



ZERO TO THREE[®]

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Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families



Early Childhood Mental Health Consultation

Reflections, Definitions, and
New Directions

Consultation Across Diverse
Settings

Establishing Professional
Competencies

Challenges and Opportunities
for Financing

THIS ISSUE AND WHY IT MATTERS

Early childhood mental health consultation (ECMHC) has emerged as an important strategy to support professionals working with young children and their families across a variety of settings and disciplines. ECMHC has been linked with many positive outcomes for children and for the programs that receive ECMHC. As ECMHC is gaining increasing momentum in states and communities, many are grappling with questions about how to define ECMHC, how to deliver effective services, and how to pay for it. This issue of *Zero to Three* was developed in collaboration with Guest Editors Deborah F. Perry and Amy Hunter from Georgetown University's Center for Child and Human Development, which has been a leader in the field of ECMHC for more than a decade. The articles in this issue span a broad range of topics including: the current evidence base for ECMHC; professional development competencies and needs; the role of reflective supervision; and how to serve diverse populations and implement ECMHC in diverse settings. Collectively, the articles represent the most current innovations and strategies for successfully integrating ECMHC into child and family serving systems.

One of the *Zero to Three* Journal's recent innovations has been the new digital edition of the Journal. We are eager for feedback on your experience of the Journal in the digital format, so please take a moment to drop me a note and let me know what you think. We are also pleased to be able to offer an institutional subscription to the digital edition to libraries and other organizations wanting access for multiple users beginning with the May 2013 issue. For more information, please visit www.zerotothree.org/journal.

We have been delighted to hear that the opportunity to earn Continuing Education Units (CEUs) through the *Zero to Three* Journal has offered a new and accessible way to meet the professional development needs of early childhood professionals. For example, a group in Wisconsin is using the Journal for training in a "Book Club" format with the opportunity for discussion about each issue prior to taking the CEU exam. An organization located abroad that does not have the funds to send their staff members to conferences is meeting their early childhood training requirements through the Journal's CEU program. We would be happy to talk with you about customizing the CEU opportunity to meet your group training needs. To learn more about Journal CEUs, go to www.zerotothree.org/JournalCEU.

I look forward to hearing from you,

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Contents

May 2013 Volume 33 No. 5

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

- 4 EARLY CHILDHOOD MENTAL HEALTH CONSULTATION: Reflections, Definitions, and New Directions**
ROXANE K. KAUFMANN, DEBORAH F. PERRY, KATHY SEITZINGER HEPBURN, AND AMY HUNTER
- 10 EARLY CHILDHOOD MENTAL HEALTH CONSULTATION AS AN EVIDENCE-BASED PRACTICE: Where Does It Stand?**
KATHY SEITZINGER HEPBURN, DEBORAH F. PERRY, EVA MARIE SHIVERS, AND WALTER S. GILLIAM
- 20 THE BUILDING BLOCKS FOR IMPLEMENTING REFLECTIVE SUPERVISION IN AN EARLY CHILDHOOD MENTAL HEALTH CONSULTATION PROGRAM**
SHERRYL SCOTT HELLER, ALISON STEIER, ROSE PHILLIPS, AND LEAH ECKLEY
- 28 EARLY CHILDHOOD MENTAL HEALTH CONSULTATION: Applying Central Tenets Across Diverse Practice Settings**
JORDANA ASH, MARY MACKRAIN, AND KADIJA JOHNSTON
- 34 ENHANCING HOME VISITATION WITH EARLY CHILDHOOD MENTAL HEALTH CONSULTATION: Building Hope, Strength, and Capacity**
MARY MACKRAIN AND PAULA C. MYTTON-ORTEGA
- 38 A NEW FOCUS FOR MENTAL HEALTH CONSULTATION: Increasing Child Care Quality and Stability for Young Children in Foster Care**
NICOLA CONNERS-BURROW, TERESE PATRICK, ALISON STEIER, AND E. CHRISTOPHER LLOYD
- 45 A QUALITY START IN LOUISIANA: Early Childhood Mental Health Consultation as a Primary Support in a Statewide Quality Rating and Improvement System**
ALLISON B. BOOTHE AND GEOFFREY A. NAGLE
- 52 TOWARD COMMON GUIDELINES FOR TRAINING, COMPORTMENT, AND COMPETENCE IN EARLY CHILDHOOD MENTAL HEALTH CONSULTATION**
KADIJA JOHNSTON, ALISON STEIER, AND SHERRYL SCOTT HELLER
- 61 THE WAY FORWARD: Paying for and Sustaining Early Childhood Mental Health Consultation in States and Communities**
FRANCES DURAN, ROXANE K. KAUFMANN, MARISA IRVINE, AMY HUNTER, AND NEAL M. HOREN

