, and promote CCEP services through marketing. The CCEP Program and Training Director also conducts state and national trainings and presentations.

EVALUATION EFFORTS AND FINDINGS

Program Outcomes

A 2004 study of CCEP (Field & Mackrain) examined outcomes for child, staff and families receiving consultation services. According to staff and parent reports on child outcomes, only 8 of the 213 children who received CCEP interventions were expelled. Further, satisfaction surveys indicated that 94% of staff and families felt they learned new strategies to help children with challenging behavior and that they had a better understanding of children’s behavior.

More recently, qualitative and quantitative data from the local projects’ FY2008 quarterly reports to MDCH revealed the child-related program outcomes listed below. Findings are derived from data that was available for 133 completed cases³⁷. Many other

CCEP PROGRAM—MICHIGAN: EVALUATION EFFORTS AND FINDINGS

children continued services into the new fiscal year. Of the completed cases for which data was available, 85% had positive outcomes:

- 75% stayed in the same child care setting with positive results, “graduated” on to Kindergarten with appropriate support services if needed or transferred to a more appropriate early care and education setting with agreement from all involved
- 3% of the children referred entered special services such as a special education program
- 7% of the children referred stayed home with parent, based on parent’s decision

Fifteen (15) percent had mixed outcomes, as follows:

- 3% of the children were expelled with no follow-up
- 4% were expelled but received services at a new site from CCEP
- 8% moved or data was not completed for extenuating circumstances

Current/Upcoming Efforts

For the last three years, Michigan State University has been evaluating CCEP. The fourth and final year of the evaluation will begin Oct. 1, 2009. This evaluation by MSU is examining CCEP outcomes for children, families, and providers and will compare them to outcomes for children with challenging behaviors in counties in which CCEP services are not available. Longitudinal, quasi-experimental, and qualitative case study methodological approaches are being used within the evaluation. The specific subprojects are listed below:

Project 1: Online survey of CCEP consultants

Project 2: CCEP services evaluation pre-and post-intervention data

Project 3: Comparison group evaluation

Project 4: Case study evaluations

The evaluation questions for this multi-project evaluation are:

• Child Outcomes

- Does the severity of children’s challenging behavior decrease from the onset of CCEP services to the conclusion of services?
- Does children’s social and emotional health increase from the onset of CCEP services to the conclusion of services?
- Does the impact of services on children’s behavior last past services?
- Do children receiving CCEP services successfully stay in child care vs. being expelled?

³⁷The term “completed” indicates that the mental health consultation intervention for this child was completed from consent to services through observation, plan development, plan implementation, transition, and ending paperwork completed. For a small percentage of children, families move, the child is expelled right after the consent is signed, or some extenuating circumstances lead to the program not getting data.

CCEP PROGRAM—MICHIGAN: EVALUATION EFFORTS AND FINDINGS

• **Family Impacts**

- Do subjective feelings of parental competence in dealing with their children’s challenging behavior increase as a result of CCEP services?
- Are families able to consistently attend work or school?

• **Child Care Provider**

- Is the child care provider better able to recognize early warning signs of social and emotional challenges in infants, toddlers, and preschoolers?
- Is the child care provider better able to manage challenging behavior in the child care settings with all children?

• **Child Care Program**

- Has the social and emotional quality of the child care setting receiving CCEP services improved?
- What is the fidelity of the child/family consultation process among CCEP programs?
- What is the fidelity of the programmatic consultation process among CCEP programs?

Measures included in this evaluation are:

NAME	FOCUS	COLLECTION PERIOD	COMPLETED BY
CCEP Intake Questionnaire*	Child/Family/Program Information, Strengths and Needs	Pre	Consultant
Positive Child Guidance Plan*	Intervention Goals/Strategies	Pre	Consultant
CCEP Completion Questionnaire*	Reported changes in Child/Family Program Strengths and Needs	Post	Consultant
Consultant Perception of Parent*	Feelings of affiliation, support, dependability & availability, shared expectations & beliefs, communication, sharing of emotions, information, general satisfaction and perception of parent	Post	Consultant
Consultation Summary of Service Form*	Child status and details of interventions	Post	Consultant
Quarterly Log Data*	Services provided	Post	Consultant
Devereux Early Childhood Assessment (DECA/DECA-IT)	Assess child social/emotional functioning	Pre/Post	Provider

*Locally-developed measures

Note: See page 91 for more information on standardized measurement tools.

A full evaluation research report is expected by September 30, 2010.

CCEP PROGRAM—MICHIGAN: EVALUATION EFFORTS AND FINDINGS

NAME	FOCUS	COLLECTION PERIOD	COMPLETED BY
Provider Perception of Parent Form*	Feelings of affiliation, support, dependability & availability, shared expectations & beliefs, communication, sharing of emotions, information, general satisfaction and perception of parent	Pre/Post	Provider
Behavioral and Emotional Screening System (BASC-2) subscales	Assess child behavior, personality, development	Pre/Post	Provider, Parent/Family
Goal Achievement Scale (GAS)	Knowledge of social/emotional development, job satisfaction	Pre/Post	Provider
Teacher Opinion Survey (TOS)	Teacher attitudes—self-efficacy as child care giver	Pre/Post	Provider
Provider Perception of Consultant Form*	General satisfaction with consultation	Post	Provider
Early Warning Signs*	Reported changes in knowledge of early social/emotional early warning signs.	Retrospective Pre and Post	Provider
Devereux Early Childhood Assessment (DECA/DECA-IT)	Assess child social/emotional functioning	Pre/Post	Parent/Family
Parent Perception of Provider Form*	Feelings of affiliation, support, dependability & availability, shared expectations & beliefs, communication, sharing of emotions, information, general satisfaction and perception of provider.	Pre/Post	Parent/Family
Child Care and Parenting Questionnaire* ³⁸	Effects of challenging behavior on parents' work life, parenting stress.	Pre/Post	Parent/Family
Parent Empowerment Questionnaire* ³⁹	Feelings of parent empowerment	Pre/Post	Parent/Family
Parent Perception of Consultation Form*	General satisfaction with consultation	Post	Parent/Family

*Locally-developed measures

Note: See page 91 for more information on standardized measurement tools.

³⁸The Child Care and Parenting Questionnaire was created using a subset of questions from both the Parenting Stress Index–Short Form (Abidin, 1995; parenting distress and parent-child dysfunctional interaction subscales) and the Quality of Worklife (Centers for Disease Control and Prevention, 2002) measure.

³⁹The Parent Empowerment Questionnaire was created using a few items/subscales from the Psychological Empowerment Scale (Akey, Marquis, & Ross, 2000).

LESSONS LEARNED/RECOMMENDATIONS

- **Think early about evaluation.** Use standardized, norm-referenced social and emotional assessment tools. Have a strong data collection system to remain accountable and to measure program success across multiple variables for child care providers, children, and families.
- **Written contracts are important.** The contracts between the Department of Community Health and local program sites are very important. The contractual language clarifies expectations and commitment to carrying out the early childhood mental health consultation program. The contract conveys the model, details the hiring/staffing commitment, describes accountability, and supports fidelity to the model.
- **Technical assistance is critical in large scale initiatives.** Strong technical assistance to sites and consultants provides essential support, training, and resources. In addition to conveying and strengthening the program model, technical assistance builds relationships, trust, and connections between CCEP projects, consultants, and CCEP state-level staff. Having all parties working together and communicating regularly with one another facilitates model fidelity, program improvement, and systems of care development.
- **Consultants need a range of specialized skills and supports.** It is imperative for consultants to have mental health experience and access to regular, ongoing reflective supervision so as to maintain continuity and sustainability of services. It is also critical for local level consultants to be supported by invested and involved administrative supervisors to support program fidelity and contractual fulfillment.
- **Flexibility is key.** Not limiting the number of consultation visits is important to CCEP's model. In the context of relationship-based practice, this flexibility allows for individual differences and recognizes the importance of pace, timing, and cultural aspects of all those involved to bring about positive change.
- **State and local partnerships are critical.** Build strong collaborative relationships at state and local levels. These collaborative relationships provide a foundation for developing early childhood mental health promotion, prevention, and intervention services across systems. Early childhood providers and other systems clearly see the need for early childhood mental health services and enthusiastically advocate for policy and funding to expand the availability of early childhood mental health consultation for early care and education settings.

PROGRAM CONTACT

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Early Childhood Consultation Partnership—Connecticut

PROGRAM BACKGROUND

For years prior to the inception of the Early Childhood Consultation Partnership (ECCP), local early childhood advocates worked to raise awareness about the importance of early childhood mental health and how the state could better meet the social and emotional needs of its young children. Two events in particular helped bolster their efforts and set the stage for ECCP to emerge: 1) a national study revealing high rates of preschool expulsion and early childhood mental health consultation's positive effects on expulsion rates (Gilliam, 2005); and 2) a 2000 gubernatorial report on mental health.

In July 2000, the Governor's Blue Ribbon Commission Report on Mental Health was issued, highlighting significant gaps in the state's mental health service system. As a result, the Connecticut State Legislature established the Mental Health Strategic Investment Fund to seed initiatives designed to improve access to and availability of quality mental health services. Concurrently, the legislature created a broad-based Community Mental Health Strategy Board to guide funding allocation by recommending targeted community-based efforts that would collectively lead to an improved service delivery system. A leader in the local early childhood community was appointed to the Board's subcommittee on children and strongly advocated for funding early childhood mental health consultation, given that it focused on young children, was innovative, and had data indicating that it significantly decreased preschool expulsion rates. In the end, the Board recommended and the legislature approved funding for five children's initiatives, one of which was early childhood mental health consultation (ECMHC).

Funds for implementing a statewide early childhood mental health system were channeled to the Department of Children and Families (DCF). Through a competitive Request for Proposal (RFP) process, DCF awarded Advanced Behavioral Health (ABH), a non-profit behavioral health management company, the \$1M contract to spearhead a 1-year pilot statewide effort. Although ABH had not previously focused on services to young children, the management team had extensive experience in children's mental health and child welfare. ABH was motivated to respond to the RFP because of mental health consultation's prevention/early intervention focus. In 2002, ABH launched the Early Childhood Consultation Partnership (ECCP), a program designed collaboratively with community stakeholders.

After the initial pilot phase and until September 2004, the program was sustained by braiding together public and private funding. Since 2004, ECCP has been primarily funded by DCF. In 2005, promising findings from a rigorous randomized-control evaluation of ECCP were released. The following year, DCF provided additional funding to support program expansion, doubling the number of consultants, extending service duration, and

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enhancing the program’s array of services. This expansion also included another rigorous evaluation. ECCP is one of the first statewide consultation programs and over time has amassed a strong base of support from public and private stakeholders, including the parents and early childhood providers whom they serve directly.

MODEL DESIGN

Philosophy/Approach to ECMHC

The overarching goal of ECCP is to reduce the risk factors associated with suspension and expulsion of young children by providing supports and consultation in order to maintain them in their early care and education settings. Given this charge and a commitment to design a research-informed model, ECCP model developers drew heavily upon research regarding early social and emotional development and school readiness, as well as best practices in social and emotional interventions. The National Center for Children in Poverty’s³⁸ work was particularly influential, stressing the need for quality social emotional interventions to include center-based, collaborative and capacity-building components. Research on various theoretical approaches to consultation (i.e., mental health, behavioral, and organizational), as well as systems theory has also shaped the ECCP model.

Key program objectives are to:

- help community child care providers, educators and families understand and promote early childhood mental health;
- assist in identifying young children’s mental health needs and respond with appropriate services and referrals to other service providers;
- address concerns raised by and between child care providers, educators and families; and
- provide linkages to community-based education, social and mental health services.

Key values and principles that underlie ECCP’s approach to consultation include the following constructs:

- **Data-driven:** use data to inform and improve service delivery
- **Research-based:** guide model development and refinement with the best available research
- **Capacity-building:** improve child outcomes by enhancing parent and provider skills through support, education, and fostering linkages to community resources
- **Prevention/early intervention:** identify and address children’s needs as early as possible
- **Strengths-based:** develop strategies that build upon the strengths, interests and positive attributes of the child, family, provider, classroom and/or center

³⁸See <http://www.nccp.org>

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- **Relationship-based:** support healthy relationships among and between all significant adults in a child's life
- **Collaborative:** engage and team with providers, educators, parents and other key partners to enhance the developmental process and emotional health of each child
- **Systemic focus:** attend to all levels impacting child experiences and outcomes, i.e., individual, family, classroom/center, and community/system

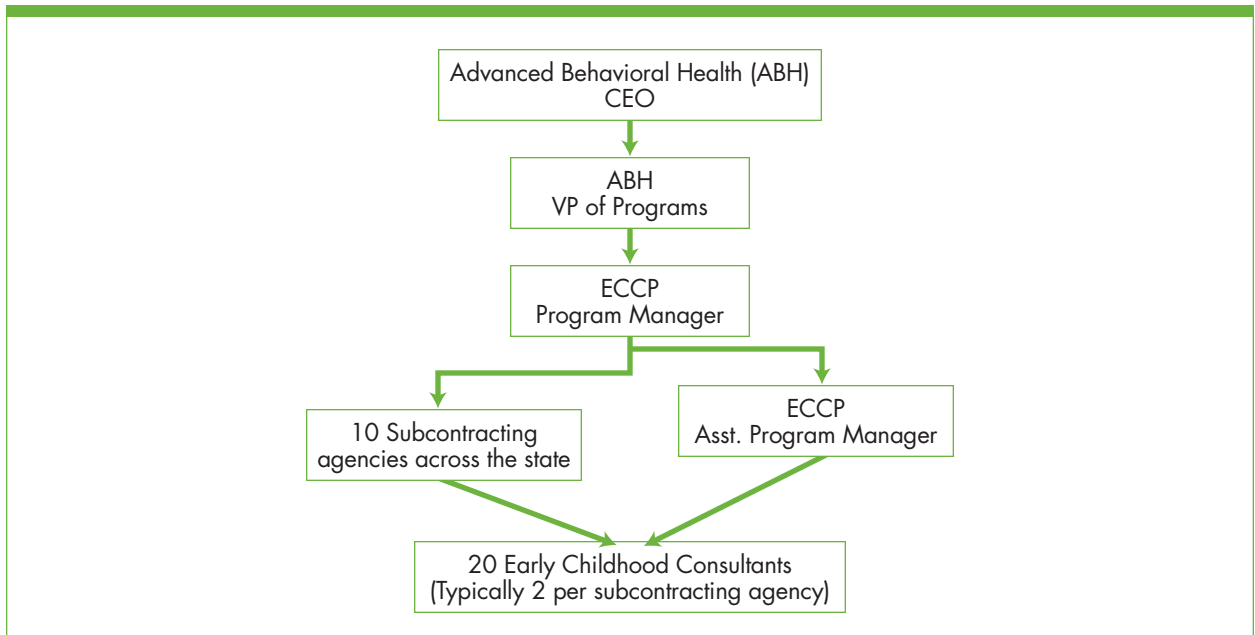
Program Scope

- Geographic area served:** Statewide
Mostly urban (51%), but also suburban and rural areas.
- Settings served:** Public and private child care centers/preschool programs; Early Head Start and Head Start programs; licensed family child care homes; foster care settings and intermediate safe homes; kinship care homes (for those raising children of their kin); substance abuse residential facilities; community resource centers.
- Ages served:** Birth to age 5
- Percent distribution (FY2008)*
- For core classroom services:
Infants/toddlers (birth to 36 months): 24%
Preschoolers (37 months to 60 months): 76%
- For child-specific services:
Infants/toddlers (birth to 36 months): 18%
Preschoolers (37 months to 60 months): 71%
Over 60 months: 11%
- Annual numbers served (FY2008):** Served 2,301 children and 224 child care centers, and trained 1,869 teaching staff (group trainings).

Organizational/Management Structure

ECCP is centrally managed at Advanced Behavioral Health (ABH) in Middletown, CT. Program management staff are employed by ABH and work out of the Middletown office. ABH subcontracts with 10 non-profit community-based child behavioral health agencies, which employ the consultants delivering ECCP services across the state. Consultants are jointly supervised by a staff person from the subcontracting agency and a member of the ABH program management team.

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Program Staffing

Staff composition: ECCP’s staff is comprised of a full-time Program Manager, Assistant Program Manager, Administrative Assistant, and 20 full-time *Early Childhood Consultants* (i.e., mental health consultants) who are assigned to work in specific regions of the state. Of the 20 consultants, 1 to 2 are Senior Consultants who, in addition to typical consultation duties, take a more active role in mentoring and training new staff, engaging in community initiatives, and leading 1 of 5 ECCP subcommittees (i.e., Infant Toddler, Pre School, Recruitment-Marketing, Director Policy, and Resources).

Consultant caseload: Consultant caseloads vary depending on the amount of travel required and the complexity of needs. On average, consultants balance 4 to 5 child-focused cases with program/classroom-wide consultation to three child care settings at any given time.

Consultant Qualifications and Training

ECCP requires that consultants are master’s level professionals in a human services related field (e.g., psychology, social work, education, marriage and family counseling). In addition, consultants must have extensive knowledge of key issues such as early childhood development, emotional and behavioral health, family systems, and children with physical and developmental disabilities, as well as demonstrated expertise in the field. Candidates for Senior Consultant must be employed through ECCP for at least four

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years and demonstrate a level of expertise in early childhood mental health consultation, as well as capacity for leadership/mentoring.

While newly-hired consultants tend to have experience with mental health and/or early childhood, very few come to ECCP with early childhood mental health consultation experience. As such, ECCP has developed a standardized training curriculum that is shaped by research and experience in the field and mandatory for all new consultants. During their first year on staff, all consultants attend a wide array of trainings, many of which are conducted by ECCP Program Management and Senior Consultants who developed the content based on best practices, literature, and their experiences. Those trainings include, but are not limited to:

- Program orientation
 - ECCP background (history, funding, etc.)
 - Service overview
 - Policies and procedures
 - Dual supervisory structure (ABH and home agency roles)
- Trainings on key programmatic components, such as:
 - ECCP Management Information System and reporting
 - Evaluation/assessment tools
 - Action plan development
- Trainings on key early childhood and consultation topics, such as:
 - Health Insurance Portability and Accountability Act (HIPAA)
 - Home Visit Safety
 - Adult Learning Theory
 - Team Building
 - Cultural Competency
 - Promoting Social and Emotional Competence in Young Children
 - Attachment
 - Supporting Transitions
 - Trauma and Resiliency
- Community Resources overview

New consultants are also given specific, required tasks to help lay the foundation for their work. Tasks include creating and circulating outreach/recruitment emails and flyers to their coverage area and preparing and scheduling presentations on ECCP to community-based groups. Consultants must also become trainers through the statewide

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early childhood professional development system (CT Charts-a-Course)⁴⁰, as the social/emotional trainings consultants conduct for early childhood providers are typically CT Charts-a-Course modules. In addition, all consultants are required to attend monthly DCF Systems of Care meetings and networking breakfasts hosted by Help Me Grow⁴¹, a key source of referrals to ECCP. As part of each sub-contract, ABH also provides funding for each consultant to take advantage of additional professional development opportunities (up to 3 days above and beyond mandatory trainings).

Consultant Supervision and Support

ECCP applies a strengths-based and solution-oriented approach to supervision. Reflective supervision of both clinical and administrative duties is provided. Supervisors strive to develop healthy relationships with their supervisees and embody the relationship-based philosophy that is promoted throughout the program. The ECCP Management Information System (MIS) provides data on consultant activities and services, which assists with supervision.

Given ECCP's organizational structure, consultants receive supervision from both ABH and the hiring agency. Administrative supervision at the program management level focuses on overall ECCP issues, while supervision by the hiring agency focuses on agency-specific issues. The intensity of clinical supervision at the program management level depends upon the clinical expertise of the hiring agency supervisor. Details on the supervision provided by each entity are provided below.

ABH/ECCP Program Management

- Monthly, two-hour individual reflective clinical and administrative supervision meetings focused on assessing progress toward program goals, model fidelity, and clinical guidance.
- Biweekly group reflective clinical and administrative supervision/staff meetings designed to provide general program updates as well as opportunities for case review and peer feedback. Although all consultants attend two meetings each month, only half of the staff are at each meeting, per regional division.
- Quarterly staff meetings attended by all consultants and Program Management staff; time is used for administrative updates, team-building activities and joint trainings.

Hiring/Subcontractor Agency

- Each hiring agency is required to provide individual reflective clinical and administrative supervision to each consultant they employ; however, the frequency and format vary. Supervision occurs at least once a month.

⁴⁰For more information, see <http://www.ctcharts-a-course.org>.

⁴¹Help Me Grow is a statewide program in Connecticut designed to help families and providers access appropriate services for young children (birth to 5) who are at risk for developmental, health or behavioral problems. For more information, visit <http://www.infoline.org/programs/Helpmegrow.asp>.

