



Research Synthesis

Early Childhood Mental Health Consultation

Contributing Authors

Frances B. Duran
Kathy S. Hepburn
Roxane K. Kaufmann
Lan T. Le
Georgetown University

Mary Dallas Allen
University of Alaska Anchorage

Eileen M. Brennan
Portland State University

Beth L. Green
NPC Research

This synthesis has been developed to describe early childhood mental health consultation (ECMHC) and the existing evidence base for its effectiveness in fostering healthy social and emotional development in young children, birth through age 6. It provides a description of the emerging evidence base that many of the beliefs and much of the current body of knowledge about consultation is grounded in literature and the experiences of mental health and early care and education (ECE) providers, educators, and other experts (i.e., practice-based evidence). Most empirical research focuses on the impact of consultation on child, program, staff and, to a lesser extent, family outcomes. Still, research efforts are occurring and data to support ECMHC as an effective model for service delivery are accumulating.

Overview

Young children's healthy social and emotional development is critical to school readiness and positive long-term outcomes (National Research Council & Institute of Medicine, 2000; Raver & Knitzer, 2002; Thompson & Raikes, 2007). Although most children progress in their development without any significant challenges, research on the high rates of preschool expulsion due to challenging behaviors (Gilliam, 2005) coupled with estimates suggesting that one in 10 young children exhibit problem behaviors (Raver & Knitzer, 2002) underscores that this is not the case for all children. In fact, early childhood providers have increasingly voiced concerns about young children showing signs of serious emotional distress and have expressed the need for training and



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assistance around managing challenging behaviors (Hemmeter, Corso, & Cheatham, 2006; Knitzer, 2000).

One approach to addressing challenging behaviors, as well as promoting social and emotional health and preventing the onset of behavioral issues, is early childhood mental health consultation. This approach is gaining popularity among ECE programs (e.g., child care centers, Head Start and Early Head Start programs, and family day care homes), and preliminary research findings are encouraging. In fact, recent reviews of research indicate that ECMHC yields positive social and emotional outcomes for young children in early childhood settings, including reductions in preschool expulsions (Perry, Brennan, Bradley, & Allen, 2006). In addition, research shows positive outcomes among ECE staff and programs receiving consultation services, such as increased staff confidence in dealing with young children's difficult behaviors and overall improvements in ECE classroom climates (Brennan, Bradley, Allen, & Perry, in press).

Within the growing evidence base, currently there are only two randomized control studies guiding the field. Thus, this synthesis will integrate available research with the more sizeable collection of knowledge from literature and practice to explore various aspects of this "emerging practice" and address the following key questions:

- What is ECMHC?
- What are the benefits of ECMHC?
- What are the characteristics of effective consultants and consultation models?
- What are the key challenges in developing and implementing ECMHC?

Key Terms

Best practices: Guidelines or practices driven by clinical wisdom or other consensus approaches that do not necessarily include systematic use of available research evidence (definition adapted from *Resource Guide for Promoting an Evidence-Based Culture in Children's Mental Health*, <http://systems-of-care.samhsa.gov/ResourceGuide/index.html>).

Cultural competence: A set of behaviors, attitudes, and policies within a system, agency, or among professionals that allows them to work in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989).

Early childhood mental health: The developing capacity of infants, toddlers, and young children to experience, manage, and express emotion; form close, secure relationships; and actively explore the environment and learn. Essentially synonymous with healthy social and emotional development (adapted from *ZERO TO THREE*, www.zerotothree.org).

Emerging practices: Innovations in clinical or administrative practice that address critical needs of a particular program, population, or system, but do not yet have scientific or broad expert consensus support (Hyde, Falls, Morris, & Schoenwald, 2001).

Evidence-based practices: Interventions for which there is consistent scientific evidence showing that they improve client outcomes (Drake et al., 2001).

Practice-based evidence: A range of treatment services and supports that are accessible and culturally appropriate and known to be effective by families, youth, and providers (National Federation of Families for Children's Mental Health, www.ffcmh.org).

What Is Early Childhood Mental Health Consultation?

Early childhood mental health consultation builds upon the well-established field of mental health consultation, pioneered by Gerald Caplan in the mid-sixties. In Caplan's seminal work (1964), he outlined an approach that involves mental health professionals working with human services staff to enhance their provision of mental health services to clients. Similarly, in ECMHC, a professional consultant with mental health expertise "works collaboratively with ECE staff, programs, and families to improve their ability to prevent, identify, treat, and reduce the impact of mental health problems among children from birth through age 6" (Cohen & Kaufmann, 2000; revised 2005). Ultimately, early childhood mental health consultation seeks to achieve positive outcomes for infants and young children in early childhood settings by using an indirect approach to fostering their social and emotional well-being.

Although the field has not reached full consensus on the scope of early childhood mental health consultation, Cohen and Kaufmann (2000) identified two sub-types of ECMHC that are frequently cited: child- or family-centered and programmatic consultation. The former and more traditional type of consultation aims to address the needs of an individual child who is exhibiting challenging behaviors or whose social and emotional well-being may be at risk due to a family crisis (e.g., death in the family, divorce). Typically, child- or family-centered consultation is provided to the child's teacher(s) and parents, and is focused on helping these adults support children more effectively. In contrast, programmatic consultation takes a more systemic approach, focusing on "improving the overall quality of the program and/or assisting the program to solve a specific issue that affects more than one child, staff member, and/or family" (Cohen & Kaufmann, p. 8). This type

of consultation is usually provided to ECE program administrators and staff and is intended to have a more widespread impact. Still, it is important to note that these distinctions are not always clear-cut when put into practice, as consultants may intermingle various strategies to meet identified needs.

Unlike traditional one-on-one therapeutic mental health services, ECMHC is primarily an indirect approach. Early childhood mental health consultants (MHCs) strive to improve children’s social and emotional well-being by building the capacity of ECE staff, parents, and other caregivers to promote healthy child development and manage challenging behaviors. Consultants educate, train, and “coach” caregivers so that they develop the skills and confidence to effectively address children’s social and emotional needs—whether it be the needs of one child or an entire classroom of children. Although the consultant may provide some direct services (e.g., observing children, conducting individual assessments, modeling effective practices), these activities are ultimately designed to enhance caregiver competence. In sum, ECMHC is both a problem-solving and capacity-building intervention.