ALSO IN THIS ISSUE:

- 2 This Issue and Why It Matters—STEFANIE POWERS**
- 71 Jargon Buster—A GLOSSARY OF SELECTED TERMS**

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Early Childhood Mental Health Consultation

Reflections, Definitions, and New Directions

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Early childhood mental health consultation (ECMHC) is a strategy that is increasingly being used to promote children's healthy social and emotional development in a variety of settings. The monograph *Early Childhood Mental Health Consultation* (Cohen & Kaufmann, 2000, 2005) put forth a definition of ECMHC that has been widely used to guide the early and ongoing development of ECMHC programs. This definition emphasized the collaborative relationship between a mental health consultant and caregivers (i.e., early childhood staff and family members) and identifies two types of consultation: child- or family-centered consultation and programmatic consultation. In both types of consultation, the goal is to build the capacity of staff, families, and programs to support the social-emotional development of young children, address concerns about an individual child, or improve program services and practices that affect more than one child and family (see box The Value of Early Childhood Mental Health Consultation).

Members of the early childhood team at Georgetown University Center for Child and Human Development (GUCCHD) have engaged in two major efforts to further define and operationalize ECMHC. One effort resulted in an in-depth study of six effective ECMHC programs and defined a model for ECMHC programs. A second effort built upon this study and resulted in the articulation of a set of practice-based principles (see box 10 Practice-Based Principles) and refined the definition of ECMHC.

In brief, the in-depth study titled *What Works? A Study of Effective Early Childhood Mental Health Consultation Programs* (Duran et al., 2009) identified five factors important in the design of an effective ECMHC program (Duran, Kaufmann, Irvine, Hunter, & Horen, this issue, p. 61). The cross-site analysis of data from the six diverse programs underscored that, while ECMHC program models vary considerably across the country, there are consistent, stable, and fundamental components that are common to these effective programs (Duran et al., 2009).

As the field struggled to establish ECMHC as an evidence-based practice, members of the early childhood team at GUCCHD designed a Delphi process to refine the definition and create a set of practice-based principles which provide a foundation for the work. The

Abstract

This article reviews the definition and practice of early childhood mental health consultation (ECMHC) and its evolution from the monograph *Early Childhood Mental Health Consultation* (Cohen & Kaufman, 2000) to the present. Key efforts to refine the definition and operationalize ECMHC include an in-depth study of six ECMHC programs, a defined model for effective ECMHC (including a list of consultant activities), and articulation of a set of practice-based principles. This work by Georgetown University Center for Child and Human Development and the contributions of others featured in this issue of *Zero to Three* continue to move the field forward in establishing the evidence base for ECMHC and the assessment of ECMHC fidelity.

THE VALUE OF EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

It is 1972, a group of 3-year-old children are sitting in a circle of sorts singing the *Itsy-Bitsy Spider*. After the short gathering, the children move around the room choosing the activity centers they most enjoy. Andrew wanders aimlessly until Dr. S invites him to join in making play dough. Together, they follow the picture recipe, with Dr. S asking Andrew some questions: "What do we add next, how does the play dough feel, and which color should we add?" Although Andrew seems engaged in the activity, he does not answer any of Dr. S's questions verbally; he demonstrates his understanding through his actions.

Dr. S is a child psychologist from a nearby community mental health center who consults with the preschool 1 day a week. The preschool director suggested to the teacher that Dr. S might be able to help her with Andrew. During a recent home visit the teacher observed Andrew talking animatedly with his parents and his pet dog, however he ignored all of his baby sister's questions and comments. He also ran away when the teacher tried to talk with him. Parent-teacher conferences were scheduled during the next few weeks, and the young teacher was very worried about how to share her concerns about Andrew.

Dr. S met with the teacher twice before the conference with Andrew's parents, and they practiced what might be shared during the conversation. He suggested inviting the parents to observe Andrew in the classroom before the conference so they could watch how difficult it seemed for Andrew to speak up and to navigate the classroom on his own. Dr. S volunteered to come to the meeting to support the teacher and to share his observations.

Further, the teacher and Dr. S developed a plan that required the teacher to be more directive with Andrew than was typically her style; taking him by hand to an activity center and getting him started in a cooperative activity. He also suggested that the teacher find a special friend in the class for Andrew and arrange activities for the two of them that required expressive language, such as staging a puppet show or "reading" picture books to each other.