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Occasionally, dual supervision takes place. The consultant might jointly meet with both supervisors due to performance issues or program changes, or to better meet the consultant's support needs. Other mechanisms for consultant support include monthly peer support/action plan support meetings and informal contacts with consultants via phone, email or face-to-face conversation. Senior Consultants volunteer to mentor newer consultants. Consultants also gather information and support from other colleagues within their hiring agencies and across agencies engaged in work with ECCP.

Accessing Services

ECCP services can be accessed in a variety of ways, partially dependent upon the type of service that is being requested. For child/family-centered services, parents, ECE providers (teachers and directors) or other community providers can make a referral by calling the toll-free state early childhood information and help line, calling the consultant assigned to that area, or calling ECCP's central office. Programmatic consultation services (i.e., *Core Classroom and Intensive Site*) are primarily initiated by the center director by contacting the consultant covering that geographic area or calling ECCP's central office. In some instance, directors may be prompted to call at the request of a teacher or parent. Intensive program-wide consultation (i.e., *Intensive Site* consultation) is typically available only for programs that have received other levels of ECCP service in the past and have demonstrated a firm commitment to systemic, program-level change.

In all cases, to formally initiate services a service-specific agreement must be signed between ECCP and the relevant parties (e.g., director, teacher, parent/guardian). These agreements specify the roles of the consultant and the center/program staff and specify the frequency and duration of services.

Service Array, Frequency and Duration

ECCP provides a system of consultation that offers providers and parents a variety of services targeted at prevention and intervention. ECCP's model includes the three core levels of service delivery: *Child-Specific*, *Core Classroom*, and *Intensive Site*. These consultation services are designed on a continuum, such that one service segues into the next, broadening the focus from an individual child to a whole classroom to an entire center. Furthermore, services build upon each other in stepwise fashion, i.e., *Child-Specific* consultation is a component of *Core Classroom* consultation and both are components of *Intensive Site* consultation. Despite variations in the breadth of focus, there are several common service elements that span across each level: screening/assessment, observation, and action plan development and support.

1. **Child-Specific Consultation:** *Child-Specific* services are designed to address the needs of a child who is exhibiting social, emotional or behavioral challenges. Consultants work closely with the child's parent(s) and child care providers to increase their ability to meet the child's needs and help him/her succeed in home and at school. *Child-Specific* services

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include child screening/assessment, classroom and in-home observation, child-specific action plan meetings with parent(s) and providers (child care teachers and director) to develop and refine strengths-based strategies, computer-generated *Child Action Plans*, action plan implementation support visits (in-home and classroom options), and referrals/referral assistance. *Child-Specific* services entail up to 9 hours of consultation and last approximately 1 month. Consultants also follow-up with parents and providers 1 month and 6 months after the service end date to assess how the child is doing, offer additional resources or strategies if needed, and gauge satisfaction with services.

2. **Core Classroom Consultation:** *Core Classroom* services provide consultation to one teacher/classroom and seek to support positive social and emotional development and behavior through caregiver skill-building and enhancements to the early learning environment. *Core Classroom* services include classroom assessment/observation, classroom action plan meetings with teacher(s) and director to develop and refine strengths-based strategies, computer-generated *Classroom Action Plans*, and action plan implementation support. In addition, the consultant offers a center-wide training based on program needs, reviews the center’s behavioral guidance policy and provides recommendations to the director. Teachers receiving *Core Classroom* consultation also work with the consultant to identify up to two children for *Child-Specific* services. Consultants spend 4 to 6 hours a week for up to 14 weeks providing *Core Consultation* services to a center.
3. **Intensive Site Consultation:** This level of consultation incorporates both *Child-Specific* and *Core Classroom* services, while adding an expanded focus on the entire center/program. *Intensive Site* services include in-depth review and enhancements to the center’s behavioral guidance policy, two center-wide trainings, and development of/implementation support for a center-based action plan. Given the amount of work required among center staff for this level of consultation, ECCP typically enters into these consultation arrangements only with centers that have demonstrated a commitment to the change process through prior work on *Core Classroom* or *Child-Specific* services.

ECCP also offers slight variations in service delivery to meet the needs of special populations. First, ECCP provides a DCF *Child-Specific* service component designed to help children in child welfare foster care settings succeed in those settings. Service delivery is very similar to the ECCP’s “traditional” *Child-Specific* services, except that the emphasis is on the foster care placement rather than the classroom, and the partners involved are slightly different (e.g., foster parents, DCF caseworkers). Second, in partnership the State Department of Education (SDE), ECCP has a specialized component designed to serve children with disabilities who are receiving special education and related services. This program subcomponent, titled *Early Childhood Behavioral Consultation (ECBC)*, offers intensive onsite consultation, training and technical assistance to six urban child care centers a year that serve children ages three and four.

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Data Collection

ECCP employs a number of forms and assessment tools to guide service planning and track outcomes. Consultants enter these data into the centralized management information system, which will calculate scores for standardized screening/assessment tools, generate an *Assessment Score Summary Form*, and channel relevant information into *Action Plans* and other key reports. The ECCP Management Information System creates a consistent record for data collection, *Action Plan* development, and reporting that supports the work of the consultant while also supporting fidelity to the ECCP model of consultation.

Child-Specific Screening/Assessment/Service Planning Tools

TOOL NAME	PURPOSE(S)	COLLECTION PERIOD	COMPLETED BY
Child Demographic Parent Form*	Collect child demographics	Pre	Parent
Center Demographic Form*	Collect center demographics	Pre	Center/Program Director
Classroom Demographic Form*	Collect classroom demographics	Pre	Teacher
Caregiver Teacher Report Form 1 ½ to 5 years (CTRF–Version 4.0)	Assess child functioning	Pre/Post	Teacher
Child Behavior Checklist 1 ½ to 5 years (CBCL–Version 4.0)	Assess child functioning	Pre/Post	Parent
Home Observation for Measurement of the Environment (HOME-EC or HOME-IT)	Home observation	Pre/Post	Consultant
Infant/Toddler or Preschool Goals and Strengths*	Assess child’s strengths and areas for improvement	Ongoing	Consultant
Child-Specific Service Visit Form (home and classroom versions)*	Activity log; produces forms for each service visit to place in charts	Ongoing	Consultant
Child Action Plan*	Written plan of work including strengths, goals, participants, and interventions	Pre	Consultant
Child-Specific Referral Form*	Specifies referrals made and tracks referral status	Ongoing	Consultant

*Locally-developed measures

Note: See page 91 for more information on standardized measurement tools.

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Child-Specific Screening/Assessment/Service Planning Tools

TOOL NAME	PURPOSE(S)	COLLECTION PERIOD	COMPLETED BY
Child-Specific Discharge Summary Form*	Specifies reason for and date of discharge	Post	Consultant
Director Satisfaction Survey*	Assesses director satisfaction with services	Post	Center/Program Director
Child-Specific Teacher Questionnaire*	Assesses teacher satisfaction with services	Post	Teacher
Parent Satisfaction Survey*	Assesses parent satisfaction with services	Post	Parent
The following tools are optional and provide additional information as needed for planning			
Ages and Stages Questionnaire (ASQ)	Screening and assessment	Pre/Post	Consultant
Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)	Screening and assessment	Pre/Post	Consultant
Sensory Profile (infant/toddler and preschool versions)	Screening and assessment	Pre/Post	Consultant
Parenting Stress Index–Short Form (PSI)	Screening and assessment	Pre/Post	Consultant

*Locally-developed measures

Note: See page 91 for more information on standardized measurement tools.

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Core Classroom Screening/Assessment/Service Planning Tools

TOOL NAME	PURPOSE(S)	COLLECTION PERIOD	COMPLETED BY
Center Demographic Form*	Collect center demographics	Pre	Center/Program Director
Classroom Demographic Form*	Collect classroom demographics	Pre	Teacher
Infant-Toddler/Early Childhood Environmental Rating Scale—Revised (ECERS-R or ITERS-R) “space and furnishings” and “parents and staff” domains only	Assess classroom environment	Pre	Consultant
Classroom Assessment Scoring System (CLASS) “emotional support” and “classroom management” domains only	Assess classroom environment	Pre/Post	Consultant
Infant/Toddler or Preschool Classroom Goals and Strengths*	Assesses teacher/classroom strengths	Ongoing	Consultant
Service Visit Form (classroom and center/director versions)*	Activity log; produces forms for each service visit to place in charts	Ongoing	Consultant
Classroom Action Plan*	Written plan of work including strengths, goals, participants, and interventions	Pre	Consultant
Discharge Summary Form*	Specifies reason for and date of discharge/completion	Post	Consultant
Director Satisfaction Survey*	Assesses director satisfaction with services	Post	Center/Program Director
Core Classroom Teacher Questionnaire*	Assesses teacher satisfaction with services	Post	Teacher

*Locally-developed measures

Note: See page 91 for more information on standardized measurement tools.

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Intensive Site Screening/Assessment/Service Planning Tools

TOOL NAME	PURPOSE(S)	COLLECTION PERIOD	COMPLETED BY
Five Minute Teacher Survey*	Assesses teacher beliefs and attitudes	Pre	Teachers
Center Demographic Form*	Collect center demographics	Pre	Center/Program Director
Center Policy Reference Form*	Guides the development new/improved center behavioral health policies	Ongoing	Consultant
Center-based Action Plan*	Written plan of work including strengths goals, participants, and interventions	Ongoing	Consultant
Center/Director Service Visit Form*	Activity log; produces forms for each service visit to place in charts	Ongoing	Consultant
Discharge Summary Form*	Specifies reason for and date of discharge/completion	Post	Consultant
Director Satisfaction Survey*	Assesses director satisfaction with services	Post	Center/Program Director

*Locally-developed measures

Note: See page 91 for more information on standardized measurement tools.

Funding

All ECCP services are provided free of charge to the early childhood community. ECCP is primarily funded through DCF’s Early Intervention Prevention Unit, with supplemental funding from SDE for the ECBC component.

NOTABLE PROGRAM FEATURES

1. **Strong public/private partnerships.** From the beginning, ECCP was conceptualized as a partnership and ABH management made a concerted effort to collaborate broadly. Partnerships are evident at all levels, from funding to referral to service delivery. With respect to funding, over the years ECCP has benefited from significant financial support from state agencies as well as private foundations/organizations. This success grew out of relationships that were cultivated over time through personal contact, shared priorities, and ECCP’s demonstrated impact. ECCP management and staff also closely partner with various community providers to ensure that services are complementary, rather than duplicative. For example, ECCP consultants are certified trainers through the statewide professional development and program improvement system, so that ECE providers completing trainings conducted by consultants receive

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professional development credits. Further, ECCP consultants collaborate with other early childhood consultants to jointly support ECE programs achieve NAEYC accreditation. Through collaboration with and support by public and private partners, ECCP has grown and expanded over the years.

2. **Centralized management information system.** As a statewide consultation model, ECCP must balance the need for individualized services with the required level of infrastructure necessary to maintain model fidelity. Part of this infrastructure is the *ECCP Information System*, which was designed by ABH to support program monitoring and continuous quality improvement. Through this system, the Program Manager can track consultant activities and provide support as needed when services fall short of program expectations with respect to quantity and/or quality. In addition, the system generates a number of reports (at both the program and consultant level) that help to guide services, meet funders' reporting requirements, and inform policymakers and other stakeholders. One of the key reports generated by the *ECCP Information System* is the *Action Plan*, which organizes the goals, objectives and hands-on, strengths-based strategies to be implemented for each child-specific, core classroom, or intensive site service. Providers, parents, and consultants alike indicate that these plans are a valuable communications and service-planning tool. From a program management perspective, the *Action Plans* support model fidelity by creating a consistency in approach, communication and intervention on a statewide basis, while also allowing for the individualized needs of the child, family, and/or classroom.
3. **Program Manual.** To guide consultants and other interested stakeholders through the steps and components of ECCP's consultation model, staff developed, "Solid Ground: A Resource for Early Childhood Mental Health Consultation." This program manual is designed to help readers understand:
 - key elements involved in developing and implementing an early childhood mental health consultation program; and
 - the importance of a data driven system in implementing and monitoring a quality program that remains consistent across large geographic areas.

The manual provides a summary of how the program evolved and evaluation findings, as well as descriptions of ECCP services and detailed instructions on the tools and procedures that are components of this model. In addition, *Solid Ground* includes a variety of resource materials including staff job descriptions, training outlines, sample reports, and a listing of relevant websites, books and publications.

EVALUATION EFFORTS AND FINDINGS

Program Outcomes

In 2004, an external, randomized-control evaluation of ECCP was conducted (Gilliam, 2007). It was designed with two cohorts, employing both pre-tests and post-tests using empirically validated measures, including the Conners' Teacher Rating Scale—Revised Long Form (CTRS-R; Conners, 1997) and the Social Skills Rating System (SSRS; Gresham & Elliot, 1990). Treatment classrooms received ECCP services immediately, while control classrooms were placed on a waitlist and received ECCP services within three to four months. It was one of the most rigorous evaluations of an early childhood mental health consultation program to date. Findings from this two-year effort indicated that children in classrooms benefiting from ECCP consultation showed significant reductions in behavior problems, compared to children in classes that did not receive services. Impacts were greatest with respect to decreases in oppositional behaviors and hyperactivity.

Other program outcomes are reported through the *ECCP Information System*. From January 1, 2003 to September 30, 2008, data indicate that:

- Ninety-seven (97) percent of children who were at risk for expulsion/suspension prior to receiving child-specific services were retained in their child care settings.
- Among parents who completed pre- and post CBCLs for children who were borderline or within clinical ranges at the onset of ECCP services, 60% reported improved child outcomes.
- Similarly, 48% of teachers who initially rated children as borderline or within clinical range on the CTRF and who completed pre- and post-tests indicated improved child functioning.
- 69% of classrooms for which ECCP has both pre- and post CLASS scores showed improvement in at least one of the two primary domains—"emotional support" and "classroom management."

The program continues to collect data through its *ECCP Information System* and to report on and hold itself accountable for the following performance outcomes:

- To develop and implement a statewide program that provides mental health consultation services to early child care providers, educators, and families
- Build the capacity of early child care providers and families to more effectively address the social and emotional needs of children ages' birth to five
- Decrease the suspension/expulsion of children with behavioral and social/emotional needs in early care settings, by supporting their inclusion in early child care settings
- Promote and facilitate the early identification of young children's mental health needs and respond with appropriate services and referrals to other service providers, before they escalate and become a mental health, family, or school placement crisis

EARLY CHILDHOOD CONSULTATION PARTNERSHIP—CONNECTICUT: EVALUATION EFFORTS AND FINDINGS

- Help community child care providers, educators, and families understand and promote early childhood mental health, through trainings and support to address concerns raised by and between early child care providers, educators, and families
- Provide linkages to on-going education, social-emotional and mental health services in the community
- Engage in and/or develop community, regional, and statewide collaboratives to support capacity building in the area of healthy social and emotional development for young children

Current/Upcoming Efforts

In 2008, through a competitive application process, Dr. Walter Gilliam was awarded a contract from DCF to conduct a second randomized-control evaluation. This evaluation will examine child, program, staff and family outcomes, using standardized measures including the Classroom Assessment Scoring System (CLASS; Pianta, La Paro, & Hamre, 2008) and the Preschool Mental Health Climate Scale (PMHCS; Gilliam, 2008). Specific areas of exploration include teacher/child interaction, home/school (i.e., child care program) collaboration, and the impact of ECCP's home-based services. The study will use time-sampling techniques and some tools will be administered by observers who are blind to the treatment/control group.

LESSONS LEARNED/RECOMMENDATIONS

- **Data and evaluation are essential.** Consultation programs should build in data collection and evaluation activities into their models to facilitate program services, management, improvement and sustainability.
- **Connecting with the community is key.** It is important for consultants to enmesh themselves in the communities with which they work. ECCP consultants seek to do this in a variety of ways, including participating in local meetings and getting on the boards of key local agencies/efforts.
- **Flexibility in home visiting is important.** Consultants should offer to provide in-home services, but should assess families' comfort level with having a consultant make multiple visits to their homes.
- **The prevention aspect of consultation is powerful.** There is much interest and support for early childhood mental health consultation because of its impact on addressing challenging behaviors in young children and improving their chances for success in school and life. Continuing to raise awareness of this important aspect of consultation contributes to the sustainability of this intervention.

EARLY CHILDHOOD CONSULTATION PARTNERSHIP—CONNECTICUT: LESSONS LEARNED

- **Clarify roles when partnering.** Collaboration with other service providers is an important component of how ECCP approaches service delivery. To achieve effective collaboration and avoid confusion and duplication of effort, it is essential to have clear communication regarding each partner's roles and responsibilities.

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Early Intervention Program Instituto Familiar de la Raza—San Francisco, CA

PROGRAM BACKGROUND

Instituto Familiar de la Raza (IFR) is a non-profit, community-based mental health and social service agency that has focused on meeting the diverse needs of the Chicano/Latino community and other multicultural communities in San Francisco for 30 years. IFR offers a range of services including mental health promotion and prevention services, early intervention, case management, psychological and psychiatric services, mentoring services and cultural/spiritual reinforcement. IFR's mission is to:

- provide a range of mental health and social services;
- support people within the context of their family, culture and community;
- draw from the wisdom and knowledge found in traditional, complementary and conventional healing practices;
- promote and support cultural activities, ceremonies and celebrations; and
- ensure that services are provided by bilingual and multicultural staff who reflect the values of the communities served.

In 1986, IFR began providing mental health consultation through its *Proveedora* Program, which was the first program in San Francisco to provide consultation to Latina family child care providers. Over the years, it expanded its consultation services to include early care and education settings and schools. In 1993, IFR established the Early Intervention Program (EIP) to integrate the agency's various mental health consultation efforts into one program. The individual chosen to lead EIP was a clinician with extensive consultation experience through his work with another local ECMHC program that had a strong relationship-based approach to consultation. He developed IFR's consultation model with the same relationship-based orientation, while infusing a strong cultural framework to meet the needs of IFR's largely immigrant service population.

In 1999, the San Francisco Board of Supervisors channeled funding to the Department of Children, Youth and Families to support eight community-based mental health agencies in their provision of consultation services to early care and education settings. IFR was one of the original eight agencies selected to be part of this city-wide effort—the Early Childhood Mental Health Consultation Initiative (ECMHCI)⁴². The goal of the Initiative is to improve school readiness by building the capacity of caregivers (early care and education providers and parents) to effectively address young children's social and emotional challenges. The San Francisco Department of Public Health (DPH) manages the evaluation of the Initiative, which focuses on child, teacher, parent and ECE program outcomes. All agencies providing consultation services through the Initiative are required

⁴²The Early Childhood Mental Health Consultation Initiative is also referred to as the High Quality Child Care Mental Health Consultation Initiative.

EARLY INTERVENTION PROGRAM/IFR—SAN FRANCISCO, CA: PROGRAM BACKGROUND

to collect and submit data as specified by DPH to inform the evaluation. Promising evaluation findings have helped to grow and sustain this effort. Additional funding from various partners over the years has led to inclusion of more early care and education settings, as well as Family Resource Centers and programs serving children and families who are homeless. At the time of this report, there are 14 agencies providing consultation services as part of ECMHCI.

Although not the focus of this report, it is important to note that IFR also offers school-based mental health consultation to elementary and middle schools in the Mission District. All but two consultants provide services to both early childhood programs and schools.

MODEL DESIGN

Philosophy/Approach to ECMHC

Consistent with the overall vision and mission of IFR, the Early Intervention Program’s approach to consultation focuses on addressing mental health needs within a cultural and clinical framework. The cultural framework is shaped by several core concepts, which EIP’s *Mental Health Specialists* (i.e., mental health consultants) embrace and model as part of their consultation. These core concepts include:

- Cultural empathy: recognition and appreciation of others’ cultures
- Cultural field: culture is the field a consultant/clinician works within and the lens through which all interventions should emerge
- “La cultura cura” (culture heals): wellness exists in the context of spiritual and cultural affirmation, self-determination and mutual interdependence
- “Tu eres mi otro yo” (you are my other self): the focus is on the interdependence and interconnectedness of all beings; “we” not “I”
- Cultural holding: creating an environment that supports and nurtures one’s culture and ensuring that interventions are implemented within the context of that culture

EIP seeks to improve child outcomes by providing supports that will lead to healthier child-adult, adult-adult and child-child interactions and ultimately, more nurturing environments. To this end, EIP consultants employ a variety of strategies that build on the strengths of the children, their caregivers and the communities in which they live. Specifically, consultants strive to:

- increase provider awareness and understanding of child development and early childhood mental health, particularly the impact of caregiver interactions with children;
- increase provider awareness and understanding of how culture impacts developmental processes and individual differences among children;

EARLY INTERVENTION PROGRAM/IFR—SAN FRANCISCO, CA: MODEL DESIGN

- enhance provider capacity to create culturally and developmentally appropriate environments that support children’s social and emotional wellness;
- enhance parents’ ability to foster children’s healthy social and emotional development;
- offer practical tools to enhance strengths and support skill development; and
- foster a sense of community in each program to support high quality learning environments.