Another hallmark of early childhood mental health consultation is the strong emphasis on collaboration. ECMHC’s approach acknowledges that in order to understand and address a child’s challenging behavior, one must look holistically at the environments in which the child functions (e.g., home, classroom, community settings). This holistic or “ecological systems perspective” (Brack, Jones, Smith, White, & Brack, 1993) in ECMHC necessitates that the consultant partners with ECE staff and families to jointly assess the challenge, determine appropriate intervention, and implement a coordinated plan of action across all settings. These collaborative relationships are essential to effective consultation and have become a special research interest in the field (Green,

Everhart, Gordon, & Gettman, 2006; Johnston & Brinamen, 2006).

Finally, ECMHC differs from many other approaches or evidence-based practices in that it is not manualized (i.e., there is no curriculum to follow). It is characterized by adherence to a core set of principles (e.g., relationship-based) as opposed to delivery of specific activities in a prescribed sequence. Accordingly, ECMHC encourages customized service delivery to meet the diverse needs of various children, families, and ECE programs. As the evidence base for ECMHC grows, the core principles of this approach will be further solidified and the impact of various

activities will be determined, helping to guide effective service delivery.

The Promotion–Prevention–Intervention Continuum

Early childhood mental health consultation recognizes that achieving positive social and emotional outcomes for young children requires a comprehensive approach that spans a continuum of mental health services and supports—from promotion to prevention to intervention (Perry, Kaufmann, & Knitzer, 2007). Although many consultants are initially engaged to provide consultation focused on an individual child needing intervention,

Table 1. What Do Mental Health Consultants Do?

A few examples:

Promotion Activities (All Children)

Child- or Family-Centered Consultation

- Provide families with information on children’s social and emotional development
- Provide tips to families on how to create a home environment that supports healthy social and emotional development

Programmatic Consultation

- Assess strengths and challenges within the early childhood setting/environment
- Support early childhood staff in creating a more prosocial learning environment
 - Engage early childhood staff and programs in promoting and encouraging staff wellness

Prevention Activities (Children At Risk for Behavioral Problems)

Child- or Family-Centered Consultation

- Conduct home visits with families and children with identified risks
- Offer families training on effective strategies for addressing challenging behaviors
- Design and help implement targeted supports to meet the needs of a child or children at risk
- Model effective strategies and coach early childhood staff in using them to support a child or children at risk

Programmatic Consultation

- Offer ideas and resources for teaching young children social skills and appropriate behavior
- Guide selection and use of social and emotional screening tools
- Support early childhood staff with classroom management strategies

Intervention (Children Exhibiting Challenging Behavior)

Child- or Family-Centered Consultation

- Provide crisis intervention services for early childhood staff regarding a child’s behavior
- Engage families and staff in developing individualized behavior support plans
 - Link child/family to community mental health services and assist with care coordination

Programmatic Consultation

- Train early childhood staff in creating and implementing individualized behavior support plans
 - Help early childhood program foster relationships with community services and providers
- Work with early childhood program to develop inclusive policies for working with children with challenging behaviors

simultaneously they often intentionally broaden their focus to include promotion and prevention-level activities as trust is established and staff skills in managing challenging behaviors improve.

For example, a consultant might focus on *mental health promotion* by conducting a workshop for parents on the importance of parent-child interactions and practical ways to maximize the benefits of those interactions. Similarly, to build capacity around *prevention of behavioral problems*, a consultant may train ECE staff on teaching strategies that enhance children’s emotional literacy and their ability to express feelings in appropriate ways. It is important to note that promotion and prevention activities do not replace intervention activities; all three are important elements within the consultants’ array of services. Table 1 provides other examples of activities MHCs might do along “the continuum.”

The Pyramid Model: A Companion to “The Continuum”

For consultants striving to implement this comprehensive, three-pronged approach, the *Pyramid Model for Promoting the Social Emotional Competence of Infants and Young Children* developed by CSEFEL (Center on the Social and Emotional Foundations for Early Learning) and the Technical Assistance Center on Social Emotional Intervention (TACSEI) provides a framework for organizing activities along the mental health continuum. The Pyramid (below) emphasizes “nurturing and responsive relationships” and “high-quality, supportive environments” for all children (promotion); “targeted social emotional supports” for children at risk for behavioral problems (prevention); and “intensive intervention” for children exhibiting challenging behavior (intervention) (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003). In addition, the bottom level of the Pyramid acknowledges the

importance of building an effective workforce that is well-trained on best practices in children’s mental health.

The Pyramid model is designed to help organize a variety of evidence-based approaches and activities focused on young children’s healthy social and emotional development. ECMHC is just one tool that might be used to support teachers and other caregivers to implement the practices at each level of the Pyramid. .



To complement the Pyramid model and support implementation of activities at each level, CSEFEL has developed accompanying training materials and a number of practical tools that can be used in the implementation of the model (e.g., scripted stories to teach children about expectations in various social situations, “cue cards” to prompt positive social skills). In addition, researchers involved in the development of the Pyramid model have created a classroom assessment tool (“Teaching Pyramid Observation Tool,” or “TPOT”) to help programs and practitioners evaluate how well each Pyramid level is being addressed (Hemmeter, Fox, & Snyder, 2008). These resources have been well-received by the early childhood community, particularly ECE staff and MHCs, who find them practical and effective. Consultants report working successfully with ECE staff to apply CSEFEL techniques and activities in their classrooms, and many

consultants have become CSEFEL trainers and/or used the TPOT to help ECE programs improve quality (Kaufmann & Horen, 2008).

Practical Resources for MHCs

The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) has developed a number of user-friendly resources to help consultants and others promote social and emotional competence in infants and young children. The resources are highlighted below. All are available for free at <http://www.vanderbilt.edu/csefel>.