As an essential first step in implementing these strategies, consultants put considerable effort toward cultivating their own relationships with programs, providers and parents through mutual respect and collaboration. A central element of fostering these relationships is establishing “confianza” (i.e., the belief that the consultant will respect an individual’s private self and exercise compassion).

Program Scope

Geographic area served: Urban. Primarily, San Francisco’s Mission District and Excelsior District, as well as the Outer Mission area that is on the south edge of the city.

Settings served: Overall, EIP serves settings that have a high percentage of at-risk Latino children and other low-income families. These setting include Early Head Start and Head Start programs; private non-profit early care and education program (only one, which serves a number of homeless children); public-funded early care and education programs that are part of the San Francisco Unified School District; licensed family child care providers; and family resource centers. Consultants do most of their work in the nine Mission Neighborhood Center Head Start programs.

Ages served: Birth through age 5.

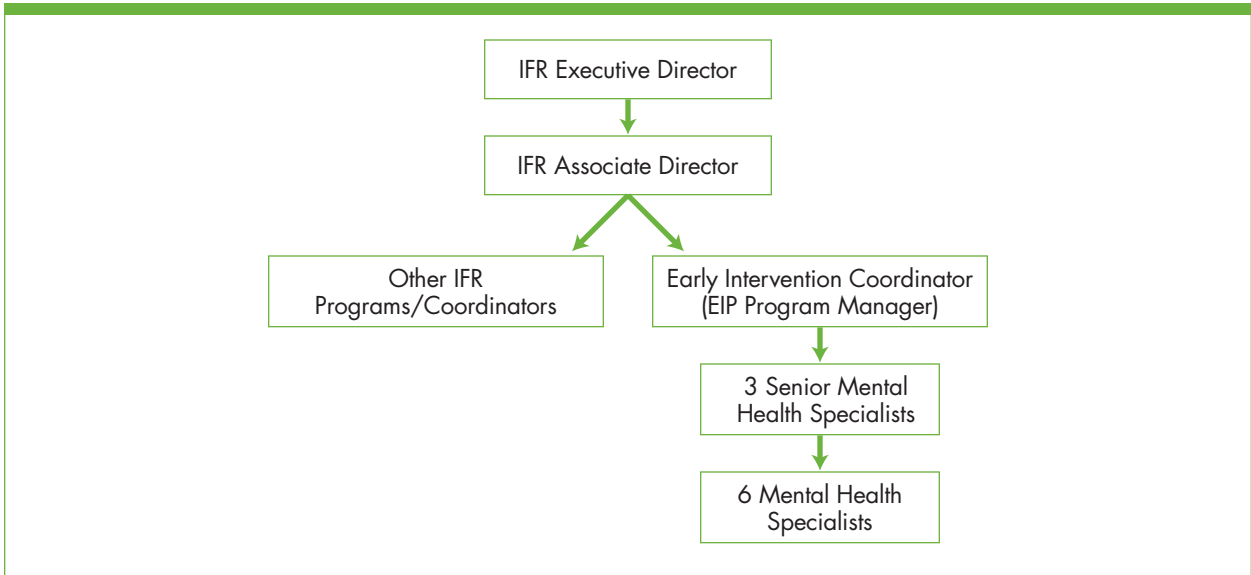
Percent distribution (FY2008)
 Infants and toddlers (under 3): 5%
 Preschoolers (3 through 5): 95%

Annual numbers served (FY2008): 20 FCC homes, 31 classrooms at 15 sites, over 740 children.

EARLY INTERVENTION PROGRAM/IFR—SAN FRANCISCO, CA: MODEL DESIGN

Organizational/Management Structure

EIP is organizationally and physically located within IFR in San Francisco’s Mission District. All EIP staff are full-time and employed by IFR, although funding for their positions comes from various sources. EIP’s program manager provides both administrative and clinical supervision to consultants.



Program Staffing

Staff composition: EIP’s staff is comprised of an *Early Intervention Coordinator* (i.e., program manager), three *Senior Mental Health Specialists*⁴³, and six *Mental Health Specialists*. Two consultants provide consultation to young children exclusively, while the rest of the team also serves school-age children. In addition to her managerial and supervisory roles, the program manager carries a consultation caseload.

Consultant caseload: On average, three sites per consultant (approximately 44 children per site), although the ratio is higher if one or more of the sites is a family child care home, which averages only six children per program.

⁴³A Senior Mental Health Specialist has over eight years of experience and has obtained licensure.

EARLY INTERVENTION PROGRAM/IFR—SAN FRANCISCO, CA: MODEL DESIGN

Consultant Qualifications and Training

EIP consultants must have a master’s degree or higher in social work, psychology or related field and be bilingual in Spanish. Although not required, it is preferred that consultants be bicultural. Other preferred qualifications include mental health licensure; experience and extensive knowledge of mental health practices with young children birth to 5 years old and their families; two-years experience working in child care settings providing both direct mental health services and mental health consultation; experience working with low-income and multicultural communities; and sensitivity to socio-economic and psychosocial issues impacting communities of color.

Newly-hired consultants must complete an intensive four-session orientation/training that is organized around three standardized modules, listed below. A critical objective of the first day of training is to orient new staff to IFR’s history, vision, mission and philosophy. “El espejo” (the mirror), a methodology of spiritual and cultural reflection is used at this orientation.

Session 1: Introduction/Overview

- Overview of IFR and its approach to service delivery
- Overview of the needs in early care and education settings
- Definition of consultation and the roles of the consultant
- Key values and principles of the EIP consultation model
- The “consultative stance” (see Johnston & Brinamen, 2006)
- Important knowledge/skills for consultants
- Common challenges consultants encounter

Session 2: Initiating Consultation

- Key questions for reflection at the onset of consultation
- Evaluating expectations
- Learning about the culture of the center/program
- Overview of EIP services

Sessions 3 and 4: Child Observation and Developmental Norms

- What to observe and how to conduct and interpret observations
 - Child’s cognitive, social/emotional, language, and motor and sensory development through observation
 - Parent-child interaction, teacher-child interaction, and child-child interaction
 - Overall environment

EARLY INTERVENTION PROGRAM/IFR—SAN FRANCISCO, CA: MODEL DESIGN

In addition, new consultants are required to read *Mental Health Consultation in Child Care* (Johnston & Brinamen, 2006) and *Enhancing Relationships Between Children and Teachers* (Pianta, 1999). They are also encouraged to read *Unsmiling Faces: How Preschools Can Heal* (Koplow, 1996) and *Transdisciplinary Play-Based Assessment* (Linder, 2008). New consultants also benefit from shadowing a senior consultant for 1 to 2 weeks. All consultants are provided opportunities to attend other relevant trainings offered outside of the agency.

Consultant Supervision and Support

Reflective individual administrative and clinical supervision is provided to consultants weekly for 1 hour by the program manager. The program manager receives clinical support for the cases she oversees from IFR's Associate Director. In addition, EIP integrates group supervision and support as an integral part of their model. For two hours each week, the EIP team meets for reflective case presentations and didactic seminars. The reflective model (*el espejo*/the mirror) is the core component of the training and parallels the practice of consultation at individual early childhood sites. The model incorporates a strength-based, developmental approach within a cultural framework. The didactic seminars are secondary to case presentations. The team also participates in monthly agency-wide Behavioral Health Team meetings where trainings occur on an array of topics relevant to mental health and cultural competence.

Accessing Services

EIP services are initiated through a Memorandum of Understanding (MOU) between IFR and eligible early care and education programs (see above for settings served). MOUs span 10 to 12 months a year and are renewable. There is no limit on service duration. All providers/programs who enter into a MOU agree to inform staff and parents of the services offered through EIP. Through weekly group and/or individual consultation sessions with the consultant, program staff/providers identify child/family-centered and/or programmatic consultation needs. Occasionally, a parent will contact the consultant directly regarding concerns about his/her child. Parental consent is always obtained before any child-centered services are initiated.

Service Array, Frequency and Duration

EIP provides a variety of services to center-based and family child care providers, including:

- Program and Case Consultation (individual and group)
- Classroom/child observation and home observations (as needed)
- Parent education/support groups
- Provider training
- Case management services (including linkages and referrals)
- Direct services to children and families (e.g., therapeutic play groups, counseling)

EARLY INTERVENTION PROGRAM/IFR—SAN FRANCISCO, CA: MODEL DESIGN

Although direct services are viewed as an important complement to consultation services for the children and families that need them, they play a supportive role to the more systemic, capacity-building interventions that are central to this model.

The cornerstone activity in this model is weekly consultation meetings, which provides opportunities for providers to identify child-focused and programmatic needs and receive ongoing support from the consultant around strategy implementation. These consultation sessions are the primary vehicle through which all other services and supports are determined. EIP consultants work very hard to maintain a consistent time each week for visiting each program and, specifically, for holding these sessions. In center-based settings, these are group sessions that usually take place during naptime or lunchtime. In family child care programs, the sessions are more informal and typically one-on-one.

Typically, consultants spend 6-8 hours per week at each center-based program, although they may increase their allocation up to 16 hours per week for large centers. For family child care programs, consultants strive to visit each provider for two hours a week, but minimally they will make three contacts a month. For child- or family-focused services, frequency and duration varies with need; there is no upper limit placed on the length of time a child/family can be involved with EIP.

Child-centered consultation

When a provider or parent identifies concerns regarding a specific child and parental consent is in place, the consultant will conduct an observation in the classroom and, if amenable to the parents, in the home. The consultant will discuss findings with the parent and provider and then work to collaboratively develop an action plan that addresses concerns and bridges different perspectives. The consultant will also provide ongoing implementation support through weekly consultation sessions with the provider and follow-up meetings or conversations with parents. Consultants are willing to conduct a follow-up session in the home, but it is not routine, and most communication takes place at the ECE program. Depending on the complexity of the child and family issues, the consultant may provide case management. If warranted, the consultant may also recommend direct services such as onsite therapeutic playgroups to improve communication and socialization skills or individual counseling. To avoid role confusion, these services would not be provided by the consultant assigned to the case, but would be referred to another EIP consultant or other local provider.

Family-centered consultation

Through parent support groups, consultants provide information to parents to increase their understanding of early childhood social/emotional health and what they can do to support it. Support groups occur monthly or bimonthly at most sites and topics have included positive discipline, understanding and managing behavior, recognizing signs of anxiety, managing parental stress, and the impact of domestic violence. In some sites, EIP

EARLY INTERVENTION PROGRAM/IFR—SAN FRANCISCO, CA: MODEL DESIGN

consultants also host drop-in hours for parents to discuss concerns and issues. Parent groups organized by family child care programs and facilitated by the consultant usually take place in the providers’ homes in the evening and providers offer a small “refrigerio” (snack) for the parents. In collaboration with the provider hosting the group, the consultant will select a theme or topic to present on and facilitate group discussion.

Programmatic consultation

In addition to sharing more generally applicable strategies (e.g., rearranging the classroom) and modeling techniques during their weekly visits, consultants conduct trainings for providers on a variety of topics, based on provider needs and interest. Some popular topics include developmental norms, red flags, facilitating smooth transitions, understanding difficult behavior and general social/emotional issues in early childhood. For family child care providers, these educational sessions are woven into a monthly community-building/support group or “Charla.” For center-based providers, these trainings are not as frequent. For example, group trainings are offered for all teachers across the nine Mission Neighborhood Center Head Starts at the beginning of the school year during teacher orientation and sporadically throughout the year during in-service days.

Data Collection

To facilitate service planning, EIP consultants use a locally-developed tool to guide their child-specific observations. This tool assesses developmental functioning across various domains, while expanding investigation of social and emotional constructs (e.g., emotional regulation, self-esteem). Further, the tool examines the prevalence of parent/caregiver behaviors that support healthy social/emotional development in young children (e.g., emotional availability, play, empathic responsiveness).

In addition, EIP consultants regularly document all their activities, including the type of activity, the number of children, parents and staff served and any referrals made using a form and systematic coding schema developed for the ECMHCI evaluation. Consultants also collect data on child, family, program and staff outcomes using measures selected as part of the ECMHCI evaluation (see Evaluation Efforts and Findings below).

Screening/Assessment/Service Planning Tools

TOOL NAME	PURPOSE(S)	COLLECTION PERIOD	COMPLETED BY
Observation Guide for Young Children*	Assess child functioning and parent/caregiver support of child’s social/emotional development	Pre	Consultant
Progress notes*	Track activities and progress/outcomes	Ongoing	Consultant

*Locally-developed measures

EARLY INTERVENTION PROGRAM/IFR—SAN FRANCISCO, CA: MODEL DESIGN

Funding

Funding for EIP’s services to young children is primarily provided by the San Francisco Departments of Public Health and Children, Youth & Families, and First Five⁴⁴, through the Early Childhood Mental Health Consultation Initiative. The overall county-wide allocation for ECMHCI for Fiscal Year (FY) 2009 is \$4.6M. EIP’s allocation from ECMHCI for FY2009 is \$556,047. To draw down ECMHCI funds, consultants must bill for the services performed. Additional program funding comes from the Preschool for All⁴⁵ initiative and through billing Medicaid’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for consultants’ direct services to Medicaid-eligible children.

NOTABLE PROGRAM FEATURES**1. Promoting and personifying cultural and linguistic competence**

EIP—and all of IFR’s programs—strive to provide services in a manner that reflects and is respectful of the collective culture being served. Through their work, EIP staff seek to help others apply this same approach to service delivery. Often, the first step is cultural self-reflection and consideration of how culture affects one’s worldview. This introspection, coupled with a heightened awareness and understanding of the cultures of the community being served, helps lead to more appropriate and effective services. Given that most of EIP’s service population is Latino/Chicano, most staff are both bilingual and bicultural, with a firm grasp of the cultural norms and traditions within this community.

2. Engaging family child care providers

IFR has a long history of supporting and engaging Latina family child care providers. By attending to the unique culture of family child care as well as the Latino/Chicano culture, IFR has built and maintained strong ties to this community. They have fostered this relationship through genuine collaboration that reinforces mutual expertise and effectively meets the needs of family child care providers in a culturally competent manner. Strategies that have been successful include regular, ongoing consultation that has strengthened relationships over time; a monthly “*Charla*” or support group; an overnight professional development retreat; regular communication about additional professional development opportunities in the community; assistance, as needed, in identifying ways to cover the expense of local trainings; and providing all services in Spanish by bilingual and bicultural professionals.

3. Nurturing staff personally and professionally

An integral part of staff development and model fidelity in EIP is the weekly Early Intervention team meetings. These meetings create a safe, supportive space for

⁴⁴First Five California, also known as the California Children and Families Commission, is a statewide initiative funded by cigarette taxes and designed to improve the lives of California’s young children and their families through a comprehensive system of education, health services, child care and other key programs.

⁴⁵Preschool for All (PFA) is a city-funded initiative providing universal access to free, high-quality, part-day preschool programs for all San Francisco four-year-olds.

EARLY INTERVENTION PROGRAM/IFR—SAN FRANCISCO, CA: NOTABLE PROGRAM FEATURES

consultants to discuss challenging cases with their peers and clinical supervisor and “wonder” with them to formulate next steps. Through a parallel process, these sessions actively provide clinicians with an opportunity to learn first-hand how to integrate and assimilate the reflective consultant stance. The regular meetings cultivate a positive group dynamic and help to establish trust among team members. They also give the program manager an opportunity to help foster staff growth and adherence to program goals and values. Furthermore, it provides consultants much-needed time for reflection and emotional support. Often it is challenging for clinicians to make the shift from a more traditional, individual service model to a consultation model. These reflective and instructional sessions help facilitate that transition.

EVALUATION EFFORTS AND FINDINGS

Program Outcomes

Since 2001, the San Francisco Department of Public Health has published several ECMHCI evaluation reports focused on assessing the impacts of consultation on social development and problem behaviors among children, as well as providers’ skill development and satisfaction with services among providers and parents. Over the years, the evaluation has employed a number of different empirically validated tools, using a pre/post design and a comparison group. The number and selection of tools varies based on current priorities. For the 2006-2007 grant cycle, only one evaluation tool was selected, the Devereux Early Childhood Assessment—Clinical (DECA-C; LeBuffe & Naglieri, 1999). Findings from this grant cycle had not been published at the time of this report. All consultation programs funded through ECMHCI, including EIP, are required to take part in these evaluation activities.

The most recent published ECMHCI report (2005) presented aggregated findings from the Caregiver-Teacher Report Form (C-TRF; Achenbach & Rescorla, 2000), Preschool Kindergarten Behavior Scales (PKBS; Merrell, 2002), Teacher Opinion Survey (TOS; Geller & Lynch, 2000), and Child Services Survey for Families (CSS; Bleecker & Sherwood, 2004), as well as qualitative interviews with child care directors, site managers and family child care providers receiving services through ECMHCI grantees. The analysis indicated that from baseline (Fall 2003) to follow-up (Spring 2004):

- children receiving services showed significant gains in their social development;
- children receiving services showed significant decreases in their problem behaviors;
- parents/guardians felt very positive about mental health consultation;
- teaching staff felt that services were helpful; and
- child care directors felt that consultants improved their sites in a number of ways, such as heightening family involvement and addressing issues of cultural competence and diversity.

EARLY INTERVENTION PROGRAM/IFR—SAN FRANCISCO, CA: EVALUATION EFFORTS AND FINDINGS

The GUCCHD study team was able to obtain disaggregated (i.e., site specific) data for EIP from the San Francisco Department of Public Health for analysis. The data included pre/post assessments (baseline: Fall 2004; follow-up: Spring 2005) conducted by consultants using the PKBS and conducted by child care providers using the Student-Teacher Relationship Scale (STRS, Pianta, 2001). The dataset also included baseline (Fall 2002) and follow-up (Spring 2003) assessments of adaptive behavior conducted by child care providers using the Socialization Domain of the Vineland Adaptive Behavior Scales (Sparrow, Balla, & Cicchetti, 1995). For all three measures, assessments were completed for a sample of children at each program who were receiving consultation services (i.e., treatment group) and for a comparison group of children who were not receiving such services (i.e., comparison group). The sample size for the PKBS and STRS analysis was 27 treatment and 21 comparison, and for the Vineland analysis was 19 treatment and 17 comparison.

Although the sample sizes were relatively small, the findings from this site parallel the overall findings from the ECMHCI reports. The analysis of these data demonstrated that children receiving EIP services showed:

- greater improvements in social skills than children not receiving services;
- significant reductions in externalizing problem behaviors; and
- greater improvements in age-appropriate play than children not receiving services.

Current/Upcoming Efforts

Beginning with the FY '06-'08 grant cycles, DPH embarked on two new ECMHCI evaluation efforts: a longitudinal analysis of child outcomes and a mental health consultation model study. The former effort is designed to investigate whether or not the benefits of consultation are sustained into kindergarten. Measures included in this study are the DECA-C and two locally-developed tools, the Kindergarten Observation Form (KOF) and the Parent Information Form (PIF). The latter study is designed to better understand mental health consultation services offered through ECMHCI and to explore the extent to which grantees have articulated consultation models and the similarities and differences across those models. Information was collected through qualitative interviews and observation. At the time of this report, data from both studies are being analyzed and prepared for publication.

LESSONS LEARNED/RECOMMENDATIONS

- **Relationship continuity is key.** Relationships are central to the success of any consultation effort and must be nurtured and sustained over time. Thus, EIP's model is designed such that one consultant works continuously with a program/provider each year and strives to establish a consistent visit schedule. When there is a need to change consultants, careful attention is paid to transferring the relationship so that the new consultant can build upon the relational foundation that has already been developed. Further, EIP program management regularly checks-in with the programs/providers they are serving to revisit the efficacy of the model and address any issues. This ongoing communication helps strengthen relationships and the impact of consultation efforts.
- **Consultation programs should focus on finding and exploring cultures.** Cultural awareness and understanding underlies the ability to develop positive relationships and provide culturally competent services. For example, EIP consultants recognize that the Latino/Chicano community is more comfortable when the boundaries between professional and client are permeable and flexible, yet maintain the professional's status as a "doctora" with the expertise to provide needed assistance. Similarly, the strategies that are developed strive to reflect the values and priorities within the community. Often, achieving this balance is not easy because regulations or prevailing societal norms can be at odds with cultural tendencies.
- **Collaboration is essential.** To improve the efficacy of strategies, consultants must collaborate with the children's providers and family members. Collaboration not only establishes a tone of mutual respect and interdependence, but helps lead to individualized interventions and vested interest in implementing the selected strategies. This collaboration should be ongoing and provide opportunities for adjusting strategies as needed until the identified needs have been adequately addressed.

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Early Intervention Project—Baltimore City, MD

PROGRAM BACKGROUND

After meeting for several years, state leaders on the Maryland State Early Childhood Steering Committee identified mental health consultation as one of several priority areas. Promising results in Anne Arundel County (Perry et al., 2008) encouraged a working group to design a pilot project in two counties using quality set-aside funds from the Child Care Development Fund. Funding was also provided for an independent evaluation, and legislation was passed to mandate that evaluation results be shared with the executive and legislative branches. Led by the Maryland State Department of Education, the pilot projects were designed to:

- provide prevention and early intervention services to children and families;
- identify and work proactively with children who may have developmental, social, behavioral, or physical concerns;
- help young children to acquire the social and emotional skills necessary to enter school ready to succeed; and
- refer children and families in need of mental health services to appropriate support programs (Maryland State Department of Education, n.d.).

Baltimore City, an urban, predominantly African-American community, was one of the two pilot sites selected to design and implement a mental health consultation program. After a planning period, the Baltimore City Child Care Resource Center (BCCCRC) began implementation of their Early Intervention Project (EIP) in 2002.

Promising evaluation findings from both pilot sites led to the state's decision to expand consultation to all regions of the state beginning in 2006. EIP is one of twelve consultation programs statewide that comprise the Maryland Early Childhood Mental Health Project, a program funded by a new state allocation of nearly \$2 million. The Project is directed by the Division of Early Childhood Development within the Maryland State Department of Education. Although all grantees are guided by common goals set forth by the State (see above), they are not required to implement the same consultation program model. Funding was allocated to support a comprehensive evaluation of the expanded ECMH Project, including EIP in Baltimore City.

MODEL DESIGN

Philosophy/Approach to ECMHC

EIP's approach to consultation focuses on:

- promoting social and emotional well-being in young children;
- strengthening provider competencies in addressing challenging behaviors; and
- fostering linkages to community supports and services for children who need more intensive intervention.

EIP based this promotion-prevention-intervention framework on The Teaching Pyramid model (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003) developed by the Center on the Social and Emotional Foundations for Early Learning (CSEFEL). The Pyramid organizes strategies and activities into levels that correspond to the social and emotional needs of children (i.e., universal, at-risk, intensive intervention). As such, mental health consultants utilize many of the strategies and materials (e.g., Tucker Turtle, visual cue cards) developed by CSEFEL to complement the Pyramid framework. EIP consultants put considerable effort into providing hands-on, ready-to-use materials for parents and teachers. It is a highly-valued part of their approach to service delivery.

EIP mental health consultants seek to improve child outcomes indirectly by enhancing knowledge and skills around early childhood social and emotional development among child care providers, parents, and community stakeholders. In addition, EIP also strives to decrease the stigma associated with mental health services. Collectively, these strategies are designed to create nurturing environments and to ensure that children needing additional help receive high-quality, developmentally appropriate supports and services as early as possible.

Program Scope

Geographic Urban.

area served: Baltimore City.

Settings served: Early Head Start and Head Start programs, licensed child care centers, public pre-kindergarten programs, and family child care homes in Baltimore City; the majority of services (70%) are provided to center-based programs.

Ages served: Birth to age 6.
Percent distribution (CY2008)
 Infants/toddlers (under 3): 36%
 Preschoolers (3 through 5): 64%

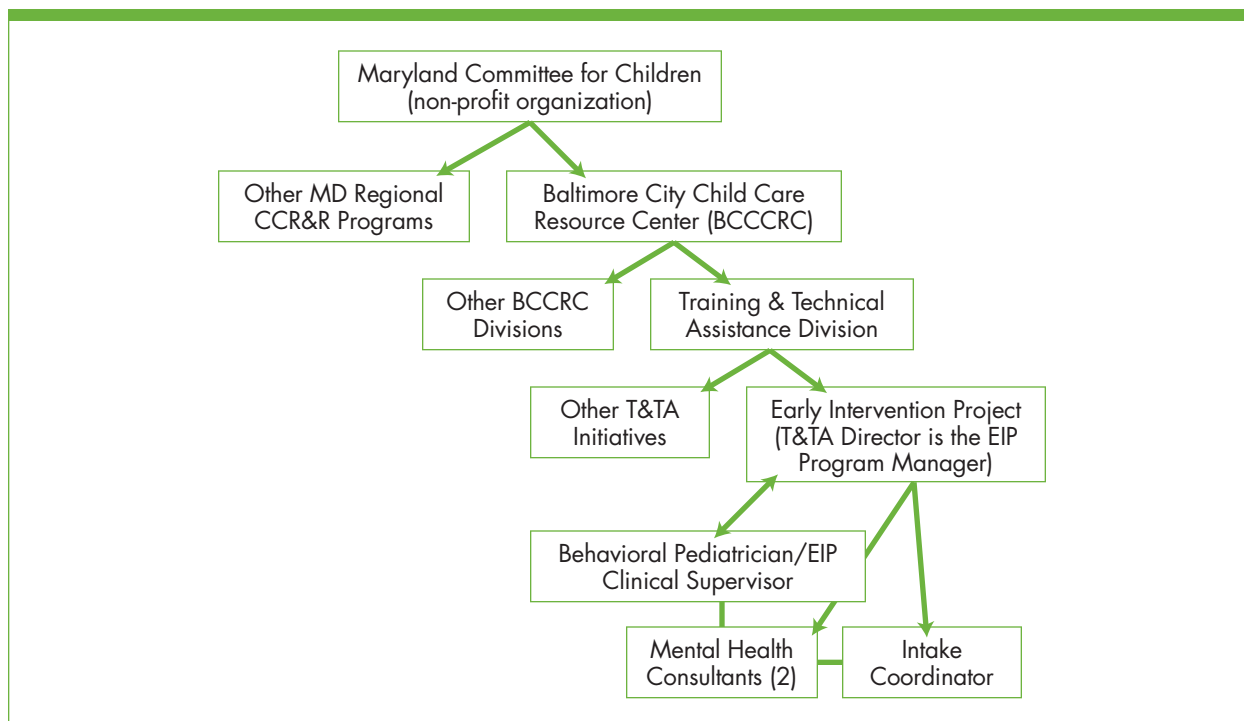
Annual numbers Individual identified children: 50
served (CY2008): ECE Programs with *Partnership Agreements*⁴⁶: 25

⁴⁶Partnership Agreements are Memoranda of Understanding (MOU) between EIP and a child care center/family child care provider that formalize a commitment to partner together for three to six months.

EARLY INTERVENTION PROJECT—BALTIMORE CITY, MD: MODEL DESIGN

Organizational/Management Structure

EIP is housed within the Baltimore City Child Care Resource Center (BCCCRC), a private, non-profit community organization that provides a myriad of services to the local child care community, including trainings for providers and child care locator services for parents. Specifically, EIP is part of BCCCRC’s Training and Technical Assistance Division, with the Division Director serving as EIP’s Program Director. All EIP staff are centrally located at BCCCRC and employed by its parent non-profit organization, the Maryland Committee for Children, with the exception of the Clinical Supervisor, who is on staff at the University of Maryland Medical Center.



Program Staffing

Staff composition: EIP has a small team comprised of a full-time Program Director, part-time Clinical Supervisor, two full-time *Early Interventionists* (i.e., mental health consultants), and a full-time Intake Coordinator, who serves as the single point of entry to the program and fields all referrals. The Clinical Supervisor is a consulting developmental and behavioral pediatrician who allocates 8 hours a week to EIP, providing clinical supervision to the consultants and conducting clinical assessments and child-focused consultation as needed.

Consultant caseload: Caseload sizes vary from 8 to 18 child-focused cases, plus 2 program-level cases. When child-focused caseloads exceed 10, consultants typically have to limit (or temporarily suspend) group provider trainings.

EARLY INTERVENTION PROJECT—BALTIMORE CITY, MD: MODEL DESIGN

Consultant Qualifications and Training

Maryland's State Department of Education (MSDE) established minimum requirements that EIP must adhere to for its consultants, namely consultants must have at least a bachelor's degree in child development, psychology, early childhood education, or special education with a concentration in early childhood, plus previous experience in the field. At the time of this report, one of the two consultants on staff had a master's degree and the other had a bachelor's degree, but was working towards a master's degree.

Although EIP does not require any specific training for consultants as part of their model, consultants typically complete trainings that are recommended to them. Some that are recommended include the Maryland Committee for Children's training on how to be an effective trainer, the CSEFEL training on the Teaching Pyramid model and various statewide trainings offered through the grant. In addition, consultants are encouraged to attend several national training institutes focused on early care and education and early childhood mental health. As part of a statewide effort to build workforce capacity around early childhood mental health, the Maryland Early Childhood Mental Health Steering Committee developed a set of recommended core areas of knowledge that include, but are not limited to, cultural competency, developmental knowledge, adult learning styles, parent-child interaction, multidisciplinary team skills/working with early care and education providers, and managing challenging behaviors.

Consultant Supervision and Support

Administrative supervision is provided by the EIP program director, while clinical supervision is provided by the developmental/behavioral pediatrician. The EIP staff meets weekly as a team for 1 1/2 hours to discuss current and pending cases (i.e., in the midst of the intake process) and other programmatic issues. Clinical supervision takes place in the context of these group meetings as well as onsite within a program; it is relatively informal. With respect to peer support, all consultants involved with Maryland's statewide consultation initiative have the opportunity to attend a monthly peer group meeting, and the EIP consultants often take advantage of these meetings. Within EIP, the consultants also provide peer support to one another, staying in frequent contact by phone or in person, when feasible.

Accessing Services

Referrals come to EIP via phone through a single point of entry: the Intake Coordinator. Primarily, referral calls are made by child care providers for individual child services. The volume of referral calls from family child care providers and center directors is evenly split. When a call is received directly from a parent, the Intake Coordinator first determines if the need is an appropriate match for EIP services. If not, the parent is referred to other services. If so, the Intake Coordinator asks the parent to have the child's child care provider call EIP directly, as services can only be initiated at their request. This process usually goes smoothly and there is rarely a problem getting the providers to make the call.

EARLY INTERVENTION PROJECT—BALTIMORE CITY, MD: MODEL DESIGN

Once the provider contact is made, the Intake Coordinator schedules a face-to-face meeting with the family child care provider or center director to explain EIP's services and review paperwork. Although most providers/centers opt to enter into more formal *Partnership Agreements*, it is not a prerequisite for EIP services. *Partnership Agreements* are Memoranda of Understanding (MOU) between EIP and a child care center/family child care provider that formalize a commitment to partner together for 3 to 6 months. These MOUs clarify roles and expectations and set forth a timeframe that factors in the need to develop new relationships as part of the work. Once a *Partnership Agreement* is in place, a "Partnership Notification" letter signed by the director/family child care provider and consultant goes out to all parents alerting them of the availability of these new services and encouraging them to contact the director/provider if they have any concerns about their child(ren). Currently, there is no limit on how many times a *Partnership Agreement* may be renewed.

In addition to the forms associated with the *Partnership Agreement*, for individual child services, parents must complete a consent form and demographic sheet and both parents and providers must complete the Ages and Stages Questionnaire (ASQ; Bricker & Squires, 1999), Ages and Stages Questionnaire: Social Emotional (ASQ: SE; Squires, Bricker, & Twombly, 2002) and the Devereux Early Childhood Assessment (DECA; LeBuffe & Naglieri, 2002). Providers are charged with notifying *all* parents about EIP's involvement, obtaining the appropriate paperwork from parents whose children will be receiving individualized services, and submitting all paperwork to EIP. Once all paperwork is received, the case is given to the consultant, who schedules an appointment for an initial child-focused observation in the classroom with the ASQ, ASQ: SE and DECA, or classroom-wide observation with the Teaching Pyramid Observation Tool (TPOT; Hemmeter & Fox, 2006), the Arnett Caregiver Interaction Scale (CIS; Arnett, 1989) and a locally-developed classroom environment rating scale.

Service Array, Frequency and Duration

EIP offers three types of services, which providers (center-based and family child care) can access in any combination.

1. **Individual child services** (child-centered consultation)

EIP provides individualized services to young children who have been referred to the program through their child care provider due to behavioral and/or developmental concerns. Individualized services include classroom observation/assessment, team meeting with parent and provider to discuss findings and agree upon a plan of action, development of practical materials and a written plan with strategies for use in the classroom and at home, regular support to provider/parents in implementing strategies, and referrals to other resources as needed. Consultants typically visit each classroom/program for 2 hours each week, although this varies depending on the

EARLY INTERVENTION PROJECT—BALTIMORE CITY, MD: MODEL DESIGN

number of identified children at each setting and the complexity of their cases. Duration of individualized services also varies according to the needs of each child/family; there is no time limitation.

2. **Center-wide training & technical assistance services** (programmatic consultation)
Training and technical assistance services are designed to enhance overall classroom/program environments through individual coaching and group skill-building sessions for providers. Based on findings from classroom-wide and individualized provider assessments, the consultant works with providers/programs to jointly develop a written service plan to address training and technical assistance needs around early childhood social and emotional development. The duration of these services depends upon the size of the child care program and individual provider needs. Furthermore, the extent to which consultants are able to conduct center-wide training sessions does fluctuate depending on their *individual child services* caseloads. Still, regardless of caseload size, consultants are consistently able to infuse programmatic consultation at the individual provider/classroom level through strategies with widespread impact (e.g., recommendations for rearranging the classroom).
3. **Social/emotional community collaborative**
EIP also manages an informal local network designed to keep providers abreast of relevant trainings and resources on social and emotional development and to foster relationships for future consultation referrals or assistance

Consultants typically visit each center/provider for 2 hours each week, although this varies depending on the needs of the children and providers, and how many identified children are at each setting. Caseloads ebb and flow, ranging from 8 to 18 children at any given time per consultant. When caseloads exceed 10 children, consultants have a hard time fitting in opportunities to conduct center-wide trainings and technical assistance sessions. However, programmatic consultation is infused into EIP's approach in other ways. Many of the activities that consultants do with providers to address the needs of a particular child(ren) are broadly applicable to and beneficial for all children in the classroom, e.g., developing visual cues to prompt appropriate behavior, revising classroom routines, and incorporating social stories into circle time.

EIP does not put a limit on the length of time a case may be open. Typically, consultation services continue for 3 to 6 months, ceasing when the child's needs have been met and/or the provider/parent feels things are under control. Cases might also close if a child ages out or is no longer in an eligible child care setting, i.e., due to relocation or removal from licensed child care because of cost issues/expiration of child care vouchers.

EARLY INTERVENTION PROJECT—BALTIMORE CITY, MD: MODEL DESIGN

Data Collection

EIP maintains a basic database on provider, child and family demographics, enrollment/discharge dates, reasons for referral and case closure, and pre/post scores from evaluation tools that are integrated into their service delivery model. Those tools are described in the table below.

Child/Family-Centered Screening/Assessment/Service Planning Tools

TOOL NAME	PURPOSE(S)	COLLECTION PERIOD	COMPLETED BY
Center Data Sheet*	Gather information on center capacity, staffing, accreditation and tiered reimbursement status	Pre	Intake Coordinator (Form is mailed to intake coordinator within five days of initial intake visit)
Individual Child Referral Form*	To facilitate new child referrals from providers who have an established Partnership Agreement with EIP	Pre	Intake Coordinator
Parent/Caregiver Information Form*	Gather demographic information on child and family as well as parents' concerns	Pre	Parent
Devereux Early Childhood Assessment (DECA)	Assess child social/emotional functioning	Pre/Post	Consultant, Parent and Provider
Ages and Stages Questionnaires (ASQ)	Identify children with developmental concerns	Pre/Post	Consultant, Parent and Provider
Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)	Identify children with social-emotional concerns	Pre/Post	Consultant, Parent and Provider

*Locally-developed measures

Note: See page 91 for more information on standardized measurement tools.

EARLY INTERVENTION PROJECT—BALTIMORE CITY, MD: MODEL DESIGN

Program/Classroom-wide Screening/Assessment/Service Planning Tools

TOOL NAME	PURPOSE(S)	COLLECTION PERIOD	COMPLETED BY
Center Data Sheet*	Gather information on center capacity, staffing, accreditation and tiered reimbursement status	Pre	Intake Coordinator (Form is mailed to intake coordinator within five days of initial intake visit)
Teaching Pyramid Observation Tool (TPOT)	Assess classroom environment	Pre/Post	Consultant
Environmental Screening*	Assess classroom environment	Pre/Post	Consultant
Arnett Caregiver Interaction Scale (CIS)	Assess caregiver/child interaction	Pre/Post	Consultant

*Locally-developed measures

Note: See page 91 for more information on standardized measurement tools.

Funding

All EIP services are provided free of charge to children, families and ECE providers in their service area. EIP is funded through the Maryland State Department of Education, Division of Early Childhood Development, Office of Child Care as part of the Maryland Early Childhood Mental Health Project. The total allocation for this statewide initiative was \$1.87M in Calendar Year (CY) 2008. EIP’s annual operating budget for CY2008 was \$150,000.

NOTABLE PROGRAM FEATURES

1. **Community development efforts.** Recognizing the importance of establishing trust and a presence within the Baltimore City provider community, EIP has worked hard over the years to develop relationships through extensive outreach efforts. Specific outreach strategies include:
 - “Cold calls” to center-based and family child care providers to gauge interest in learning about EIP and having a staff member come onsite to explain the program; sometimes staff will also just drop by at local centers or family child care homes
 - Mass mailings to the child care and pediatrics communities with an introductory letter and audience-specific brochure on EIP

EARLY INTERVENTION PROJECT—BALTIMORE CITY, MD: NOTABLE PROGRAM FEATURES

- Brief presentations on EIP at BCCCRC trainings and local conferences
- Attending all orientations for new family child care providers and introducing providers to EIP

Now that the program is better established in the community, word of mouth has also become an effective vehicle for outreach.

2. **Behavioral pediatrician.** It can be very difficult for parents to accept that their young child has social/emotional challenges and/or a mental health diagnosis. Yet, it is clearly an important first step in addressing those issues through consultation or any other intervention method. While EIP’s behavioral pediatrician complements the consultation team in a number of ways, one of the areas of greatest impact is around parent engagement. For some parents, the message regarding the need for intervention has more credibility when delivered by a doctor, leading to greater acceptance and willingness to collaborate on a plan of action. The behavioral pediatrician that is part of the EIP team meets with parents to help facilitate this conversation and, in collaboration with the assigned consultant, helps to guide service planning as needed.
3. **“Cultural Broker.”** Cultural brokers help ease people into each other’s cultures. Although no one at EIP has the job title “cultural broker,” this is an important yet unofficial role that the Intake Coordinator plays. The Intake Coordinator is typically the first person that individuals meet when initiating services with EIP. The Intake Coordinator has deep roots in the Baltimore community and, at the time of this report, is the only EIP staff member of the same cultural background as the majority of providers seeking and receiving services through EIP. In addition, through her twenty years of experience in family child care, she has firmly established relationships in the local child care community. Thus, her involvement from the beginning goes a long way in establishing the program’s credibility and paving the way for a positive working relationship between the EIP consultant and provider.

EVALUATION EFFORTS AND FINDINGS

Program Outcomes

The pilot project evaluation funded by the Maryland State Department of Education (Perry, 2005) employed a participatory action approach that engaged key stakeholders in the evaluation’s design and implementation. Core data elements and tools were selected that aligned with the logic models jointly developed by key stakeholders from the two pilot sites and the external evaluator. The resulting tools implemented by EIP included the Preschool Kindergarten Behavior Scales (PKBS), an empirically validated measure, and a locally-developed observation measure designed to assess classroom environment. Data was collected on 98 children receiving EIP services, with 42 children having complete pre/post data for analysis.

EARLY INTERVENTION PROJECT—BALTIMORE CITY, MD: EVALUATION EFFORTS AND FINDINGS

The overall evaluation revealed positive outcomes across both pilot sites, including the fact that nearly 90% of young children at highest risk for expulsion were maintained in their child care placement. Only two children receiving EIP services were expelled during the three-year pilot. Further, children receiving EIP services showed significant improvement on the following domains from intake to case closure, as measured by the PKBS:

- Decreases in problem behaviors: 71% to 36% (69% improved)
- Decreases in internalizing behaviors: 59% to 29% (67% improved)
- Decreases in externalizing behaviors: 69% to 33% (71% improved)
- Improvements in social skills: 53% to 31% (76% improved)

EIP services also led to enhanced classroom/program environments, as indicated by improvements from intake to discharge on all items included in EIP's classroom environment measure. This locally-designed observation tool assessed the following program and staff outcomes:

- Provider interacts frequently with children showing affection and respect
- Provider uses positive approaches to help children behave constructively
- Provider's expectations of children's social behaviors are developmentally appropriate
- Children are encouraged to talk about feelings and ideas instead of solving problems with force
- Developmentally appropriate hands-on activities for children are provided to 1) foster positive self-concept, 2) develop social skills, 3) encourage child to think and ask questions, 4) encourage creative expression, and 5) encourage communication skills
- Provider conducts smooth transitions between activities (Perry, 2005)

Current/Upcoming Efforts

In 2008, the Maryland State Department of Education set aside funds for a three-year study to assess the impact of the thirteen-site Early Childhood Mental Health Project. Researchers from the University of Maryland and Georgetown University are partnering to document the different models that local sites are implementing and examine the efficacy of these models in:

- reducing expulsions from child care;
- increasing children's positive behavior;
- decreasing children's problem behavior;
- changing teachers' behaviors and attitudes;
- changing the emotional climate of the child care environment; and
- changing parents' behavior management practices.