- Training modules for infant/toddler, preschool, and parent with accompanying slides, handouts, video clips, and facilitator’s guide.
- Tools and resources that provide “Practical Strategies” for teachers and caregivers. These resources include tools for working on building relationships; a list of recommended children’s books that support social and emotional development, and accompanying activity ideas to bolster the themes discussed in those books, teaching social emotional skills; and tools for developing behavior support plans, including observation cards and functional assessment interview forms.
- *What Works Briefs* that summarize effective practices for supporting children’s social-emotional development and preventing challenging behaviors. The Briefs describe practical strategies, provide references to more information about the practice, and include a one-page handout highlighting major points. Based on the *What Works Briefs* topics, short training packages are available that include PowerPoint slides with accompanying note pages, activities, and handouts, which provide a trainer with the materials needed to conduct a short staff development program on a focused topic.
- A series of six modules to help professionals working with parents

promote positive and effective parenting behaviors that encourage children's social and emotional development and address the challenging behaviors and mental health needs of children in child care and Head Start programs.

- Short one- to two-page decision-making guideline documents to aid programs in making decisions about practical issues (e.g., selecting a social-emotional curriculum, selecting screening and assessment tools focused on social-emotional competence).
- State planning materials are available from several states working with CSEFEL to implement the Pyramid model.

Additional resources can be found on the website for the Technical Assistance Center for Social Emotional Intervention for Young Children (www.challengingbehavior.org), including

- A review of screening instruments for social-emotional concerns.
- *Teaching Tools*: A guide that helps classroom teachers develop practical interventions for disruptive behavior, including ready-made materials for use in the classroom.
- A manual of guidance and materials that can be used to implement the individualized positive behavior support process.
- Webinars on topics relevant to early childhood systems, policy, and professional development.

Variations in ECMHC Models

As programs continue to explore the potential of mental health consultation to produce positive outcomes, varying methods of implementing this approach have surfaced. For example, some programs provide ongoing, on-site consultation, whereas others provide intensive consultation for a relatively brief time period, followed by additional support as needed or requested. Further, some programs have grounded their models in certain

theoretical frameworks, such as attachment theory or child development theory. An additional strategy that has emerged is providing ECMHC services in combination with other services or with other early childhood mental health curricula, such as *The Incredible Years* (see www.incredibleyears.com) or *Second Step* (see www.cfchildren.org). Two examples of this blended approach are highlighted below.

COMBINING CONSULTATION AND DIRECT SERVICES

Given the complementary nature of therapeutic intervention and consultation, some ECMHC programs, including California's Early Childhood Mental Health program, offer direct services (e.g., psychotherapy and therapeutic play groups) when consultation services alone are not enough to address a child's or family's identified needs. Direct therapeutic intervention services are provided to the child, family, or staff member by the mental health professional to reach specific treatment goals. It is not unusual for mental health professionals to serve in both roles—as a consultant and as a therapist—particularly in communities where there are few individuals trained in early childhood mental health. While both roles are important, they are distinct. An MHC provides consultation services, whereas a therapist offers direct services or therapeutic interventions. Currently, there is a need for research that formally evaluates the effect of adding a direct service component to an ECMHC model. Although the evaluation of the Early Childhood Mental Health program did identify some promising outcomes, it did not measure the specific impact of therapeutic intervention (James Bowman Associates & Kagan, 2003).

COMBINING ECMHC WITH ESTABLISHED EARLY CHILDHOOD MENTAL HEALTH CURRICULA

Another variation to enhance the impact of ECMHC involves infusing

established evidence-based practices into service delivery, such as curricula that support early childhood mental health. In two recent studies of ECMHC (Raver, Jones, Li-Grining, Metzger, Champion, & Sardin, 2008; Williford & Shelton, 2008), researchers examined the efficacy of integrating ECMHC with the Incredible Years Parent and Teacher Training Series, a well-established, empirically supported program designed to educate parents and teachers on techniques to address challenging behaviors and promote social and emotional competence and well-being (Webster-Stratton, 1999a, 1999b). Although both studies evaluated the impact of the same evidence-based practice on consultation, each applied the intervention in a slightly different manner.

In the Chicago School Readiness Program model that Raver et al. (2008) evaluated, Incredible Years was adapted to fit into five six-hour training sessions delivered to teachers. This training was complemented by mental health consultation services one morning a week, including three months of child-centered consultation towards the end of the study. Similarly, the North Carolina model that Williford and Shelton (2008) studied included one group training session for teachers on a modified version of the Incredible Years, followed by individual consultation sessions with teachers to guide their learning and use of relevant concepts and techniques in Webster-Stratton's program. In addition, North Carolina offered a shortened (10-week) parent training based on the Incredible Years. Both research teams found promising results from these integrated approaches, including a better emotional climate (i.e., more teacher responsiveness and less harshness) in intervention classrooms than in control classrooms (Raver et al., 2008), and a more positive impact on child behavior (according to reports by teachers and caregivers) in the intervention group than in the comparison group (Williford & Shelton, 2008).

Who Receives ECMHC Services and in What Settings?

Currently, most ECMHC services are provided to children (birth through age 6), staff, and families in center-based care. Licensed family child care homes and unlicensed child care providers (e.g., family, friends, and neighbors) are less likely to receive consultation services, although some consultation models, (such as Instituto Familiar de la Raza's Early Intervention Program in San Francisco; www.ifrsf.org) offer services to licensed family child care homes. Still, even in Early Head Start, which serves a large number of infants and toddlers through home visiting (41%), the majority of services are provided in a center-based environment (51%; Hoffman & Ewen, 2007).

Primary consumers of early childhood mental health consultation services across the country are Early Head Start and Head Start (E/HS) programs, as their performance standards require them to "secure the services of mental health professionals on a schedule of sufficient frequency to enable the timely and effective identification of and intervention in family and staff concerns about a child's mental health" (Head Start Performance Standards and Other Regulations, 45 CFR Part 1304.24.2). Outside of E/HS programs, there is generally limited availability of consultation. Although a few states (including Maryland, Connecticut, and Michigan) have statewide consultation programs/initiatives, most states have consultation programs that serve limited geographic areas or service populations, or have not yet implemented consultation beyond what is offered through E/HS programs.