LESSONS LEARNED/RECOMMENDATIONS

- **Building relationships takes time.** EIP learned early on that developing the level of trust and respect needed to be successful in this work takes time. Thus, after its first year in operation, the program shifted its approach from providing short-term (3 to 4 week) infusions of consultation to establishing longer-term (3 to 6 month) and formalized *Partnership Agreements* that afforded time for relationships with providers, children and their families to grow.
- **Timeliness of service initiation is key.** Responsiveness is important, particularly when parents and providers reach out for services for the first time. To ensure that those needing services receive them as quickly as possible, EIP designed their model such that an intake coordinator triaged all requests/inquiries and conducted the first visit to introduce services and collect all required paperwork (e.g., consent forms). This lightened the consultants' workload, enabling them to spend more time on service delivery and less time on the important, but time-consuming, administrative tasks associated with service initiation.
- **Linkages to the child's home setting are important.** Although EIP has always worked hard to engage and partner with families, the model is designed such that contacts take place at the child care setting or via telephone. Over time, staff members have recognized the need for a home visiting component to better inform assessments, support strategy implementation, and optimize outcomes. As such, EIP is moving towards refining their model to incorporate four one-hour in-home sessions with parents/family members.
- **Persistence is critical.** When attempting to initiate services, consultants often encounter resistance on the part of providers or family members. Instead of getting discouraged, consultants must be tenacious in their efforts to find the "common ground" that will allow the collaboration to move forward.
- **Start slow.** ECMHC programs take a while to flourish, in large part because of the need to develop relationships in the community to seed referrals and critical partnerships. Program administrators, funders and others with vested interests in new consultation programs should be aware of this slow start-up trajectory and plan accordingly.
- **Develop a network of experts.** EIP worked diligently to develop working relationships with numerous organizations/individuals (e.g., Kennedy Krieger Institute, Johns Hopkins University) that could provide clinical services and supports beyond those offered through their consultation program.

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Kid Connects—Boulder, CO

PROGRAM BACKGROUND

Kid Connects began in 1997 as one of two mental health early intervention pilot programs in Colorado funded by the state legislature. Inspired in approach by the Daycare Consultants/Infant-Parent Program⁴⁷ in San Francisco, the focus of the pilot project was to prevent severe emotional and behavioral problems from escalating and reduce the number of children in out-of-home placement. The pilot phase lasted until 2002, with Boulder's program working independently and in parallel with the other pilot site in Denver. Both pilot sites took part in an extensive evaluation, which demonstrated positive outcomes including improvement in classroom quality, staff-child interaction scores, teacher satisfaction and reduction in emotional disturbances (Gould, 2000).

These positive outcomes helped to secure additional funding to sustain the effort and led to expansion of services. In 2002, Kid Connects expanded its model to serve family child care homes and integrate health screenings. As a result, it was awarded a State Innovation Grant from the U.S. Department of Health and Human Services. Within that same timeframe (2002-2003), Kid Connects staff visited the Infant-Parent Program in San Francisco and was inspired to further adapt their model to more intentionally and consistently deliver services and focus on outcomes in a relationship-based approach. Currently, Kid Connects is supported through federal funds, state funds (Temporary Assistance for Needy Families [TANF]), and local foundation dollars (Colorado Health Foundation, Temple Hoyne Buell, Pajwell Family Foundation).

In 2007, based in part on Kid Connects' success, the Colorado Department of Human Services received \$1.1 million in state dollars to fund one early childhood mental health consultant (called *Early Childhood Specialists*) in each of Colorado's 17 community mental health centers, including the Mental Health Center serving Boulder and Broomfield Counties, where Kid Connects is housed. These *Early Childhood Specialists* are charged with providing early childhood mental health services to non-Medicaid children and increasing the capacity of the mental health centers to offer early childhood mental health services within the array of mental health center services and in the communities that they serve⁴⁸. The *Early Childhood Specialist* in Boulder is part of the Kid Connects consultation team.

Well-established in the Boulder community, Kid Connects is currently working with North Range Behavioral Health in Weld County, CO in an effort to replicate the Kid Connects model there.

⁴⁷Daycare Consultants, a component of the Infant-Parent Program (IPP) at the University of California, San Francisco, provides consultation services to early care and education programs and training for individuals interested in becoming consultants. For more information go to <http://infantparentprogram.org/> or see page 198 of this report.

⁴⁸For more information, go to http://www.cdhs.state.co.us/dmh/programs_early-childhood.htm

MODEL DESIGN

Philosophy/Approach to ECMHC

Kid Connects is a mental health consultation model integrating mental health, primary health care and early education through mental health consultation, health care screenings, and coordination of referrals and follow-through. Kid Connects uses a relationship-based approach supported by the science of early child development and the centrality of relationships for positive child outcomes (National Research Council and Institute of Medicine, 2000). This approach also embraces core values including flexibility in responding, humility and integrity, honoring every story, focusing on possibilities, and generosity.

Consultants deliver clinically-based, developmentally-appropriate services in early care and education (ECE) settings and homes. Consultants offer a wide variety of services to all children on a prevention basis and provide targeted services to children who need additional support. The goals of Kid Connects are:

- to improve health, developmental and mental health outcomes for children in child care settings;
- to reduce expulsions from child care settings; and
- to improve the capacity of caregivers to respond to the social and emotional needs of very young children.

Kid Connects provides consultation to build ECE providers' and parents' capacity to understand and respond to the social and emotional needs of young children. This includes infusing social and emotional development into all settings and working at various levels—from prevention/early identification to intervention.

The key values and philosophical foundations for Kid Connects include:

- mental health is integral to optimal development of young children;
- mental health consultation for young children must focus on relationships and strengths;
- young children are best served within natural relationship contexts—including early care and education settings and their families; and
- caregivers, including parents and ECE providers, are experts in their own right and consultation must value and validate caregiver expertise.

KID CONNECTS—BOULDER, CO: MODEL DESIGN

Program Scope

Geographic area served: Boulder and Broomfield Counties, CO.

Settings served: To be eligible for services, children must be enrolled in a community-based child care center or family child care home that serves at-risk populations (i.e., accepts state child subsidy or at-risk preschool subsidy), although there are no income restrictions on eligibility. The majority of services are provided to private (for-profit or non-profit) center-based child care settings.

Ages served: Birth through age 5.
Percent distribution (FY2008)
 Infants and toddlers (under 3): 50%
 Preschoolers (3 through 5): 50%

Annual numbers served (FY2008): 72 children received child/family-centered services (23 of whom received Intensive Intervention services); 321 children received programmatic/classroom-wide services; 7 child care centers and 5 family child care homes received consultation; 90 parents and 100 ECE providers were trained via group trainings (Kid Connects, 2008).

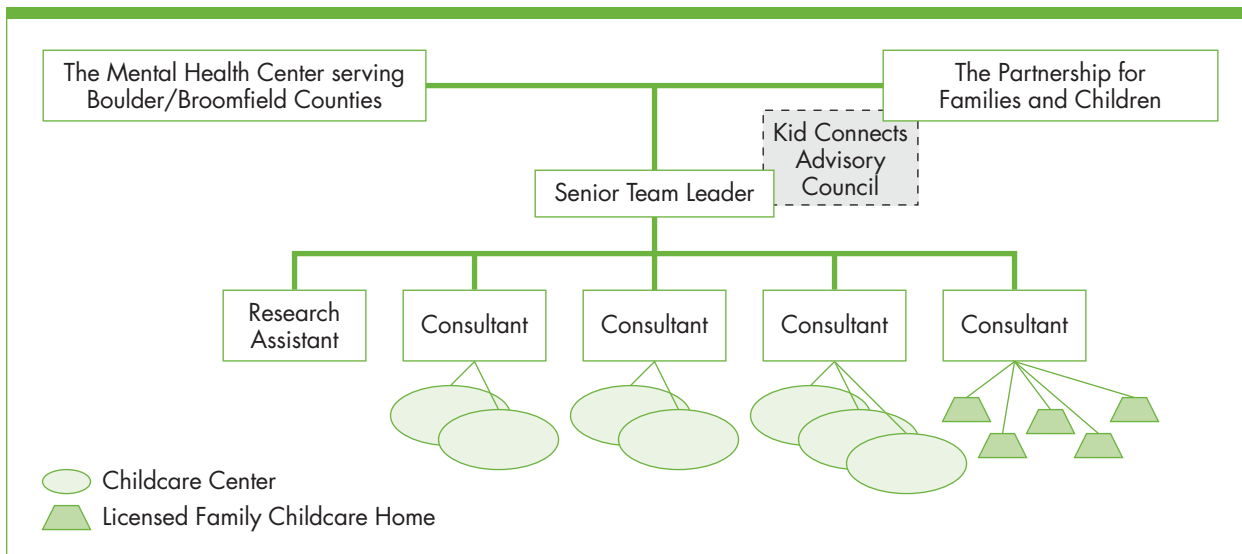
Organizational/Management Structure

Kid Connects is physically located within The Mental Health Center serving Boulder and Broomfield Counties and all Kid Connects staff is employed by the Center. In July 2008, the Partnership for Families and Children (PFC), formerly known as the Colorado Foundation for Families and Children, was designated as the administrative and fiscal home for the program as well as the central hub for statewide replication and dissemination of the Kid Connects model. This arrangement will extend at least through June 2010.

The newly formalized Kid Connects Advisory Council is comprised of members representing Kid Connects, the higher education system, PFC, the State of Colorado Division of Behavioral Health and Division of Child Care, the Early Childhood Councils in Colorado, Invest in Kids,⁴⁹ the Colorado Department of Public Health and Environment, a mental health advocacy group, and parents. Together, this Council works to understand and address high-level policy, funding opportunities, and strategies that may guide and influence plans for replication of Kid Connects. In addition, the Council provides guidance on issues related to intellectual property (for Kid Connects program features and publications) and linkages with other early childhood mental health consultation efforts in the state.

⁴⁹Invest in Kids is a nonprofit organization that endorses evidenced-based models and serves as a statewide catalyst and resource for communities interested in implementing the Nurse-Family Partnership program & Incredible Years.

KID CONNECTS—BOULDER, CO: MODEL DESIGN



Program Staffing

Staff composition: Kid Connects’ staff is comprised of a Senior Team Leader, who acts as the director for Kid Connects and supervises one research assistant and four mental health consultants, three of whom are full-time and one who is a .75 full-time equivalent (FTE). The research assistant is responsible for data management for program service recording/reporting and evaluation. Three of the consultants provide services to community-based child care centers while the fourth serves family child care homes. One of the consultants is the state-funded *Early Childhood Specialist* (see above). This consultant must meet state requirements for this position, but delivers services according to the Kid Connects program model. In addition, there are two other consultants (one at .30 FTE and one at .25 FTE) with whom Kid Connects subcontracts for specific services; these individuals are not considered formal staff members. The specific services include support to the Early Childhood Council’s School Readiness initiative by coaching and mentoring teachers in their use of the SECOND STEP violence prevention curriculum (Committee for Children, 2003) and providing an abbreviated Kid Connects approach to a high needs center and offering classroom consultation and family outreach.

Consultant caseload: The three full-time consultants each work with 2-3 large centers and approximately 120-180 children. The .75 FTE consultant serves 5-7 home providers, collectively serving 50-75 children. Consultants carry an active caseload of between 8-12 children and families receiving intensive child/family-centered consultation (i.e., *Intensive Intervention*) at any one time. The state-funded *Early Childhood Specialist* consultant has a slightly higher caseload of 12-15 children and families, as required for that position.

KID CONNECTS—BOULDER, CO: MODEL DESIGN

Consultant Qualifications and Training

Qualifications for mental health consultants were developed based on requirements set forth by The Mental Health Center serving Boulder and Broomfield Counties and input from the Kid Connects Senior Team Leader. The essential qualifications include:

- Master's degree or higher in social work, psychology, or a related field
- Knowledge of early childhood mental health
- Experience in a clinical setting
- Experience in early care and education
- Experience working with young children and families
- Experience working in a collaborative setting
- Familiarity with child care industry
- Clinical license preferred

New consultants receive training that includes orientation to the model, guidance on the consultation approach, training on assessment/evaluation tools and program documents, and essential readings such as the *Kid Connects Replication Manual* (Kid Connects, 2009), the *Mental Health Consultation Resource and Sustainability Toolkit* (JFK Partners, 2006), *Mental Health Consultation in Early Childhood* (Donohue, 2000) and *Mental Health Consultation in Child Care: Transforming Relationships with Directors, Staff, and Families* (Johnson & Brinamen, 2006). In addition, new consultants have the opportunity to shadow an experienced consultant in order to observe the model and consultation in action.

Consultant Supervision and Support

The Senior Team Leader provides administrative and clinical supervision to all consultants on a weekly basis and orientation and staff development to all new consultants. In addition, consultants meet for peer supervision, led by a senior consultant, twice a month, with a focus on case conferences and reflective practices.

Kid Connects uses a checklist from the *Mental Health Consultation in Early Care and Education Resource and Sustainability Toolkit* (JFK Partners, 2006) to identify core knowledge and competencies for consultants and to help guide consultant supervision and staff development. Ongoing staff development and training is provided on early childhood development, work in early care and education settings, consultation skills, early childhood diagnosis and intervention, and other relevant topics.

KID CONNECTS—BOULDER, CO: MODEL DESIGN

Accessing Services

Access to Kid Connects services is supported by outreach efforts throughout Boulder County, including participation in local advisory groups, close working relationships with other agencies, presentations at ECE provider gatherings, posted flyers in the community, and word of mouth. For child care centers or family child care homes with whom Kid Connects begins a working relationship, an interview process and readiness assessment is conducted by the Senior Team Leader to clarify Kid Connects services and mutual expectations. Once contracted with a center or home, Kid Connects assigns a consultant, and the consultant introduces him/herself to the director and program staff, provides a letter of introduction to Kid Connects to be given to all parents in the program, and provides a picture and personal introduction of him/herself to be posted in a prominent location in the center or home. The center/home director distributes and collects general consent forms from parent at the initiation of child care services. By signing these forms, parents acknowledge that they have been informed that the consultant will be in the ECE setting, interacting with children and discussing children's needs with providers. This allows for program-level services and general consultation regarding children in care. Separate health permission forms and Health Insurance Portability and Accountability Act (HIPAA) notification are completed prior to any health screenings. In addition, notification with opt-out provisions is provided to families prior to the formation of specific social skills groups.

Early care and education providers can initiate child/family-centered services by talking with a family about their child and their concerns, talking to the consultant about the concerns and planning next steps for contacting the family, or having the ECE director encourage the parents to work with the consultant. Families who self-refer can work with their ECE provider to initiate the referral or call Kid Connects directly.

The initial face-to-face contact and subsequent meetings may occur in the ECE setting, the family home, or a neutral location identified by the family. During the first contact, the consultant gathers information about the family, the child, their concerns, risk factors, and other information needed to complete the intake assessment and the *Colorado Client Assessment Record*⁵⁰. As part of the information gathering and intervention planning, the consultant works with the family and ECE provider to complete a Devereux Early Childhood Assessment—Clinical (DECA-C), makes observations of the child in the home and ECE setting, and supports a planning process that reviews strengths and concerns, identifies goals and strategies, and results in a written *Action Plan*. Families who receive *Intensive Intervention* services must agree to be registered with the community mental health center. All providers receive programmatic services on a weekly basis. Initial priorities are discussed between the

⁵⁰Colorado Client Assessment Record, a document designed and used by Colorado's public mental health system for tracking client and service data as well as information on cost benefit and other more complex kids of research questions. For more information go to http://www.cdhs.state.co.us/dmh/de_CCAR.htm

KID CONNECTS—BOULDER, CO: MODEL DESIGN

director and consultant using a *Mutual Goal Setting* document, but the intent of the model is to be responsive to needs as they arise while making overall progress on skill enhancement of the providers.

Service Array, Frequency, and Duration

The service array provided by Kid Connects consultants includes health care screenings (in partnership with the Boulder County Public Health partners) and mental health consultation for young children in early care and education settings.

Health Care Screenings

Nurses and nurse assistants conduct health care screenings through a formal collaboration with Boulder County Public Health. The mental health consultants work with parents to encourage them to complete the Ages and Stages Questionnaire (ASQ), which screens for children's developmental issues, and to follow up on any identified health issues. Overall, children are screened for vision, hearing, dental/oral health, and development.

Mental Health Consultation

Mental health consultation involves two tiers of consultative services: program-based services and child-specific services.

- **Program-based** services involve consultation to center directors and staff regarding child development, strategies to handle challenging behavior, overall classroom environment, and appropriate practices. Consultants are available to respond to caregivers' stress as it impacts their emotional availability to children in their care. Health screenings are included in program services. These services benefit all children.
- **Child-specific** services include direct involvement with specific children and consultation with the parents and teachers of those children on reducing challenging behavior and encouraging social and emotional competence in that particular child. These services may include working with the child individually or in a small group and may also include referral for evaluation and treatment of related developmental issues. In child-specific services, there is no fixed number of visits per referral. Within child-specific services, there are two levels:

– *Intensive Intervention* services:

In *Intensive Intervention* services, children receive individual and specific mental health intervention, which may include formal therapy, designed to address concerns arising in the classroom and/or at home. Parents specifically consent to this level of services and can expect regular contact from the consultant. Many of the parent meetings will occur in the family home. Information about the child, family, and plan for interventions is collected from both the parents and the teachers. Observations of the child are completed in the home and the ECE setting. The child is enrolled as a mental health center client. Parents and teachers work closely together to develop and implement effective strategies to help the child and family.

KID CONNECTS—BOULDER, CO: MODEL DESIGN

– *Prevention Plus* services:

In *Prevention Plus* services, families receive a minimum of 3 service hours over the course of the year. These families benefit from consultation services including parent and teacher meetings, observation and intervention for the children, as well as referrals and case management. Families may also be classified as *Prevention Plus* when parents are unwilling to have a mental health center case opened but give permission for the consultant to assist the teacher in addressing the child’s needs in the classroom.

In their work, consultants also utilize evidence-based and promising practices such as materials from the Center on the Social and Emotional Foundations for Early Learning (CSEFEL)⁵¹ and the Committee for Children’s SECOND STEP⁵² social skills and violence prevention curriculum.

In general, eighty percent of a consultant’s time is spent providing direct consultation services (as opposed to case management). On average, a consultant will provide onsite services to a center/program twice a week for a weekly total of 16-20 hours. For family child care homes, a consultant will spend, on average, 4 hours per home each week providing onsite services. Both settings require additional time for indirect or case management services and planning, including resource development, training preparation, etc.

As part of the program scope, the Kid Connects model includes a 2-year limit on services to any one center or family child care home. This 2-year limit is intentionally long, but limited, anticipating that:

- a center or family child care home will benefit from consultation services, and over time, learn strategies to support social and emotional development and address challenging behavior so that they will be able to apply what they have learned independently, without the support of a consultant; and
- Kid Connects will identify new centers or family child care homes to serve that will meet Kid Connects’ “readiness” criteria and can benefit from mental health consultation.

These terms of service are negotiated at the time of contracting with a center or family child care home to participate in Kid Connects services. A transition process at the end of two years includes anticipatory discussions and planning; leaving the center or home with a book of resources; providing forms used for observations, etc. to support them

⁵¹Center on the Social Emotional Foundations of Early Learning (CESEFL) is a national resource center funded by the Office of Head Start and Child Care Bureau for disseminating research and evidence-based practices to early childhood programs across the country. For more information, go to <http://www.vanderbilt.edu/csefel>.

⁵²SECOND STEP violence prevention program integrates social and emotional learning with academics. Kids from preschool through Grade 8 learn and practice vital social skills, such as empathy, emotion management, problem solving, and cooperation. For more information visit <http://www.cfchildren.org/programs/ssp/overview>.

KID CONNECTS—BOULDER, CO: MODEL DESIGN

after the consultant's departure; and fielding periodic calls. If a crisis occurs, Kid Connects will respond with as much support as possible, including facilitating linkages to community resources

Data Collection

Each Kid Connects consultant is responsible for gathering both quantitative and qualitative data on a regular basis to track information such as population demographics, consultant activities, referrals, and expulsion rates, as well as assess impact through pre/post measures on child, family and staff outcomes. (For a complete list of measures, see page 179.) The data is submitted to the administrative office where the Research Assistant (RA) enters the data, and analysis is completed by the Senior Team Leader and RA. The data is used to review program service delivery and model fidelity, as well as to inform service planning, program improvement, and staff development.

Funding

ECE programs do not pay any portion of service cost. A variety of state and local funders support Kid Connects. In Fiscal Year (FY) 2009, these funders contributed at the levels indicated below:

- Department of Human Services—Social Services, TANF reserves (\$297,518)
- Department of Human Services Early Childhood Services (\$68,828)
- Local Foundations (\$65,000)

Kid Connects' total operational budget for FY2009 is \$431,346.