Regardless of whether consultation is provided through E/HS or another ECE setting, there has been a tendency for consultants to focus on intervention for children who exhibit challenging behavior as opposed to promotion and prevention activities

that involve greater numbers of children. Several factors have contributed to the focus on intervention in ECMHC. First, programs typically engage MHCs because their most pressing need is for help with a particular child or children. Further, consultants often have limited time to spend with early childhood programs and providers, due to large caseloads and/or lack of program funds for consultation services. Limited access to consultation can greatly undermine the ability to integrate promotion and prevention activities into early childhood settings—not only because much of the consultant's time is spent "putting out fires," but also because it is hard for consultants to build the trust and rapport necessary to shift attention towards promotion and prevention. In their study of Head Start centers, Yoshikawa and Knitzer (1997) learned that when a consultant was only available on an "on-call" basis, mental health promotion activities were essentially ignored.

Funding also plays a role in channeling services to children exhibiting behavioral challenges. Financing mechanisms are typically designed to provide reimbursement for direct services to individual children, particularly those with a mental health diagnosis. Children at risk for social and emotional challenges are generally excluded from funders' eligibility criteria (Johnson & Knitzer, 2005). These funding constraints not only undermine promotion and prevention efforts, but ECMHC in general, given its indirect, capacity-building design.

To broaden the impact of mental health consultation, provisions need to be made to widen access to mental health consultation in home-based care and education settings (i.e., licensed family child care homes and unlicensed family/friend/neighbor arrangements), and to expand the focus to include promotion and prevention activities that benefit all children as part of the array of consultation services. Ideally, ECMHC

would be available to all early care and education settings and subsidized or reimbursable through a variety of sources.

What Are the Benefits of ECMHC?

Studies on the impact of mental health consultation in early childhood settings are increasing in complexity, and evidence of the effectiveness of this approach is mounting (see below). However, the field still lacks randomized controlled trials that provide rigorous evidence of the link between the effects of consultation on staff knowledge, attitudes, and behavior, and better outcomes for young children and their families.

IMPROVEMENTS IN TEACHER ATTITUDES, SKILLS, AND STRESS LEVELS, AND CLASSROOM CLIMATES

In a clustered randomized control study of Chicago School Readiness Program classrooms, outside observers found that teachers receiving ECMHC had significant improvements in teacher sensitivity and enhanced classroom management skills, compared with teachers in classrooms without consultation (Raver et al., 2008). Observers also found that the classroom climates improved after consultation, with more positive interactions between teachers and children and fewer negative exchanges, in contrast to classrooms where no consultation was present. Staff members also rated themselves as significantly more able to manage children's difficult behavior after consultation in 9 of 11 studies reviewed by Brennan et al. (in press; see, for example, Alkon, Ramler, & MacLennan, 2003; James Bowman Associates & Kagan, 2003; Olmos & Grimmer, 2004). Finally, teachers have also generally reported lower levels of job stress after they receive consultation services (Green et al., 2006; Langkamp, 2003; Olmos & Grimmer, 2004).

BETTER OUTCOMES FOR CHILDREN

Teachers in classrooms with ECMHC services reported that children had fewer problem behaviors after these services were implemented (Bleecker & Sherwood, 2004; Gilliam, 2007; Perry, Dunne, McFadden, & Campbell, 2008; Upshur, Wenz-Gross, & Reed, 2008). Particularly, there is evidence that externalizing (aggressive, disruptive) behavior was less frequent after consultation (Gilliam, 2007; Raver et al., 2008; Williford & Shelton, 2008). Children with difficult internalizing (withdrawn, disconnected) behavior showed improvement in some studies (Bleecker, Sherwood, & Chan-Sew, 2005; Raver et al., 2008), but not in others (Duffy, 1986; Gilliam, 2007). Positive social skill development also accelerated for children with ECMHC services in several studies (Bleecker & Sherwood, 2003, 2004; Farmer-Dougan, Viechtbauer, & French, 1999; Upshur et al., 2008). Finally, there is evidence that when mental health consultation is available in early childhood programs, the rate of expulsion of children with difficult or challenging behavior decreases (Gilliam, 2005; Perry et al., 2008).

UNCLEAR IMPACT ON FAMILIES

There are fewer studies that report on the effects of ECMHC on families, and the impact on family-level outcomes is less clear. Most evaluations of mental health consultation do not report family data, making the determination of family-level effects problematic. However, several researchers have found evidence that staff and families communicated more effectively after consultation of longer duration (Alkon et al., 2003; Pawl & Johnston, 1991; Safford, Rogers, & Habashi, 2001), and that parents interacted with their children in a more positive and effective way after services were received (Langkamp, 2003; Pawl & Johnston, 1991; Williford & Shelton, 2008). Additionally, there were reports that consultation provided greater family access to mental health services

(Brennan, Bradley, Ama, & Cawood, 2003; Field & Mackrain, 2004). Although several researchers tracked parenting stress level over time, no significant decreases in stress were detected before and after consultation (Lehman, Lambarth, Friesen, MacLeod, & White, 2005; Williford & Shelton, 2008).

Who Are the Professionals Providing ECMHC?

Mental health consultants have diverse educational and training backgrounds, and bring a wide range of knowledge, skills, and experience to their work. This is due, in part, to the absence of a national licensing or accreditation process that establishes required competencies for those providing ECMHC services. Consistent with Head Start regulations, the consultant pool is largely comprised of mental health professionals licensed or certified within their state to practice a variety of human service disciplines, including counseling, marriage and family therapy, psychology, psychiatry, and social work (Green, Everhart, Gettman, Gordon, & Friesen, 2004). In addition, some states employ early childhood or special education professionals with training, but not licensure/certification, in early childhood mental health. These professionals provide similar services with the exception of clinical mental health interventions.

Educational attainment among MHCs is mixed, indicative of varying program-level competency requirements and diversity in the type of mental health services consultants provide. For example, some programs may require MHCs who provide screening, assessment, or intervention services to have at least a master's degree. Consultants are also employed in a number of differing ways: a national survey of 69 Head Start programs found that a relatively small proportion of mental health consultants were employed directly by the programs (22%), while the majority were employed outside of Head Start by a

non-profit agency (23%), by a government agency (7%), by a school or other agency (15%), or were in private practice (33%; Green et al., 2004).

“The early childhood mental health consultation workforce is in transition from one of broad diversity in terms of training, experience, roles, responsibilities, and work expectations to one that has specific expertise in early childhood mental health and the specific skills required to take on the role of consultant.”

(Allen, Brennan, Green, Hepburn, & Kaufmann, 2008, p.21)

What MHC Competencies Are Most Important for Effective Consultation?

Despite the variation in MHCs' professional affiliations and level of education, a set of core competencies essential to the provision of effective consultation is emerging from practice-based knowledge. These skills and attributes include the following:

- Knowledge, skills, and experience in early childhood mental health, child development, and early childhood education
- Ability to build positive relationships with staff and families
- Knowledge of community services and supports
- Cultural sensitivity

KNOWLEDGE, SKILLS, AND EXPERIENCE

Effective mental health consultation requires a unique set of knowledge and skills. While expertise in early childhood mental health is essential, it must be coupled with an ability to work successfully in early childhood settings and within family and community contexts. Based on feedback from a roundtable of experts in early childhood mental health (Cohen, E., & Kaufmann, R. K. (2000)), the recommended competencies for consultants include the following:

Knowledge of...

- Normal growth and development of young children, including developmental milestones
- Atypical behavior in infants, toddlers, and preschoolers
- Underlying concepts of social and emotional development, such as attachment, separation, and relationship development
- Best practices and various intervention strategies
- Early childhood, child care, family support, and early intervention systems
- Adult learning principles

As well as the following skills and experience...

- Ability to integrate mental health activities and philosophies into group settings
 - Child and classroom observation and assessment
 - Ability to work with staff and families and recognize their diverse perspectives
 - Communication facilitation
 - Sensitivity to community attitudes and strengths
 - Cultural competence
- (adapted from Cohen & Kaufmann, 2005)

The competencies outlined above mirror many of those identified by researchers in Colorado, who developed a checklist of core knowledge and competencies for MHCs to guide workforce development in their state (JFK Partners, 2006). Informed by literature review, expert opinion, and a survey of Colorado professionals involved in ECMHC, the checklist reflects the importance of a strong background in child development and early childhood mental health, and the ability to collaborate with ECE staff to foster high-quality care and to build linkages with child- and family-serving systems and community-based organizations. Colorado's checklist also highlights skills that support effective service delivery, such as reflective practice; developing strategies that integrate health and mental health

considerations; and advocating for policies, resources, program evaluation, and other components that support effective service delivery.

In addition, participants in a qualitative study of Head Start MHCs stated that consultants who work in early childhood environments should have experience in early childhood education and an understanding of the challenges of teaching young children (Allen, 2008). In some instances, MHCs may also need specialized expertise in certain areas (e.g., maternal depression, post-traumatic stress) to address the needs of a child or family. When the consultant does not have this expertise, it underscores the need for knowledge of local systems, providers, and resources and the ability to facilitate these linkages.

“[T]he effective consultant not only has expertise in the particular content area in which she offers assistance, but also has the interpersonal skills to motivate staff to take action.”
(Cohen & Kaufmann, 2005, p. 19)

RELATIONSHIP BUILDING WITH STAFF AND FAMILIES

Another essential skill for MHCs is the ability to develop strong relationships with ECE staff and families. Positive relationships between early childhood staff and MHCs are an important predictor of whether staff believe that consultation improves child outcomes (Green et al., 2006). Further, Green and colleagues (2004) found that “[h]aving a mental health consultant who is trusted, who makes him/herself accessible to staff, and who is perceived as being ‘part of the team’ may be more important than the actual number of hours a consultant is available” (p. 58). With respect to families, a strong relationship between a MHC and a young child's parents is critical, because those caregivers act as gatekeepers for the child's access to mental health services (Allen, 2008) and are the primary source of ongoing

support for social and emotional development in the home.

Developing positive relationships with early childhood staff requires MHCs to avoid an expert stance, have good listening skills, use a strengths-based approach, and be a non-judgmental, supportive team player (Donahue, Falk & Provet, 2000; Johnston & Brinamen, 2006). Similarly, developing these collaborative relationships with families requires MHCs to have opportunities to connect with families, to maintain a family-centered approach, and to be culturally sensitive (Allen, 2008). Consultants can help to facilitate these relationships by routinely spending time in ECE classrooms, particularly during events when parents are present, for example, drop-off and pickup times. This regularly scheduled time also allows consultants to observe staff, children, parents, and overall environments, and to model approaches for working with children, thus helping staff to develop these skills themselves. Further, it underscores the role of the consultant in *preventing* serious emotional and behavioral issues, rather than being called on only when problems have already emerged.

CULTURAL AND LINGUISTIC COMPETENCE

Cultural and linguistic competence is a vital skill for MHCs if they want to build solid partnerships with staff and families. An important step in achieving cultural and linguistic competence, which is a developmental process that evolves over time, is an awareness of one's own culture and how that impacts personal beliefs and values (Cross et al., 1989; National Center for Cultural Competence, n.d.). According to Hepburn and Kaufmann (2005), indicators that a consultant is culturally and linguistically competent include the following:

- Demonstrated respect for diverse backgrounds
- Understanding of the variance across cultures in mental health practices and how clinical issues present

- Provision of treatment and information in the appropriate language or literacy level (through interpreters, as necessary and appropriate)
- Utilization of culturally appropriate screening, assessment, and intervention tools and service plans
- Ability to distinguish between resistance to change and a desire to uphold culturally appropriate behavior

According to findings from Allen's (2008) focus groups with MHCs, cultural sensitivity is also demonstrated through a non-judgmental approach, a willingness to learn, and a sense of curiosity that allows an MHC to identify, understand, and respect differences. Focus group participants also asserted that MHCs need to understand how cultural and community contexts influence stigma towards mental illness and, in turn, affect a family's willingness to partner with the consultant.

In essence, to be effective, MHCs need to develop a complex set of competencies and have the ability to draw on the skills and knowledge that are most relevant at any given time to the needs of children, staff, and families in diverse programs and communities. As summarized by the team of researchers from Colorado, "[t]he competencies define the range of skills that a mental health consultant needs while programs dictate which of the skills will be most important for a mental health consultant working within their setting" (JFK Partners, 2006).

"A consultant's advice, no matter how intelligent and how 'right,' is useless if it does not consider the caregiver's perspective and understanding of the situation and, ultimately, the caregiver's willingness to participate in particular changes."

(Johnston & Brinamen, 2006, p. 14)

What Preparation and Support Do Mental Health Consultants Need?