NOTABLE PROGRAM FEATURES

1. **Integrated health screening and follow up.** Kid Connects has a partnership with Boulder County Public Health that supports the integration of health care screenings into the consultation model. The public health nurses and consultants work together to educate providers on the interplay of primary health and mental health, and encourage parents to have their children participate in health screenings. The nurses complete the health screenings (vision, hearing and dental), and the consultants have the parents complete the Ages and Stages Questionnaire (ASQ) developmental screening. Consultants receive the screening results and recommendations, then support families in making follow-up appointments and seeking further assessment and/or treatment. The results of this partnership are high participation in health screenings, early identification and eligibility for Early Intervention services, and high follow through on referrals.
2. **Early Care Site Readiness Assessment tool.** Kid Connects serves child care centers and family child care homes that serve, to some degree, at-risk populations (i.e., those that accept state child care subsidy or at-risk preschool subsidy). Kid Connects completes

KID CONNECTS—BOULDER, CO: NOTABLE PROGRAM FEATURES

a readiness assessment for centers that may be interested in mental health consultation. The *Kid Connects Early Care Site Readiness Assessment* tool describes model elements, the importance of fidelity to the model, and readiness/lack of readiness indicators. Through an interview process and rating by the interviewer affiliated with Kid Connects, an early care and education program or site is determined to be ready for mental health consultation services based on demonstration of need, interactions, environment, parent/home connections, expulsion and at-risk protocols, interest in/expectations of mental health consultation services, and readiness to partner. Rating categories include: 1) Administrative Support for Mental Health Consultation, 2) Current Practices, 3) Flexibility of Programming to Incorporate Mental Health Consultation, and 4) Readiness for Partnership with Mental Health Consultation. Once determined to be ready, a site is required to complete a *Letter of Commitment to Participate*, co-signed by the child care Director and the Kid Connects Team Leader. If determined not to be ready, a site may be offered guidance and support to improve their readiness in the future.

3. **Replication manual.** Kid Connects is developing a replication manual as a guide for new communities planning to replicate the Kid Connects model. Informed by the experience of the first replication site in Weld County, CO, the manual will include an overview of mental health consultation and a guide to key implementation elements of the Kid Connects service model, including: project staffing, community partners, site-specific implementation, and program evaluation. Another section of the manual will address topics related to sustainability of a service system including: advisory council, advocacy, funding recommendations, and social marketing. A final section will provide information on tools, contacts and resources, critical definitions, and relevant references (Ash, 2009). The manual will also include intervention and consultation prescriptions. Completion is anticipated for later this year.

EVALUATION EFFORTS AND FINDINGS

Program Outcomes

As part of the initial pilot effort that launched Kid Connects, both pilot sites (Boulder and Denver) participated in an extensive evaluation. Aggregated findings from these two programs using pre/post data provided by teachers and parents using the Devereux Early Childhood Assessment—Clinical Form (DECA-C) indicated that:

- Over 32% of children who received intensive intervention services showed an improvement in behavioral concerns
- According to teachers, 21% fewer children had scores in the concern range on total protective factors or mental health functioning after services
- According to parents, 28% of children showed an increase in strength ratings after receiving services (Colorado Department of Human Services, n.d.)

KID CONNECTS—BOULDER, CO: EVALUATION EFFORTS AND FINDINGS

Kid Connects’ continues to collect evaluation data, integrating data collection into their program model. Consultants gather qualitative and quantitative data by completing a variety of forms, submitting process data, and administering specific pre- and post-measures. These data are submitted to the Kid Connects administrative office where the Senior Team Leader and the Research Assistant analyze the data.

The current evaluation effort is focused on the following core outcomes for children, families, and ECE staff:

CHILDREN	FAMILIES	COMPLETED BY
<ul style="list-style-type: none"> • Increased protective factors • Reduced concerning behaviors • Improve school readiness • Prevention of expulsions 	<ul style="list-style-type: none"> • Greater understanding of their child’s social emotional needs and development • Greater skills in responding effectively to their child’s social emotional needs • Reduced caregiver stress • Increased access to health care for their children and families 	<ul style="list-style-type: none"> • Greater understanding of the social emotional needs and development of children in their care • Greater skills in responding effectively to social and emotional needs • Increased self-efficacy • Decreased staff stress

(Trierweiler, 2008)

Kid Connects uses the measures/instruments listed in the table below to plan services and measure program outcomes. The first five measures are used with the children and families receiving *Intensive Intervention* services. The next two measures in the table are used with all children impacted by *program-based* services and *Prevention Plus* services. The last two measures in the table are used with all early care and education providers.

KID CONNECTS—BOULDER, CO: EVALUATION EFFORTS AND FINDINGS

TOOL NAME	PURPOSE(S)	COLLECTION PERIOD	COMPLETED BY
Devereux Early Childhood Assessment—Clinical (DECA-C)	Assess child social/emotional functioning and behavioral concerns	Pre/Post	Parents Teacher
Colorado Client Assessment Record*	Mental health risk factors and disposition	Pre/Post	Consultant
Monthly Director Interview*	Risk of expulsion and identify expulsions	Monthly	Consultant
Parenting Stress Index (PSI)	Identify parental level/experience of stress	Pre/Post	Parents
Consumer Satisfaction Survey*	Parental experience of consultation/satisfaction	Post	Parents
Health Process Data*	Health/developmental screening	At screening and intervention	Consultant/ Health Partner
Devereux Early Childhood Assessment (DECA)	Assess child social/ emotional functioning and design classroom strategies; school readiness	Pre/Post	ECE Provider/Staff
Teacher Opinion Survey (TOS)	Sense of efficacy	Pre/Post	ECE Provider/Staff
End of Year Consultation Survey*	Consultation quality	Post	ECE Provider/Staff

*Locally-developed measures

Note: See page 91 for more information on standardized measurement tools.

Based on current research efforts, including qualitative and quantitative data, the child-related program outcomes for FY2008 are listed below. Findings are derived from data that was available for 321 children who received services during FY2008, including 29% of children that received some level of *child-specific* services, and 24% of children who received either *Prevention Plus* or *Intensive Intervention* services.

- 40% of children who received *Intensive Intervention* showed improvement in behavioral concerns as assessed by the DECA-C, according to teacher ratings
- 19 of 20 children at risk of expulsion were maintained in their ECE setting with Kid Connects supports
- Over 96% of children were rated in the typical or strength range for total protective factors in the DECA post-test measure, representing a 12% increase from the pre-test measure.

KID CONNECTS—BOULDER, CO: EVALUATION EFFORTS AND FINDINGS

Current/Upcoming Efforts

In 2008, Kid Connects engaged a consultant to complete a study that examined the program's current evaluation strategy. The purpose of the study was to gather key stakeholder input on desired outcomes, review and revise the program's logic model, examine elements of model fidelity, and recommend any changes in the evaluation strategy. Ultimately, the study is designed to help Kid Connects move forward in establishing itself as an evidence-based practice, according to guidance set forth through Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP)⁵³. Recommendations were made to the Kid Connects Senior Team Leader in December 2008 and as a result, Kid Connects is planning to:

- pursue a study of Kid Connects that will satisfy SAMHSA's NREPP criteria;
- update the *Cost of Failure Study* (Gould, 2000), comparing the costs of effective early childhood intervention and prevention programs to the societal costs associated with failure to prevent negative outcomes for children;
- develop a fidelity questionnaire and test model fidelity each year;
- revise/improve the parent and staff end-of-year surveys;
- explore alternative valid and reliable measures for staff outcome measures;
- organize evaluation reports to align more closely with the logic model; and
- explore opportunities to formally publish results of Kid Connects (Trierweiler, 2008).

LESSONS LEARNED/RECOMMENDATIONS

- **“Readiness” for consultation should be explored.** Assessing and addressing a center's “readiness” for consultation services should be built in to the process for exploring initial interest in consultation services and formally contracting for services. Communities must have a community-based mindset and centers must have leadership that supports early childhood mental health consultation from philosophical, administrative, and practical points of view.
- **Supervision and support for consultants is essential.** In addition to clinical supervision, preparation and guidance on reflective practice and its role in working as a consultant are critical to delivering a consultation model that is relationship-based.
- **Replication and program expansion is extremely challenging.** Beyond the understanding of the program model and all of its elements, replication must also consider essential community partnerships, community readiness to work in an untraditional way, and community resources to support the program with ECMH referrals/services. A community taking on a new program such as Kid Connects, requires significant preparation, training, technical assistance and support over time to really help get the program in place and allow flexibility for local differences.

⁵³For more information about the National Registry of Evidence-based Programs, go to <http://www.nrepp.samhsa.gov>.

KID CONNECTS—BOULDER, CO: LESSONS LEARNED/RECOMMENDATIONS

- **Supporting the ECE workforce is critical.** Early care and education quality issues including staff qualifications, the impact of low wages, and staff turnover make consultation implementation and effectiveness more challenging. It is important to support professionalization of ECE providers and improve the quality of care as an essential feature in supporting the social and emotional development of infants and young children.
- **Work at the policy level.** Policy change may be essential to bringing a program to scale, resolving challenges related to accountability and untraditional mental health services, promoting a public health approach, and accessing funds for community-based prevention, promotion, and intervention services.

PROGRAM CONTACT

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Together for Kids—Central Massachusetts

PROGRAM BACKGROUND

Together for Kids (TFK) grew out of the work of over 30 professionals from early childhood education, health care, child welfare, and social service agencies in Central Massachusetts, who came together in 2000 to respond to the rising incidence of young children exhibiting challenging behaviors in preschool settings. As these behaviors increasingly resulted in disrupted classrooms and preschool program expulsions, these concerned constituents decided to meet and form a coalition (currently called the TFK Coalition) to address early childhood mental health issues. Local concern about the growing number of students in public schools with diagnoses of emotional impairment or behavioral disorders in the early grades also bolstered this effort (Wenz-Gross, Upshur, & Hennigan, 2006).

In 2001, the Coalition received a planning grant from The Health Foundation of Central Massachusetts (THFCM) to help the group develop a specific intervention to apply towards addressing these issues. After much exploration of the research on early childhood mental health and effective interventions, the Coalition decided to focus on planning and implementing an early childhood mental health consultation model with a comprehensive array of mental health promotion, prevention and intervention services. The TFK model focuses on increasing providers' and family members' level of skill 1) to respond appropriately to young children with challenging behaviors; and 2) to understand social-emotional development in young children.

After the planning phase, THFCM committed funds to pilot and evaluate the TFK model. Through a Request for Proposals (RFP) process, Community Healthlink, the largest provider of behavioral health services in Central Massachusetts, was selected to implement the early childhood mental health consultation (ECMHC) program. At the same time, the United Way of Central Massachusetts (UW) awarded TFK additional funding to implement services in a Head Start program. From the very beginning, evaluation has been a required component of the project to demonstrate the efficacy and feasibility of the intervention and to address implementation questions that could lead to program improvement.

Together for Kids first began as a pilot project in July 2002 (Year One) to implement the ECMHC model in two preschools and a Head Start program, and to use two additional centers as comparison sites. In Year Two, TFK continued the intervention in the three pilot sites and expanded the intervention to include the two sites that had served as comparison sites in Year One. All five sites continued with the intervention in Year Three (2005). The results of the pilot study showed significant behavioral improvement in children receiving the consultation services, as well as suggestive evidence for broader classroom positive effects (Upshur, Wenz-Gross, & Reed, 2009).

TOGETHER FOR KIDS—CENTRAL MA: PROGRAM BACKGROUND

Following strong advocacy efforts by the Coalition, along with the positive evaluation findings from the TFK program, early childhood mental health consultation programs are now available throughout the Commonwealth of Massachusetts.

MODEL DESIGN

Philosophy/Approach to ECMHC

Together for Kids is a comprehensive early childhood intervention and prevention model of service, consisting of mental health consultation for educators and families of toddlers and preschoolers. This program is seen as a “marriage of early education and the clinical world.” Consultation is viewed as indirect and capacity-building, using the approach that there are multiple sources of support and difficulty for each child in the classroom and at home. The intervention is based on the analysis of these sources of risk and support, focusing on multiple levels: the family, the child, the teachers, the classroom, and the ECE center. The overarching philosophy is having ECE providers, parents, and consultants (called *Child Development Advisors* or *CDAs*) working together, with the parent being the most important person at the table. The program offers two different service delivery levels—*embedded* and *non-embedded*—which provide the flexibility of having different types of services provided at different levels of intensity.

Program Eligibility

TFK serves the original pilot sites plus toddler/preschool programs in Worcester County (North and South, Central MA) that receive a subsidy from the MA Department of Early Education and Care (EEC). These programs are eligible to receive free mental health consultation services. Priority status has been granted to center-based programs in seven high-impact communities. Consultation services can also be accessed on a fee-for-service basis if they do not qualify through EEC.

Program Scope

- Geographic area served:** Central Massachusetts, which includes Worcester County (Region II of the MA Department of Early Education and Care); ECMHC services are predominantly provided in those cities and towns with high levels of poverty, although suburban and rural communities can and do access services as well.
- Settings served:** Early care and education centers, preschool programs, and Head Start programs. Most work is center-based, mainly in centers accredited by the National Association for the Education of Young Children (NAEYC), but there is still a good deal of variance among the accredited sites in terms of geographic region (i.e., urban versus suburban versus rural) and management structure (i.e., free-standing

TOGETHER FOR KIDS—CENTRAL MA: MODEL DESIGN

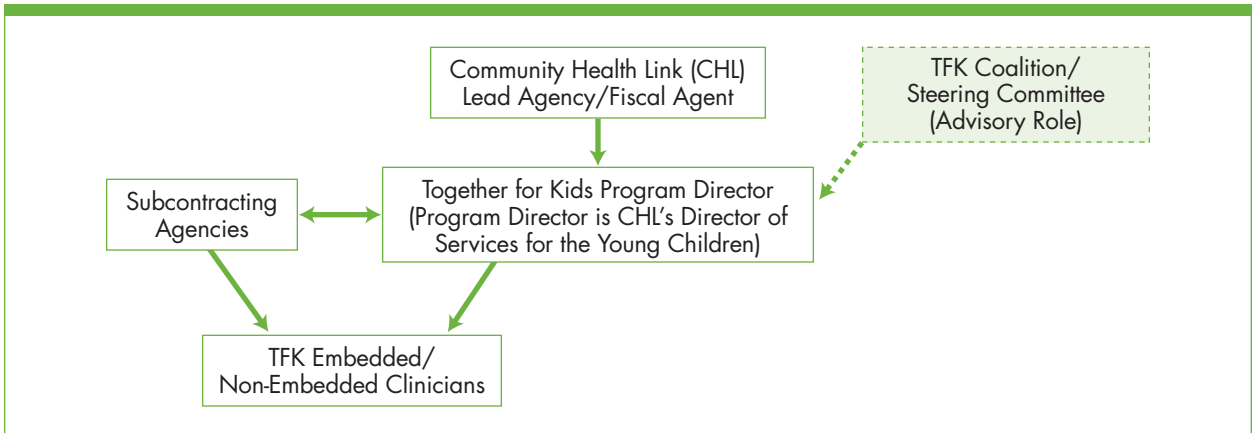
programs versus programs affiliated under a unifying agency). Family child care providers can access the service through existing grants or on a fee-for-service basis.

Ages served: Serves children ages 2 to 5, predominantly ages 3 and 4, including both private-pay families and those using public subsidies.

Annual numbers served (FY2008): Over 49 early care and education (ECE) agencies, 85 ECE sites, 180 classrooms, 400 teachers, and 4000 children. TFK consultants provided child-specific consultation and/or direct therapy services for approximately 600 children and families.

Organizational/Management Structure

Community Healthlink (CHL) is the lead agency and fiscal agent for the Together for Kids project. In addition to being a TFK service provider, CHL subcontracts with four collaborating mental health agencies to extend consultation services throughout Central Massachusetts. The TFK Coalition/Steering Committee acts in an advisory role and supports advocacy and policy development.



TOGETHER FOR KIDS—CENTRAL MA: MODEL DESIGN

Program Staffing

Staff Composition: TFK’s staff is comprised of a full-time Project Director, 13 full/part-time consultants and 4 interns who are employed by Community Healthlink, as well as 13 full/part-time consultants and an additional 4 interns who are employed by local agencies with whom CHL subcontracts. Consultant positions are funded by a combination of state consultation funds and third-party insurance billing.

Consultant Caseloads: TFK recommends approximately 1 full-time equivalent (FTE) consultant per 200 children in state subsidized care. Currently, they are staffed at 1 FTE per 250 children, per state funding requirement. In practice, caseload per consultant varies based on various factors including size of the ECE setting, child/family/provider level of need, and level of service intensity (i.e., *embedded* or *non-embedded*).

Consultant Qualifications and Training

Although all TFK providers are required to implement the same mental health consultation model, there is some degree of flexibility and variability in consultant qualifications, trainings, and supervision across the different hiring agencies. Strong relationships and consistent communication between the Project Director and the agencies has enabled this flexibility and individualization. Still, TFK consultants must be at least a master’s-level psychology or social work-trained clinician and be license-eligible, although licensed clinicians are preferred. Consultants must also have experience in a clinical setting working with children and families.

Further, it is strongly recommended that all consultants regularly attend TFK staff trainings and meetings. The consultants typically take advantage of the scheduled trainings because they recognize the value and importance of these opportunities. One training that is particularly valuable to consultants and important to the TFK model is a year-long seminar titled “When Young Children Need Help: Challenges and Possibilities.” Through this seminar, consultants meet once a month with an instructor who is on faculty at Boston University to discuss topics in early childhood mental health, including:

- the impact of relational difficulties, trauma, and neglect on early development;
- the nature of effective communication and growing cognitive capacity in young children
- the development of regulatory capacities that impact children’s ability to harness attention, modulate energy, and manage intense emotion;
- the nature of comprehensive child and family assessment;
- creative strategies for working collaboratively with parents, teachers/early care providers, and other specialists;

TOGETHER FOR KIDS—CENTRAL MA: MODEL DESIGN

- models for parent and teacher/provider training, including those that help parents set effective expectations at home as well as those that allow teachers/providers to offer appropriate developmental scaffolding in early care and education settings;
- communication and play techniques for entering a child’s world, including those clinicians can share with caregivers; and
- practical approaches to culturally attuned, skill-based work that supports the development of healthy connections, effective communication, impulse control, frustration tolerance, and sustained focus at home and in school (see Hirschland, 2008).

Consultant Supervision and Support

All TFK consultants are required to receive clinical and administrative supervision, the amount of which is based upon level of clinical licensure (i.e., licensed or unlicensed) and the guidelines set forth by their professional organization and credentialing body. Clinical supervision is provided to the consultants by an experienced licensed psychologist or clinical social worker at the hiring entity. Unlicensed clinicians⁵⁴ are required to have 1 to 2 hours of weekly supervision, with access to additional supervision as needed. Licensed clinicians receive supervision based on agency protocol and clinical need. All consultants participate in weekly clinical team meetings.

Each agency is responsible for monitoring the implementation of the TFK program model. The TFK Project Director has a staff liaison at each subcontracting agency, so there is a flow of communication to address issues as they arise. The Project Director interacts with the executive, fiscal, and clinical individuals at each agency who oversee the contract. The program model (e.g., clinical protocol, data collection, etc.) is reviewed and discussed on an ongoing basis. Consultants at all agencies have to complete and submit monthly detailed service delivery reports and the project director reviews these for ongoing feedback of what is happening across the TFK program sites. Interagency meetings are regularly scheduled for 1) administrators/ supervisors and 2) clinical teams that provide *embedded* services.

Accessing Services

Toddler and preschool programs in Worcester County (North and South, Central MA) that receive a subsidy from the MA Department of Early Education and Care (EEC) are eligible to access free mental health consultation services from TFK and their agency partners.

Together for Kids sends out letters to the eligible sites, inviting them to attend a meeting to hear about the services offered by TFK. These meetings are held during the day and evenings so they are convenient for the early care and education (ECE) providers. If sites

⁵⁴Unlicensed consultants are those clinicians with a master’s degree, but without requisite clinical hours and the subsequent passing of a test resulting in state licensure.

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are interested, they then enter into a consultation agreement with TFK (this agreement can be informal or formal depending upon the needs of the particular agency). Brochures and handouts also list a phone number providers can use to access TFK services.

Outreach also happens through the Coalition partners and with the Community Partnership for Children (CPC) coordinators. CPC coordinators are individuals who work with the ECE centers towards accreditation for the CPC program, which helps income-eligible working families to pay for preschool programs for their children.

Service Array, Frequency and Duration

A unique feature of the TFK model is the flexibility to provide *embedded* and *non-embedded* levels of service. The TFK model blends programmatic consultation with child/family-centered consultation and direct therapeutic services. In the more intensive embedded service, specially trained master's/doctoral level mental health consultants are assigned to an ECE program for a specified number of hours per week. ECE staff complete child behavioral screenings, confer with consultants, develop/implement behavioral plans (e.g., teach specific social and emotional skills, modify classroom environments) and refer children and families for more intensive services on an as-needed basis. When parental/guardian consent has been obtained, children become eligible to receive individual child and family mental health intervention services onsite. This includes traditionally billable services—child and family assessment and individual and family therapy—as well as other services such as child and classroom observation, consultation, and team meetings. The *embedded* approach offers a combination of services that assists the child, the family, and the ECE program staff.