TRAINING

Although the number of mental health consultation programs across the country is growing, there is a scarcity of research to guide the training and ongoing support of consultants. Few states or universities provide training or coursework on early childhood mental health, and even fewer offer instruction on mental health consultation (Cohen & Kaufmann, 2005). Michigan has made strides in this area with its Michigan Association of Infant Mental Health (MI-IMH) endorsement, which is designed to build workforce capacity around early childhood mental health. There are four professional levels of attainment within the MI-IMH endorsement, which looks at skills and competencies for all professional personnel working with infants and young children, including early childhood mental health consultants. Each level has guidelines describing areas of expertise, responsibilities, and behaviors that demonstrate competency, and requires the preparation of a portfolio, references, and evidence of having met the competency-based requirements for work experience and education. At this time, a number of other states are working to implement Michigan's model, including Arizona, New Mexico, Texas, Oklahoma, Kansas, Minnesota, and Connecticut.

Training efforts focused exclusively on building the capacity of MHCs are happening sporadically

across the United States. Many of these efforts include standard training protocols for consultants that build or reinforce skills and provide opportunities for practicing new skills. Adding a practice component is consistent with current research on acquiring new skills (Fixen, Naom, Blasé, Friedman, & Wallace, 2005). Johns (2003) describes the intensive training provided by Daycare Consultants at the University of California, San Francisco, which offers intensive training to all mental health clinicians who desire to become consultants, including experienced clinicians. As Johnston and Brinamen (2006) explain, "training in mental health consultation is essential for both veteran therapists and newcomers from different disciplines...[because] new application [of skills] requires new knowledge" (p. 7). Daycare Consultants' training integrates mental health principles and knowledge of early childhood education and development, and is comprised of four key elements: 1) a didactic training seminar; 2) a clinical conference; 3) clinical supervision; and 4) direct consultation experience (Johns, 2003; Johnston and Brinamen, 2006).

Workforce Development/ Training Resource

Michigan Association for Infant Mental Health, MI-AIMH Endorsement (IMH-E)

See http://www.mi-aimh.org/endorsements_overview.php

Daycare Consultants Training for Mental Health Consultants
The Early Childhood Mental Health Project: Child Care Center Consultation in Action, Section VII: Training Mental Health Consultants (Johns, B., 2003) Available at <http://www.jfcs.org>

SUPERVISION AND PEER CONSULTATION

Mental health consultants also need adequate support and supervision in order to be successful in their work. This includes opportunities to share lessons learned, express feelings and frustrations, and discuss challenges and appropriate next steps with those who can relate to their experiences and provide informed guidance. These opportunities are particularly important for MHCs because without them, many consultants are isolated from other early childhood mental health providers due to the independent and itinerant nature of their work.

To address this need, many consultants receive regular clinical supervision from a senior clinician who is associated with the organization, agency, or entity where the consultant is employed. Consultation programs in some states and communities, including Michigan, Kentucky, San Francisco, and Louisiana, employ the practice of “reflective supervision,” in which an experienced clinician supervises MHCs—individually or in groups—by providing support and knowledge to guide decision making; offering empathy to help supervisees explore their own reactions to the work; and helping supervisees manage the stress and intensity of the work (Parlakian, 2002, p. 1).

An additional supportive strategy that some states and communities are using is providing a forum for consultants to gather with their peers to discuss issues, tackle problems, share strategies, and celebrate successes. In Sarasota, Florida, consultants benefit from a hybrid model that integrates reflective supervision and peer consultation. MHCs get together for monthly team meetings and meet either weekly or bi-weekly for individual supervision depending on the intensity of services the consultant provides (Wu, Driver, Jaekel, & Skoklund, 2008).

Another level of support that some consultants may have is administrative supervision by the

director or another senior staff member from the ECE program(s) with whom the MHC works. This level of support is important since most consultants are not formally employed by ECE programs/providers, and supervisors from the consultants’ hiring entity may be detached from the environment in which the consultant is working. Regardless of whether the consultant benefits from clinical supervision and/or peer consultation, this additional supervisory structure is important for communication and integration of the consultant into the early childhood program. The supervisory relationship should be clarified within any contractual agreement between the program and a consultant from an outside organization or agency. For those consultants who are employed directly by the ECE program, the supervisory relationship fits within the organizational structure.

“Supportive relationships between staff members and leaders are the foundation for nurturing relationships between parents and children. Strong supervisory relationships provide the staff with a model of, and experience with, supportive, individualized responses.”

(Parlakian, 2002, p.1)

What Can ECE Programs and Providers Do to Support Effective Consultation?

ECE DIRECTORS/ADMINISTRATORS

Strong program leadership is critical to forming a foundation for effective mental health consultation (Green et al., 2004). Early care and education program directors and administrators greatly influence collaboration between staff, consultants, and families through their leadership style and their attitudes toward consultation and early childhood mental health. To facilitate positive relationships, they can

demonstrate a commitment to ECMHC by championing a shared vision for promoting children’s mental health and supporting positive social and emotional development, and ensuring that this vision permeates all aspects of the program (what is sometimes called a “mental health perspective”; Knitzer, 1996).

Early care and education program directors and administrators also have a strong impact through their oversight of key administrative processes such as the following:

- Determining the consultant’s organizational role (external consultant or staff member?)
- Specifying the consultant’s scope of work
- Recruiting and choosing which consultant to hire
- Negotiating the contractual agreement
- Facilitating the consultant’s entry into the program
- Evaluating the impact of consultation and making adjustments as needed

These decisions have significant implications for the success of the consultation. With respect to hiring, Hepburn and Kaufmann (2005) emphasize that it is critical to “match” the program’s needs with a consultant’s skills, and to find a consultant who shares the program’s philosophy on early childhood mental health. Similarly, the roles and responsibilities of the MHC should be shaped by this intersection of program need and consultant ability and evaluated at least annually to ensure that services provided continue to meet the program’s needs.

Another important consideration in defining the work scope and structuring the consultant role is the extent to which it provides a framework for collaboration with staff and families. Research suggests that consultants who are integrated into program functioning, whom program staff view as “part of the team,” and who are accessible and available to program staff and families are more effective (Gilliam, 2005;

Green et al., 2006; Yoshikawa & Knitzer, 1997). The way in which a consultant's role is structured can greatly impact program integration and, likewise, the quality of the relationship between the consultant, staff, and families. For example, will the MHC be in classrooms on a regular basis to provide ongoing support to staff or only when there is a problem? Furthermore, to elicit staff trust, it is important to structure the consultant role in a way that focuses on supporting staff, not monitoring them (Donahue et al., 2000).

Directors and administrators should also consider highlighting the value of consultation services by encouraging staff to utilize the consultant's services and making sure consultants have the opportunity early in the school year to talk about their role and how they can help support both staff and parents. In fact, Allen's (2008) focus groups with MHCs found that having a program director take the time to introduce the consultant to staff early on goes a long way in building the foundation for trusting relationships.

Providing these communication opportunities at the onset of consultation is particularly important given that teachers are sometimes reluctant to admit they are facing challenges with certain children or families, and therefore hesitate to work with the consultant, as doing so might imply that they have somehow "failed" in their job. The program director (as well as the consultant him- or herself) plays an important role in addressing these concerns and being clear that working with the consultant does not indicate a lack of teacher skills. In fact, the director should assure staff that the consultant is not there to report on teacher performance, but rather to provide support. Table 2 provides additional guidance on how directors and administrators can lay the groundwork for effective consultation by fostering positive relationships.

Table 2. Do's and Don'ts for Fostering Staff–Consultant–Family Relationships (adapted from Green et al., 2004)

| DO | DON'T |
|--|--|
| Hire or contract with an MHC who has experience in early childhood and ECMH, as well as in providing consultation (not just direct therapy) | Assume the MHC knows what it means to be a "consultant" rather than a direct service provider |
| Provide the MHC with training about your program | Assume that the MHC knows about early childhood programs generally, or your program in particular |
| Be clear with staff about the role of the MHC and when, how, and what services will be provided | Assume that staff will welcome the MHC into their classroom |
| Put processes in place that protect confidentiality, but do not hinder information-sharing among a child's teacher and MHC, nor compromise open communication with parents | Establish a process for obtaining parental permission that puts up unnecessary obstacles for the MHC in working with a child |
| Make sure all staff and parents have a chance to meet the MHC early in the school year | Wait until issues arise before introducing the MHC |
| Allow staff to have direct access to the MHC through email or phone | Put up a lot of barriers that hinder staff members' ability to access the MHC |
| Have scheduled time for the MHC to be in classrooms regularly | Only have MHCs visit classrooms when there is a problem |
| Have the MHC provide training in mental health issues to staff and families | Use the MHC just for one-on-one services |
| Have the MHC attend ongoing meetings to discuss specific children and families with staff | Assume the problem is solved once a referral to the MHC is made |
| Establish a long-term relationship with a consultant (or consultants) | Have a "rotating" consultant who changes from year to year |

ECE PROVIDERS

ECE providers (i.e., teachers, assistant teachers) also play an important role in maximizing the effectiveness of consultation services. Often, providers are the ones identifying consultation needs, and ultimately, they are the ones charged with implementing the consultant's classroom recommendations. The extent to which providers engage the consultant, participate with the MHC and parents as part of a team, and follow through with consultant recommendations has clear

implications for whether consultation will succeed or not.

First and foremost, providers can support effective consultation by setting the tone for a good working relationship with the consultant. This includes reaching out to the consultant for help and remaining open to his/her ideas, while sharing their own thoughts and perspectives. In addition, providers can help facilitate the development of positive relationships between the consultant and parents so that the three partners can work collaboratively to

improve behaviors at home and in the classroom. Clearly, MHCs must do their part if these provider overtures are to lead to successful consultation. As Allen's (2008) qualitative research suggests, providers are more likely to engage parents in working with an MHC if they themselves have had a good experience with the consultant. Another way providers can support effective consultation is by trying to implement the consultant's recommendations, seeking guidance and support as necessary, and providing feedback to the MHC so that modifications can be made to the recommended strategies as needed.

What Are Some of the Challenges That Need to Be Addressed?

As discussed earlier in this synthesis, making ECMHC available in all of the ECE settings that need/want it is a fundamental challenge. Relatively few early childhood programs and providers across the country benefit from consultation, and those that do receive services of varying type and intensity from a diverse group of consultants. Issues stifling widespread implementation and presenting obstacles the field must overcome include limited rigorous research, lack of sustainable funding, and insufficient workforce capacity.

RESEARCH

Although the evidence base for the overall effectiveness of the ECMHC approach is growing (Brennan et al., in press; Perry et al., 2006), there are still lingering questions about which aspects of consultation are causally related to positive outcomes and, hence, most important to retain across ECMHC programs. This lack of clarity has led to variability in program models across the country and made it challenging to expand the field and establish ECMHC as an evidence-based practice. Thus, more research is needed to decisively respond to these

seminal questions:

- What are the service boundaries of ECMHC?
- When does a service shift from being “consultation” to “therapy”?
- What are the characteristics of effective consultants?
- What is the value-added of reflective supervision?
- What are the best service models?
- What types of activities are most important for the consultant to provide?
- What level of service intensity is needed to effect change?
- Which outcomes should be targeted and how should these be measured?
- Is mental health consultation more effective when used in conjunction with an evidence-based practice (e.g., MHC and The Incredible Years or MHC and Second Steps)?

Given the variability in consultation models, answering these questions will be challenging and require an incremental approach. Additional challenges facing evaluators are the lack of agreement on which outcomes should be tracked, which outcome measures should be used, and the ethical issues associated with establishing control groups in early care and education settings (Allen, 2008). Other methodological considerations include how to design research projects that focus on the effects of consultation alone, as opposed to the cumulative impact of a number of program enhancements. In a climate where service dollars are limited, there are fewer dollars available to support high-quality evaluation studies. These issues must be taken into consideration when researchers and programs engage in evaluation efforts.

To expand the evidence base for ECMHC, high-quality process and impact evaluations need to be funded and implemented through partnerships between researchers and program managers. As states and communities expand their capacity to provide mental health services to young

children and their families and the field of ECMHC continues to grow, the capacity of programs to evaluate their service components and outcomes should also be developed. To this end, Hepburn et al. (2007) developed an evaluation toolkit to help stakeholders better address these gaps in the evidence base.