At the *embedded* sites, the programmatic services are available to each classroom regardless of whether or not the classroom teacher has specifically identified children in need of referral for child/family-centered services. The preschool teachers use a standardized behavioral screening instrument that identifies externalizing behavioral issues in individual, at-risk children. Families of children whose scores indicate significant risk of clinical problems are notified by the center directors or family outreach coordinators (Head Start programs) and are invited to participate in services.

Embedded services include:

- Child and family assessment
- Child specific/general classroom observation
- In-classroom modeling
- Individual therapy (onsite/home-based)
- Family therapy (onsite/home-based)
- Crisis intervention

TOGETHER FOR KIDS—CENTRAL MA: MODEL DESIGN

- Consultation with educators/parents/guardians
- Training sessions on child behavior and development to teachers
- Center-wide parenting education activities
- Team meetings (parent/educator/clinician)
- Individual work with the child in the classroom
- Case consultation with other providers
- Help linking families to other resources and longer-term services

With *non-embedded* services, consultants are available to observe and consult on an as-needed basis and provide a less intensive service option. The consultant typically conducts 1 to 4 visits per referral, each visit lasting approximately 2 to 3 hours in duration. After developing a written report for providers/parents, the consultant offers optional follow-up visit(s) to provide assistance as necessary.

Non-embedded services include:

- Child-specific/general classroom observation
- In-classroom modeling
- Consultation with educators/parents/guardians
- Team meetings (parent/educator/consultant)
- Linking families to other resources and longer-term services

On average, the consultant spends 16-20 hours per week providing consultation services of any kind to a particular early care and education center/program. For *embedded* services, the consultant works with the center for the entire year (sometimes two years and into kindergarten to maintain continuity of care), on an ongoing basis. For *non-embedded* services, each intervention is brief, although consultants can go back for repeated follow-ups. Every effort is made to maintain continuity of care with a specific consultant; however program needs (e.g., crisis intervention, goodness of fit, etc.) sometimes require a change in assignment.

TOGETHER FOR KIDS—CENTRAL MA: MODEL DESIGN

Data Collection

TFK collects a variety of data to assist in service planning and implementation, as well as to inform continuous quality improvement efforts and assess program outcomes. The data collection tools employed by TFK are detailed below.

Child/Family-Centered Screening/Assessment/Service Planning Tools

TOOL NAME	PURPOSE(S)	COLLECTION PERIOD	COMPLETED BY
TFK Family Information Sheet*	Demographic data	Pre/Post	Consultant Parent
Child and Adolescent Needs and Strengths (CANS Birth-5 Years)	Assessment	Pre/Post	Consultant Parent
Sutter-Eyberg Student Behavior Inventory-Revised	Behavioral screening	Pre/Post	Consultant Parent
Behavior Assessment System for Children (BASC) or Treatment Outcome Package (TOP) ⁵⁵	Behavioral assessment	Pre/Post	Provider Parent
Questions about TFK Services*	Parent feedback about TFK services	Pre/Post	Consultant Parent

*Locally-developed measures

Program/Classroom-wide Screening/Assessment/Service Planning Tools

TOOL NAME	PURPOSE(S)	COLLECTION PERIOD	COMPLETED BY
Sutter-Eyberg Student Behavior Inventory-Revised	Classroom behavioral screening	Fall and Spring As-needed Discharge	Consultant/ Provider
Collaborative Classroom Assessment*	Assessment of classroom milieu	Pre/Post	Consultant/ Provider
Teacher Questionnaire*	Teacher feedback about TFK consultation services	Spring and/or Fall	Providers
National Association for the Education of Young Children (NAEYC) Family Questionnaire	Parent feedback about child care quality	According to agency timelines	Program Administrators

*Locally-developed measures

Note: See page 91 for more information on standardized measurement tools.

⁵⁵One of the agencies providing TFK services uses the TOP instead of the BASC.

TOGETHER FOR KIDS—CENTRAL MA: MODEL DESIGN

Funding

Community Healthlink (CHL), the lead agency for the project, is the recipient of the grant funding and develops subcontracts with partnering agencies. Consultation services are provided free of charge to eligible toddler/preschool programs (see above). In addition, some private, for-profit centers may request TFK *non-embedded* services and pay on a fee-for-service basis. Rates are roughly \$100-\$150/hour for consultation; \$150/hour for training.

TFK's funding comes from the following sources:

- MA Department of Early Education and Care (EEC): A line item in the state budget was created in 2007 for statewide ECMHC and increased from \$1.4M (FY2008) to \$2.4M (FY2009). Unfortunately, despite the governor's recommendation to increase funding to \$2.9M in FY2010, tough economic times led to a final appropriation of \$1.0M. Although TFK gets the largest portion of this money to provide services throughout Central Massachusetts/Region 2, TFK's FY2010 allocation from EEC (\$284,738) represents a 56% decrease from its FY2009 funding level (\$641,143). EEC does provide additional monies to TFK for consultation through a "Comprehensive Mental Health in Child Care" contract (approximately \$100,000 in FY2010).
- The Health Foundation of Central Massachusetts (THFCM): Beginning with the planning grant in 2001, THFCM has provided close to \$2M in funding to TFK (variable yearly: approximately \$200,000-\$400,000/year). Funding concluded June 30, 2009.
- Additional funding comes from the United Way of Central Massachusetts, Head Start, Community Partnership for Children⁵⁶ programs, and third-party insurance billing for direct therapy services.
- Also, some additional *ad-hoc* funding along the way (e.g., Rotary Club, Fred Harris Daniels Foundation) for discrete materials and program components.

TFK's total FY2009 budget was approximately \$1.1M.

NOTABLE PROGRAM FEATURES

1. **Successful public policy efforts.** TFK has effectively advocated for expansion of early childhood mental health consultation in Massachusetts, strategically using positive findings from their program that demonstrate the efficacy of ECMHC. TFK Coalition members succeeded in influencing state-level policy, specifically by securing the inclusion of early childhood mental health language in the enabling statute for the then-new Department of Early Education and Care, as well as a new line item in the Fiscal Year (FY) 2008 state budget for statewide ECMHC services. Although tough economic times led to a significant decrease in the FY2010 allocation in the state budget for ECMHC, the line item was not eliminated.

⁵⁶Community Partnership for Children is a program that helps income-eligible families pay for preschool programs for their children.

TOGETHER FOR KIDS—CENTRAL MA: NOTABLE PROGRAM FEATURES

2. **Third-party billing.** TFK employs third-party billing to public and private insurance companies when services shift from consultation to direct, individualized therapy. This financing mechanism allow TFK consultants to provide individualized therapy onsite at the early care and education center, which allows for ease and consistency of service delivery.
3. **Diverse evaluation and research studies.** Since the program’s inception, evaluation has been a core component of TFK. In addition to in-depth annual program evaluations that took place during the pilot phase, evaluators have conducted a kindergarten follow-up study to determine the long-term effectiveness of the ECMHC intervention and an economic evaluation to estimate the costs and benefits of a statewide implementation of the TFK model in state subsidized licensed preschool centers. Further, through a recent National Institute of Medicine Health (NIMH) Development Grant award, researchers are evaluating the efficacy and feasibility of using an adapted evidence-based curriculum (SECOND STEP⁵⁷) as a primary prevention strategy in four ECE settings receiving TFK consultation services.

EVALUATION EFFORTS AND FINDINGS

Program Outcomes

In each year of the Together for Kids pilot project (2002-2005), the evaluation of the TFK model involved teacher ratings of child behavior using a standardized instrument (Early Screening Project questionnaires, Walker, Severson & Feil, 1995); center-wide anonymous surveys of parents and teachers (including the Maslach Burnout Inventory, Maslach, Jackson & Leiter, 1996, and the National Association for the Education of Young Children Family Questionnaire, NAEYC, n.d.); qualitative interviews and focus groups with center personnel and the mental health consultants; and assessment of behavioral and family change for those children and families who received individual services (Developmental Profile II, Alpern, Boll & Shearer, 2000; Family Resource Scale, Dunst & Leet, 1985; Parenting Stress Index—Short Form, Abidin, 1995; Parenting Scale, Arnold, O’Leary, Wolff, & Ackler, 1993; and the Home Observation Measurement of the Environment (HOME; Caldwell & Bradley, 1984).

Rates of significant behavior problems as assessed by preschool teachers using a standardized scale were high, with 34% of all children enrolled in preschool classrooms in the sites over a three-year period identified at risk of behavioral problems. Analysis of outcomes for 47 children and families with externalizing behavior problems (e.g., hyperactivity, aggression) who received individualized consultation, compared to 89 control children, and analysis of outcomes of a matched group of 19 intervention and

⁵⁷SECOND STEP violence prevention program integrates social and emotional learning with academics. Kids from preschool through Grade 8 learn and practice vital social skills, such as empathy, emotion management, problem solving, and cooperation. For more information visit <http://www.cfchildren.org/programs/ssp/overview>.

TOGETHER FOR KIDS—CENTRAL MA: EVALUATION EFFORTS AND FINDINGS

19 control children, revealed that the intervention was associated with significant improvements in classroom behavior (Wenz-Gross, Upshur, & Hennigan, 2006).

Effects of TFK services on child behavior:

- On average, children's scores for aggressive behavior decreased 23%; for maladaptive behavior they decreased 21%; and for adaptive behavior, they increased 12%, as measured by the Sutter-Eyberg Student Behavior Inventory—Revised (Eyberg & Pincus, 1999).
- Parents, almost without exception, agreed that TFK services helped their child behave better at school and most also felt that it helped their child behave better at home, and helped improve their child's learning skills.

Effects of TFK services on parents:

- Results in terms of benefits to parents were less clear than the children's. Findings of pre-post improvement in parenting stress and parenting skills were weak and inconsistent from year to year, and when combined across years, did not show significant change. However, over 90% of parents felt that TFK services had taught them better ways to handle their child's behavior.
- Most parents felt that TFK services helped them feel more comfortable talking to teachers, and helped them feel more comfortable at the early care and education center.

Effects on preschool teachers:

- The TFK intervention model also appeared to have positive effects on preschool centers in terms of increasing training, and access to and use of resources, by teachers.
- Compared to baseline, teachers in Year 3 felt they had more adequate training regarding children's behavior problems and more adequate help from specialists.
- Teachers reported more access to and use of consultation services for individual children, and made more referrals for individual treatment when needed.

Effects on overall center climate:

- Center-wide benefits also appeared to have occurred with overall levels of baseline behavior problems dropping significantly after one year of TFK services, and this lower level was sustained the following year.
- Suspension rates dropped drastically, and the expulsion of children from preschools was all but eliminated (less than 1%).
- Most parents whose children received the targeted intervention also felt that TFK made the preschool a better place for all the children (Wenz-Gross, Upshur, & Hennigan, 2006).

TOGETHER FOR KIDS—CENTRAL MA: EVALUATION EFFORTS AND FINDINGS

Additional Evaluation Activities

The TFK Kindergarten Follow-Up Study: This study was initiated to determine if the improved outcomes demonstrated for children during the preschool years had lasting effects. The follow-up study was designed to follow a small cohort of children (n=15) served by TFK during the 2005-2006 school year into their kindergarten years to determine if the children maintained gains in behavior and development achieved in preschool with TFK services, how many of the children received special services or Individual Education Plans (IEPs), if there was evidence that the provision of TFK services in preschool reduced the special education services in kindergarten, and that parents continued to see improvements in behavior at home

The study found the following results:

- Children overall maintained and slightly increased gains in development and behavior in kindergarten. Both parent reports, and parent and kindergarten teacher ratings, of children's behaviors showed improvements post TFK services.
- About one-third of the children had an IEP or one in progress, while about two-thirds of the cohort of children was receiving or teachers were requesting some special services. Most of the services delivered or requested were for developmental needs (physical, occupational, and speech therapy), while less than a third of the children required behavioral assistance for externalizing behaviors, a reduction of 60% from preschool.
- Evaluators estimate that the provision of TFK services reduced the need for kindergarten IEPs by 14%, and special services by 36% (Upshur, Davis & Friderici, 2007).

A second kindergarten study is currently underway and is scheduled for completion Summer 2009. This study will have the benefit of a control group for analysis.

Economic Evaluation of the Together for Kids Project: Using findings from the TFK evaluation in combination with data from related research and demonstration studies, evaluators estimated the costs and benefits of a statewide implementation of the TFK model in state subsidized licensed preschool centers. The following results were found:

- To implement the TFK model statewide, a ratio of 1 full-time consultant to 200 children in state-supported licensed preschools is recommended.
- At the recommended ratio, the average direct cost of TFK is estimated at \$295 per child per year or \$1.13 per child per day.
- Based on the projected reduction in the need for special education, investing one dollar in TFK can yield monetary benefits of approximately \$1.67 to \$2.23 one year later.
- Additional savings can be expected throughout the elementary, middle, and high school years from reductions in grade repetition, the use of mental health services, and interactions with the juvenile justice system (Warfield, 2006).

TOGETHER FOR KIDS—CENTRAL MA: EVALUATION EFFORTS AND FINDINGS

NIMH Grant: TFK evaluators have also received a National Institute of Mental Health Intervention Development Grant (funded through Spring 2010) to develop and evaluate a primary prevention curriculum in four randomly assigned Worcester early care and education centers. The project is adapting SECOND STEP, a violence prevention curriculum, for use as a primary prevention strategy for all children enrolled in preschool classrooms. Child behavior outcomes and classroom impacts are being measured, and curriculum adaptations and feasibility are being reviewed. The overall goal is to develop a transportable “real world” intervention model to decrease the number of children in preschool who require intensive behavioral intervention services and provide a sustainable mechanism for identifying and appropriately intervening with those who do.

LESSONS LEARNED/RECOMMENDATIONS

- **“Grow your own.”** The consultant role is a difficult one to fill, requiring not only a solid understanding of early childhood behavior and development, but honed clinical skills, and the ability to adapt those skills to an early childhood educational setting (as opposed to a clinical setting). A consultation program should consistently build capacity and “grow your own” by providing information on topics requested by staff; increasing training and credentialing for early childhood mental health specialists; and changing policy at the state level to include social and emotional development in the curriculum for all preschool teachers.
- **Foster communication, collaboration, and gain teacher buy-in and support.** Finding the right match between the personality and style of the consultant, and the personality, needs, and style of the center and ECE providers can be a challenge. Teacher engagement is also crucial, as resistance and defensiveness can be high. This requires the ability to work effectively with teachers in a collaborative model. Consultants must recognize and support teacher skills and ideas, while helping them to develop greater knowledge and skill in preventing and dealing with behavioral problems in the classroom. Provide ongoing, positive feedback to the teachers and recognition of their efforts in making TFK a success and regularly communicate with teachers on the successes of the project in terms of children’s behavioral improvements and center-wide benefits is needed.
- **Address a child’s behavior and functioning in a collaborative and positive manner with parents by providing the early care and education programs with a support system for engaging parents.** A first contact regarding the sensitive issue of a child’s behavioral problems requires personal communication with the family by the teacher in collaboration with the child care administrator and/or the mental health consultant. The more families feel a part of the center, and the more collaboration there is between teachers and parents, the easier and less shocking or threatening this conversation should be. It also requires a good deal of time, flexibility in scheduling, self-direction, and initiative.

TOGETHER FOR KIDS—CENTRAL MA: LESSONS LEARNED/RECOMMENDATIONS

- **Encourage good communication and linkages within and across systems.** It takes thoughtful and careful implementation activities with each ECE center to successfully manage the multiple complex systems that affect children and families. It takes the commitment of ECE centers and teachers to change their practices, an adequate workforce to supply quality early childhood mental health consultants, and a commitment by the Commonwealth of Massachusetts to establish new policies and resources that make this model sustainable.

PROGRAM CONTACT

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APPENDIX A

Additional ECMHC Programs of Note

1. **Daycare Consultants: A Program of the Infant-Parent Program, San Francisco, CA**

The UCSF Infant-Parent Program (IPP) is a multifaceted early childhood mental health program offering direct clinical services, assessment, consultation, and intensive training. Established in 1979 at San Francisco General Hospital, the IPP is the West Coast's pioneering mental health program specializing in infant mental health. Daycare Consultants, a component of the IPP began in 1988 and offers mental health consultation to settings where young children (birth through age 5) reside or are cared for. Currently, these venues include, Family Resource Centers, residential substance abuse treatment programs, homeless and domestic violence shelters and most extensively to child care centers. To date, Daycare Consultants has provided on-going mental health consultation to over 100 child-care settings.

This service was developed in recognition of the fact that an increasing number of our youngest children spend a large portion of their lives in the care of those other than their parents. Experiences in child care contribute mightily to children's sense of themselves, their competence and their ability to flourish in school. All too often, however, child care is far from a positive force in children's lives. Research on child care quality shows that most children receive care that is characterized as inadequate. The children who are often most in need of high quality child care are consigned to the settings least able to offer them opportunity.

The services of Daycare Consultants attempt to address this problem by assisting child care programs serving low-income families to improve the overall quality of the center through program consultation. Additional attention is paid to particular children who are demonstrating difficulties in the child care setting. Expulsion has often seemed the only option, and some children are set on a treadmill of serial placements. In such situations, the mental health consultant works in case consultation with both child care providers and parents to understand the sources of the child's difficulties and arrive at approaches for him which will support better functioning in the group setting and at home.

Children whose needs exceed the efforts of their providers and parents in case consultation are seen in *individual therapy or therapeutic groups* that complement but do not replace their child care experience. The combination of these direct clinical and consultative services aids child care providers in creating quality, providing attuned and compassionate care to children of concern and offering children the best chance to progress positively through the preschool years.

A unique strength of the Daycare Consultants Program is the training and supervision component. Each year since 1996, a cadre of trainees learn the content and practice of consultation that incorporates mental health principles and understanding of early childhood education and development.

Several evaluations of Daycare Consultants have shown positive outcomes in the areas of improved program quality, sensitive and less harsh interactions by child care staff, and increased teacher self-efficacy.

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2. **Chicago School Readiness Project**

The Chicago School Readiness Project was a cluster-randomized intervention program focused on Head Start-funded classrooms in Chicago, Illinois. Mental health consultation services were delivered in combination with teacher training. Teacher training consisted of five sessions (6 hours each), which were a modification of Webster-Stratton's Incredible Years program (Webster-Stratton, 1999a, 1999b). In addition, coaching on a weekly basis provided for consistent and intensive support and training of teachers. More specifically, classroom teachers received a weekly visit from a Mental Health Consultant (MHC). The MHC attended all teacher trainings delivered (total for five). In addition, consultants followed a manualized cycle of "coaching" that provided teachers with the opportunity to practice newly learned classroom management skills after each training session. Mental health consultants also provided stress reduction techniques as well as child-focused consultation with three to five children within the treatment-assigned classroom. The model is broken into four components delivered sequentially; teacher training in the fall, coaching of strategies learned in training, stress reduction and child-centered consultation in the latter part of the school year.

With regards to the evaluation results, the program is somewhat unique in that the evaluation study used randomization to treatment at the preschool site level. Measurement instruments used included the Classroom Assessment Scoring System (CLASS; Pianta, La Paro, & Hamre, 2008) to measure impact on classroom quality. Results indicated that those classrooms that received the model had significantly more positive climate than did classrooms that were in the control group. Specifically, Raver and colleagues (2008) found close to a one-point difference between treatment and control group classrooms in positive climate. Additionally, intervention-assigned teachers were found to be more sensitive than were teachers in the control group, by spring of the school year. Teachers' ability to deal with classroom management of disruptive behavior was also enhanced through participation in CSRP services.

Overall, teachers who received CSRP training and consultation services were noted to demonstrate greater enthusiasm with students, more responsiveness and less use of negative strategies.

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3. **Project Mastery**

Project Mastery is a community-based consultation model based in a semi-urban county in North Carolina. Child-centered consultation was delivered for at least four months within the classroom and individualized intervention plans were developed. These plans included individual and classroom-wide behavior management strategies, consultation and training for teachers, social skills training and parent behavior management training. Specifically, teachers received a group training session and weekly individual consultation during the school year. All of the training and consultation was based on Webster-Stratton's Incredible Years program (Webster-Stratton, 1999a, 1999b). Parent training also incorporated the Incredible Years parent training on a truncated basis. Measures of outcomes included the AD/HD—IV Rating Scale (DuPaul, Power, Anastopoulos, & Reid, 1998) as rated by parents and teachers. The Behavioral and Emotional Screening System (BASC; Reynolds & Kamphaus, 1992) was also completed by teachers and caregivers. Teachers completed the Teacher Strategies Questionnaire (Webster-Stratton, n.d.). Caregivers also completed the Parent Stress Index-Short Form (PSI-SF; Abidin, 1995) and the Parenting Scale (Arnold, O'Leary, Wolff, & Ackler, 1993) as well as the Child Behavior Management Questionnaire (O'Dell, Tarler-Benlolo, & Flynn, 1979).