Research & Evaluation Resource

Early Childhood Mental Health Consultation: An Evaluation Toolkit (Hepburn, Kaufmann, Perry, Allen, Brennan, & Green, 2007) Available at <http://gucchd.georgetown.edu>

FUNDING

While limited scientific evidence of the effectiveness of ECMHC is one barrier to obtaining steady funding in many states and communities, there are a variety of fiscal challenges that keep ECMHC from going to scale. Some of these funding issues are common to expanding children's services in general: scarce public and private resources, and a high demand for these limited dollars. There are also unique aspects of ECMHC that make sustainable funding particularly challenging.

First, it is much more difficult to obtain reimbursement for “consultation”—particularly program-focused consultation—than for direct intervention with one child, given the funding structures inherent in private insurance and public programs like Medicaid, the State Children's Health Insurance Program (SCHIP), and the Individuals with Disabilities Education Act (IDEA). Current reimbursement systems are geared toward paying for a single, face-to-face encounter with an identified patient with a diagnosed condition. Additionally, it is challenging to secure funds for promotion and prevention activities because funders may only be willing

to cover expenses associated with meeting the needs of children who exhibit serious social and emotional problems and/or have a mental health diagnosis (Florida State University Center for Prevention & Early Intervention Policy, 2006).

Some consultation programs are funded through private foundations, universities, and/or pilot/demonstration projects, while others rely on public funding or some combination of both. This blending or braiding of funds is often critical because, as Collins et al. (2003) suggest, funds that are earmarked to address social or emotional challenges in young children are often tied to individual children, whereas “[f]lexible resources that can be used to support child care–mental health partnerships generally do not focus on children’s social and emotional development” (Collins, Mascia, Kendall, Golden, Schock, & Parlakian, 2003, p.45).

Medicaid, particularly the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, is a significant source of revenue for many programs that receive ECMHC services. Other sources of public funding include the following:

- Early Head Start/Head Start
- Individuals with Disabilities Education Act (IDEA Part B, Section 619, Part C)
- Mental Health and Substance Abuse Block Grants
- Child Care and Development Fund
- Child welfare funds, such as Title IVE of the Social Security Act
- Maternal and Child Health Block Grant under Title V of the Social Security Act
- Temporary Assistance to Needy Families (TANF)
- Supplemental Security Income (SSI, Title XVI of the Social Security Act)

(Cohen & Kaufmann, 2005; Collins et al., 2003)

Through the *Early and Periodic Screening, Diagnosis and Treatment (EPSDT)* program, states are required to provide a comprehensive set of benefits and services—including mental health services—for children enrolled in Medicaid. Given that an estimated one in three children under age 6 is eligible for Medicaid (Health Resources and Services Administration), EPSDT can be a valuable funding source for child-focused ECMHC.

In Vermont, services—including ECMHC—provided through the statewide Children’s UPstream Project (CUPS) were funded equally through federal grant dollars and Medicaid. This funding mix was established by project leaders to promote sustainability after the grant period ended. The grant monies stemmed from the Comprehensive Community Mental Health Services for Children and their Families Program, administered by the Children’s Mental Health Services (CMHS) division of the Substance Abuse and Mental Health Services Administration (SAMHSA). To generate the other half of the funding, local agencies were tasked with maximizing the use of Medicaid funds and providing the necessary Medicaid match money through existing regional allocations of State General Funds. Interagency sharing of General Funds, coupled with a state-level policy change that authorized payment for services for children birth to age 6 with the diagnosis of a parent-child relationship disorder (a “V” code in the Diagnostic and Statistical Manual of Mental Disorders [DSM]), made it possible for the program to support and gradually expand its array of mental health services (Bean, Biss, & Hepburn, 2007).

Clearly, ECMHC’s inherent array of services and the mode of service delivery present significant challenges to those endeavoring to develop and/or

sustain consultation programs. Yet, there is practical and theoretical guidance available. For example, in addition to Vermont, several other states have succeeded in applying state funds toward early childhood mental health consultation, including Maryland (Early Childhood Mental Health Project), Massachusetts (Together for Kids), and Connecticut (Early Childhood Consultation Partnership). Further, in her chapter titled “Strategic Financing of Early Childhood Mental Health Services,” Perry (2007) outlines a multiple-step process model (adapted from Striffler, Perry, & Kates, 1997) for braiding together federal, state, public, and private funds to support early childhood mental health services that address the continuum of promotion, prevention, and intervention.

Funding Resources

Funding Early Childhood Mental Health Services and Supports

(Wishmann, Kates, & Kaufmann, 2001)

Available at

<http://gucchd.georgetown.edu>

Spending Smarter: A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness

(Johnson & Knitzer, 2005)

Available at www.nccp.org

WORKFORCE

Finally, workforce capacity is a significant challenge facing the ECMHC field. As Johnston and Brinamen (2006) suggest, mental health consultants need such a broad knowledge base that no one could possibly have all the relevant skills and experience without targeted training and preparation. Per previous discussion, provision of quality mental health consultation requires multiple competencies, including a firm grasp of best practices in mental health and

child development, as well as an understanding of, and appreciation for, early care and education settings. The scarcity of mental health professionals with the necessary attitudes, skills, knowledge, and experience to meet the needs of young children and their families and to provide effective consultation services is well-documented (Green et al., 2006; National Research Council & Institute of Medicine, 2000; President's New Freedom Commission on Mental Health, 2003).

Unfortunately, while cross-disciplinary training is critical, it is not widespread. In fact, Meyers (2007) highlights that the training on early childhood mental health alone is inadequate, citing a lack of high-quality training among mental health professionals on the unique skills required to serve young children with social and emotional needs. She also notes the absence of infant and early childhood mental health pre-service training in most graduate clinical education programs. Cohen and Kaufmann (2005) add that few higher education programs provide courses that teach students how to become mental health consultants.

Summary

Although early childhood mental health consultation programs have grown in number over recent years, this is still a relatively new approach to providing mental health services to young children. As such, the field is continuing to build its evidence base and learn about the most effective way to structure ECMHC programs. While current evaluation findings on the efficacy of consultation are encouraging, a concerted research effort is needed to refine the approach, build consensus in the field, and firmly establish ECMHC as an evidence-based practice.

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