Results indicated that while children's disruptive behavior did not decrease, these behaviors actually increased in comparison classrooms. Classrooms in Project Mastery demonstrated increased use of more positive or effective teaching strategies. Caregivers did not report decreases in parenting stress. However, caregivers displayed more positive parenting skills including pro-social behavior management strategies and reported less over-reactivity and overall improvements in their children's behavior as did the teachers in intervention classrooms. Teachers also reported feeling more confident, more likely to promote parent involvement and more likely to offer parents advice.

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4. **Arkansas Early Childhood Mental Health Consultation Pilot Project**

The State of Arkansas launched a pilot project to assess the impact of collaboration between community mental health centers and the early care and education community in 2004. The primary goals of this effort were to: 1) Enhance the capacity of child care centers/teachers to prevent and manage mental health problems in children, and 2) Improve the outcomes of children enrolled in the collaborating child care programs. While the main focus of this project was building the capacity of the early care and education community in three sites, the project also sought to improve the skills of parents and mental health professionals working with children. Each team was led by a mental health professional that had at least a master's degree, some had a Ph.D. The major activities that the consultants did include: teacher training and consultation, screening children for behavioral concerns and protective factors, making referrals for individual mental health services, conducting small and large group classroom activities, conducting parenting education classes, and collaborating with local colleges and universities to offer training opportunities to students. The pilot project also included a comprehensive evaluation conducted by the University of Arkansas for Medical Sciences/ Partners for Inclusive Communities.

Evaluation data were gathered from three to five child care sites that received consultation services from the community mental health centers as well as four comparison sites selected on the basis of their demographic similarities during three school years (2005-06 to 2007-08). Data suggested that the consultation services were associated with positive changes in both the teachers and the children served in the intervention sites. Specifically: teachers who received the consultation services were more positive and sensitive in their interactions with the children in their care; they were also less permissive and detached. These changes over time were not seen in the comparison sites. Furthermore, there was evidence that within the intervention sites, teachers who received more consultation services had greater changes in their behavior compared to teachers who did not avail themselves of services. In addition, there were a sizable minority of children with significant behavior problems at the beginning of the study: 16% in community child care and 46% at the special needs site. These children showed a decline in problem behaviors over the course of the pilot projects: greater reductions in problem behaviors and increases in protective factors were seen in the intervention sites versus comparison sites. Qualitative data from focus groups suggested that parents also found the consultation helpful and saw changes in their children's behavior.

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5. Louisiana Quality Start Mental Health Consultation to Child Care Centers

In Louisiana, a statewide ECMHC project is being implemented as an integral part of their Quality Rating System. This effort is funded through their federal Child Care and Development Fund (CCDF) dollars and has three main goals: 1) to promote the social and emotional health of young children; 2) to support teachers' promotion of healthy child development within the classroom setting, and 3) to refer for treatment and/or design interventions for young children exhibiting behavioral problems. Their consultation model was informed by the work of Johnston and Brinamen (2006) and has a strong focus on capacity-building for child care providers and parents through relationships with licensed mental health professionals. There are approximately 15 mental health consultants that enter into relationships with child care centers for a period of six months; they are onsite every other week for a full-day.

The primary activities that the mental health consultants perform as part of child-specific and program-focused consultation include: conducting classroom observations, modeling evidence-based interventions, leading didactic group meetings, meeting with caregivers, meeting with families, and designing specific interventions for individual children with challenging behaviors (with parents' consent), leading parent education seminars, and facilitating referrals to outside agencies (e.g., speech and language evaluation, individual or family therapy, behavioral intervention in the home). In addition to individualized consultation to teachers and families, consultants are also responsible for providing five interactive didactic meetings/trainings, based on materials developed by the Center for Social-Emotional Foundations for Early Learning (see <http://www.vanderbilt.edu/csefel/>).

Another important component of their model is ongoing group and individual reflective supervision for the mental health consultants. The consultants participate in 1 hour of individual reflective supervision twice a month and 1 hour of group reflective supervision once a month with an experienced mental health professional. A comprehensive evaluation is underway led by the Institute of Infant and Early Childhood Mental Health at Tulane University. This evaluation is measuring the impact of the consultation on teachers' beliefs and behaviors and classroom environments using the Classroom Assessment Scoring System (CLASS; Pianta, La Paro, & Hamre, 2008) and Caregiver Interaction Scales (Arnett, 1989). Initial results are expected in summer 2009.

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APPENDIX B

Select Resources

Books/Monographs

Collaborative Intervention in Early Childhood (Hirschland, 2008)

Available through Oxford University Press: www.oup.com/us

Early Childhood Mental Health Consultation (Cohen & Kaufmann, 2000, rev. 2005)

Available at: <http://mentalhealth.samhsa.gov/publications/allpubs/svp05-0151/>

Early Childhood Mental Health Consultation: An Evaluation Tool Kit (Hepburn, Kaufmann, Perry, Allen, Brennan, & Green, 2007)

Available at: <http://gucchd.georgetown.edu>

Enhancing Relationships Between Children and Teachers (Pianta, 1999)

Available through the American Psychological Association: www.apa.org

Mental Health Consultation in Child Care (Johnston & Brinamen, 2006)

Available through ZERO TO THREE Press: www.zerotothree.org

Mental Health Consultation in Early Childhood (Donahue, Falk & Provet, 2000)

Available through Paul H. Brookes Publishing: www.brookespublishing.com

Social and Emotional Health in Early Childhood (Perry, Kaufmann, & Knitzer, 2007)

Available through Paul H. Brookes Publishing: www.brookespublishing.com

Research Articles

Brennan, E. M., Bradley, J. R., Allen, M. D., & Perry, D. F. (2008). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. *Early Education and Development*, 6, 82-1022.

Perry, D. F., Allen, M. D., Brennan, E. M., & Bradley, J. R. (2009). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing children's behavioral outcomes. *Early Education and Development*. Manuscript submitted for publication.

Websites

Center on the Social and Emotional Foundations for Early Learning

www.vanderbilt.edu/csefel/index.html

Georgetown University Center for Child and Human Development

<http://gucchd.georgetown.edu>

ZERO TO THREE

www.zerotothree.org

APPENDIX C

MHC Education, Skills and Experience Inventory

1. What is the highest degree you have achieved (check one):

Degree	<input checked="" type="checkbox"/>
Associate	<input type="checkbox"/>
Bachelor	<input type="checkbox"/>
Master	<input type="checkbox"/>
Doctorate	<input type="checkbox"/>
Other (please specify):	<input type="checkbox"/>

2. Are any of your degrees in a mental health field? YES NO
 (for example: social work, counseling, psychology, psychiatry)

2a. If YES, which field(s)? _____

3. How many total years of experience do you have in early childhood mental health consultation? _____ Years

4. How many total years of experience do you have providing mental health services to young children? _____ Years

5. Are any of your degrees, licenses or certifications in early childhood education? YES NO

5a. If YES, how many years of experience do you have as an early childhood educator? _____ Years



Please indicate your level of knowledge/skill/experience by shading in the appropriate bubble along the continuum of minimal - moderate - strong.					
	Minimal		Moderate		Strong
Answer Selection: Correct = ● Incorrect = ☒ ✓ ⊖					
1. Knowledge of typical and atypical early childhood development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Knowledge of infant and early childhood mental health/social-emotional development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Knowledge of diverse mental health treatment/intervention approaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Knowledge of early intervention systems (Part C and preschool special education)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Knowledge of family support and adult service systems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Knowledge of community resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Understanding of diverse cultures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Experience working in child care settings (prior to job as a consultant)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Experience observing/screening/assessing children in classroom, home or other natural settings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Experience working with children with challenging behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Experience providing direct therapy to children birth through five	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Experience working with children in foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Experience providing training/education to adults	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Ability to develop and support implementation of individualized intervention plans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Ability to integrate mental health activities into group care settings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Ability to integrate a 'wellness approach' to mental health that includes activities focused on promotion and prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Ability to collaborate with child care directors/teachers/providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Ability to collaborate with families	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Ability to facilitate team meetings/manage diverse perspectives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Communication skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Crisis intervention skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Care management/care coordination skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Thank you!

APPENDIX D Service Array and Frequency Checklist



Directions: Please tell us about the activities you do with child care providers/programs and indicate how often by putting a checkmark in the appropriate box.

Support to Child Care Providers and Programs	Frequency				Notes
	Never	Few times a year	Few times a month	Weekly or more	
ADDRESSING THE NEEDS OF AN INDIVIDUAL CHILD (CHILD-CENTERED CONSULTATION)					
Conduct observations/assessment of an individual child identified because of concerns					
Develop classroom-based strategies to address child's specific needs					Example(s)?
Train providers on strategies to use with a specific child					
Model those strategies in the classroom					
Provide ongoing support and guidance to providers in implementing strategies					In what ways?
Help providers manage crisis situations					In what ways?
Provide direct therapeutic intervention with a child (for example, play therapy)					Example(s)?
Refer to community resources to meet child's needs					
Other(s):					

Support to Child Care Providers and Programs	Frequency				Notes
	Never	Few times a year	Few times a month	Weekly or more	
FOCUSING ON OVERALL PROGRAM QUALITY AND/OR ISSUES THAT IMPACT MULTIPLE CHILDREN (PROGRAMMATIC CONSULTATION)					
Conduct screenings/observations of all children in the classroom/program					
Assess the overall classroom/program environment (e.g., room arrangement, daily schedules)					
Develop strategies to enhance overall classroom/program environment					Example(s)?
Model those strategies					
Provide ongoing support and guidance to providers in implementing strategies					In what ways?
Provide therapeutic counseling to individual providers (e.g., for stress management or other personal issues)					Example(s)?
Conduct trainings/educational sessions to providers (e.g., on child development, general behavior management techniques)					Topics?
Attend program staff meetings					
Advise on program policies (e.g., developing a crisis response plan)					Example(s)?
Assist with selection of social-emotional screening/assessment tools					
Train providers on how to administer and/or use findings from screenings/assessments					
Other(s):					

Directions: Please tell us about the activities you do with parents/caregivers and indicate how often by putting a checkmark in the appropriate box.

Support to Child Care Providers and Programs	Frequency			Notes
	Never	Few times a year	Weekly or more	
FAMILY-CENTERED CONSULTATION				
Conduct home visits				
Conduct informational sessions for parents/caregivers				Topics?
Provide informal or one-on-one education to parents/caregivers				
Develop home-based strategies to help parents/caregivers address child's challenging behaviors				Example(s)?
Model those strategies in the home				
Provide ongoing support to parents/caregivers in implementing strategies				In what ways?
Help families link to other supports or services in the community				
Provide individual counseling to parents/caregivers (on stress management, for example)				Example(s)?
Other(s):				

APPENDIX E

National Scan Questionnaire

Request for Participation

This electronic/on-line scan is being sent to you as a leader in the planning, delivery, and coordination of early childhood mental health services and supports for children birth to six and their families. We are requesting that you participate, represent your state, and contribute to a **National Scan of Early Childhood Mental Health Consultation**. Your participation is essential to this effort; contributing to research about what early childhood mental health consultation (ECMHC) activities are in place or in process and to the development of a print and on-line resource that can support leaders like you in the area of early childhood mental health.

The scan should take about **30 minutes to complete**, but may require additional time to retrieve information that is requested in some of the scan items. We suggest the following steps:

1. Print the scan and use the hard copy to guide your gathering the requested information.
2. Once you are ready, complete the scan questions to the best of your ability; by entering your data electronically on-line and submitting your completed scan.
3. If you would like to send hard copy materials to support or supplement your completed scan, see the e-mailing or regular mailing instructions below.

PLEASE NOTE: This scan has been sent to **both** the Children’s Mental Health Director and the Early Childhood Comprehensive Systems coordinator/administrator in each state in order to have **both perspectives**. Thank you in advance for your contribution to this important project.

Please fill out and return this electronic scan by December 18, 2008

Questions? Contact Kathy Hepburn at ksh@georgetown.edu or call 760-632-9641

If you wish to send **supplementary electronic materials**, please e-mail to:
Kathy Hepburn, ksh@georgetown.edu

If you wish to send **supplementary hard copy materials**, please mail to:
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Background Information

This scan is part of an exciting new project at The National Technical Assistance Center for Children’s Mental Health at Georgetown University—**Early Childhood Mental Health Consultation as an Evidence-Based Practice**. The major goals of this project are to identify the salient features of effective consultation programs, to provide data-driven guidance for those developing or refining their consultation models, and to **document and describe the diversity of existing mental health consultation models**.

Ultimately, this scan data, along with data from six, separate site visits taking place in Connecticut; Central Massachusetts; Michigan; Baltimore City, MD; Boulder, CO; and San Francisco, CA, will be synthesized and shared with experts in the field, who will develop practice, program and policy guidelines and recommendations based on key findings. These recommendations and findings will be summarized in a final report, which will be available in print and online.

NATIONAL SCAN:

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

Below is a literature-based definition of early childhood mental health consultation to clarify our use of the term. We look forward to learning the perspective and description of your state's unique effort.

State: _____

Name: _____

Title: _____

Agency: _____

Address: _____

Phone Number: _____

Email: _____

May we print your name, title and affiliation in our listing of scan respondents? Y N

Early Childhood Mental Health Consultation

Early childhood mental health consultation (ECMHC) involves a professional consultant with mental health expertise working collaboratively with early care and education staff/programs and families to improve their ability to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age 6. The consultant works primarily to improve children's social emotional well-being by building the capacity of early care and education staff, parents and other caregivers to promote health child development and manage challenging behaviors. (Cohen& Kaufmann, 2005; Green, Everhart, Gordon & Gettman, 2006; Johnston & Brinamen, 2006)

Scan/Questions:

1. Using the definition provided above as a guide, are early childhood mental health consultation (ECMHC) services available in your state for providers of child care and early education services, outside of and including Head Start/Early/Head Start Programs? (check one)

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Don't know

If yes, please skip to Question 3.

2. If no, please explain any challenges or circumstances that have lead to the **absence** of ECMHC in your state outside of and including Head Start/Early Head Start Programs:
3. Please briefly discuss what contextual factors (e.g., preschool expulsion data, early childhood mental health link to school readiness, legislation, funding opportunities, etc.) have influenced the development or expansion of ECMHC efforts in your state:
4. Does your state have a statewide ECMHC initiative/program? (check one)

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Don't know

- 4a. If yes, how would you describe this statewide effort (check one):

<input type="checkbox"/>	One service delivery model used in multiple sites across the state
<input type="checkbox"/>	Multiple service delivery models used in multiple sites across the state
<input type="checkbox"/>	Other, please describe:

5. How many consultation programs in your state are providing ECMHC? _____

- 5a. Who is/are the lead or coordinating agency(ies) for consultation programs or sponsors. (Check all that apply)

<input type="checkbox"/>	Early Care and Education
<input type="checkbox"/>	Mental Health Agencies
<input type="checkbox"/>	Child Care Resource and Referral Agencies
<input type="checkbox"/>	Other, please describe:

6. How much state funding is allocated to ECMHC? _____

6a. What are the major sources of funding for ECMHC services in your state? When possible, indicate the funding level.

Sources	Level of Funding
<u>Federal</u> , please specify (e.g., Medicaid/EPDST):	
<u>State</u> , please specify (e.g., general funds):	
<u>Other</u> , please specify (e.g., foundations):	

7. Please indicate whether the following age populations are eligible for ECMHC services in your state (check all that apply):

<input type="checkbox"/>	Infants (please specify age definition, if known, e.g. under 18 months):
<input type="checkbox"/>	Toddlers (please specify age definition, if known):
<input type="checkbox"/>	Preschoolers (please specify age definition, if known):
<input type="checkbox"/>	School-age children (please specify age definition, if known):
<input type="checkbox"/>	Don't Know

8. Please indicate service delivery in your state across the various service populations and settings listed below. **Check all that apply.** If known to you, please provide the percentage served and indicate whether percentages are derived from **existing data** or **estimation**.

8a. Geographic Distribution

%	Category	Existing Data	Estimation
<input type="checkbox"/>	Urban		
<input type="checkbox"/>	Rural		
<input type="checkbox"/>	Suburban		

8b. Children's ages (for children receiving services)

%	Age	Existing Data	Estimation
	Infants		
	Toddlers		
	Preschoolers		
	School-age children		
	Other, please specify:		

8c. Early childhood settings

%	Settings	Existing Data	Estimation
	Licensed non-profit child care center		
	Licensed private child care center		
	Head Start/Early Head Start		
	Licensed family child care home		
	Unlicensed/informal child care providers (e.g., kith and kin)		
	Other, please specify:		

8d. Race/Ethnicity

%	Race/Ethnicity	Existing Data	Estimation
	Caucasian		
	African American		
	Latino		
	Asian		
	Native American		
	Other, please specify:		

8e. Income

%	Category	Existing Data	Estimation
	At or below poverty level		
	Above poverty level, but still low-income		
	Middle or upper income		

9. At the state level, are there required qualifications/competencies for early childhood mental health consultants?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Don't know

9a. If yes, please check all that apply:

Qualifications/Competencies	
<input type="checkbox"/>	Bachelor's degree
<input type="checkbox"/>	Advanced degree, Masters or Doctorate
<input type="checkbox"/>	Licensure
<input type="checkbox"/>	Knowledge of Child Development (including social/emotional)
<input type="checkbox"/>	Knowledge of Early Childhood Mental Health
<input type="checkbox"/>	Other, please specify:

10. At the state level, are there support mechanisms for early childhood mental health consultants (e.g., trainings, peer networking sessions, technical assistance)?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Don't know

10b. If yes, please check all that apply and provide a brief description.

Support Mechanisms for Consultants	Description
<input type="checkbox"/>	Preservice training
<input type="checkbox"/>	In-service training
<input type="checkbox"/>	Supervision
<input type="checkbox"/>	Peer networking sessions
<input type="checkbox"/>	Technical assistance
<input type="checkbox"/>	Other, please specify:

11. At the state level, are you coordinating with any of the following partners in conjunction with ECMHC (e.g. as referral sources, service delivery partners)? (check all that apply)

<input type="checkbox"/>	Early Intervention/Part C–IDEA
<input type="checkbox"/>	Preschool Special Education/Part B–IDEA
<input type="checkbox"/>	State Head Start/Early Head Start Collaboration Office
<input type="checkbox"/>	Child welfare system
<input type="checkbox"/>	Primary care settings/providers
<input type="checkbox"/>	Home visitation programs
<input type="checkbox"/>	Public health system
<input type="checkbox"/>	Education system
<input type="checkbox"/>	Social services system
<input type="checkbox"/>	Other, please specify:

12. Has there been a coordinated statewide evaluation of ECMHC in your state?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Don't know

12a. If yes, please describe and provide the Lead Evaluator contact information:

Lead Evaluator Contact Information
Name: _____
Title: _____
Agency: _____
Address: _____

Phone _____
Number: _____
E-Mail: _____

12b. If no, how would you describe evaluation efforts across your state?

	Most ECMHC programs have evaluated their services
	Some ECMHC programs have evaluated their services
	None of the ECMHC programs have evaluated their services
	Don't Know

13. What have been the major challenges or lessons learned around ECMHC in your state?

14. Please provide us with the name of each ECMHC program in your state, along with a key contact person for each program (name, phone, email) so that we may learn more about efforts in your state **OR** provide guidance on how we might obtain such a listing.

14a.

Program Name	Key Contact	Phone/E-mail

14b. Describe how we might obtain the requested listing (key contact, web-site, etc.).

Thank You for Your Responses to Our Scan

Who, if anyone, should we list in our report as the primary contact person for those interested in learning more about your state's ECMHC efforts?

Resource Contact for More Information	
	Myself
	Other
	Name: _____
	Title: _____
	Agency: _____
	Address: _____

	Phone Number: _____
	E-Mail: _____

APPENDIX F

Expert Panel Roster

Eileen Brennan

Research and Training Center on Family Support and Children's Mental Health
Portland State University
Portland, OR

Dominique Charlot-Swilley

CEO/President
Charlot-Swilley & Associates, P.C.
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Walter Gilliam

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Marla Himmeger

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Ohio Department of Mental Health
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Amy Hunter

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Kadija Johnston

Director, Infant-Parent Program
University of California, San Francisco
San Francisco, CA

Wendy Jones

Research Instructor
National Center for Cultural Competence
Georgetown University Center for Child and Human Development
Washington, DC

Mary Mackrain

CCEP Program and Training Director
Child Care Expulsion Prevention
Birmingham, MI

Geoff Nagle

Director
Tulane University Institute of Infant and Early Childhood Mental Health
New Orleans, LA

Jim O'Brien

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Office of Head Start/ACF/HHS
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