* * * * *

As a new teacher, I treasured the consultation Dr. S provided me and wished that all teachers had access to that kind of support. When I left teaching, I went to work at Georgetown University to provide technical assistance to Head Start grantees, programs which also had access to a mental health consultant as part of their array of services and supports. On the basis of these early experiences, I continued to pursue opportunities to increase awareness about the value of this approach in building the competence of professionals and parents working with young children. As part of the National Technical Assistance Center for Children's Mental Health, I advocated for an increased focus on young children's mental health—before children were diagnosed with serious emotional disturbances and needed services from multiple public and private sector service providers. In 2000, the Center was able to use a small grant from the Substance Abuse and Mental Health Services Administration to explore best practices in ECMHC. We convened a roundtable on the topic—bringing together families, mental health consultants and administrators, policymakers, early care and education providers, and other professionals to share strategies; this meeting resulted in the development of a monograph, *Early Childhood Mental Health Consultation* (Cohen & Kaufmann, 2000). The so-called "green book"—which was reprinted in a revised edition with a red cover in 2005—served as an important catalyst for many in the field to expand the use of this approach to child care programs that were not Head Start programs.

—Reflections by Roxane Kaufmann, Director of Early Childhood Policy, Georgetown University Center for Child and Human Development.

Delphi method is a collaborative, consensus-building process. A pool of about 30 experts was recruited from a list of participants in a national conference call series that disseminated the findings of the *What Works* study (*What Works*, 2010). These stakeholders were selected to reflect diverse perspectives: mental health consultants who were active in the work currently, supervisors and program managers who were running ECMHC programs, policymakers, and researchers. The questions posed to guide this work included:

- Is there a common core that unites existing ECMHC programs?
- What are the central or foundational principles or activities that these ECMHC models share that help define ECMHC?
- Can this set of principles and practices differentiate ECMHC from other activities in early childhood settings?
- How can these principles and practices be applied to ECMHC and establish a practice model that supports fidelity assessment?

10 PRACTICE-BASED PRINCIPLES

As the field has built the evidence base for early childhood mental health consultation (ECMHC), there is growing interest in how to measure "fidelity." However, unlike other evidence-based interventions, there is not a single model of ECMHC. Therefore, a core set of principles which guide the work were identified through a consensus process with national stakeholders. High-fidelity ECMHC adheres to the following principles:

1. Relationship-based
2. Collaborative
3. Individualized
4. Culturally and linguistically responsive
5. Grounded in developmental knowledge
6. Evidence-informed
7. Data-driven
8. Delivered in natural settings
9. Spans the continuum from promotion through intervention
10. Integrated with community services and supports

The definitions of each principle include specific activities that can help define a program practice model.

Kaufmann et al., 2012

Participants were presented with a definition of ECMHC and 10 practice-based principles that guide the work. They were asked to provide specific feedback on the importance and relevance of these principles and to suggest changes in the wording. Feedback was incorporated, and then participants had several opportunities to review, reflect on, and revise the definition and principles.

This process also resulted in a revised definition of ECMHC and a consensus-based definition of the primary goals of ECMHC. The final text appears here:

Definition of ECMHC

ECMHC is a capacity-building and problem-solving intervention implemented in early childhood settings and homes. A professional consultant with infant-early childhood mental health expertise develops a collaborative and reflective relationship with one or more consultees (e.g., an early care and education [ECE] provider, service provider, or family member). ECMHC focuses on enhancing the quality of young children's social and emotional affective environments, as well as the needs of individual children.

The Primary Goals of ECMHC

ECMHC aims to strengthen the capacity of staff, families, programs, and systems to promote positive social and emotional development as well as prevent, identify, and reduce the impact of mental health problems among children from birth to 6 years old and their families. The consultant works with consultees, strengthening their capacity to reflect, problem solve, and change practices that will help them be effective in their roles. With new perspective, knowledge, skills, and strategies, consultees can promote infant and early childhood mental health, address current problems, and prevent future

concerns that might arise (Kaufmann et al., 2012, p. 2).

Following a model set forth by leaders in the children's mental health community that helped to establish Wraparound as an evidence-based practice, the outcome of this consensus-building process served as an initial step in moving the assessment of ECMHC fidelity forward. A corollary process that needs to occur next is articulating the essential activities of ECMHC. In other words, "What does a mental health consultant do?" We lay out some initial thoughts about that in the next section of this introduction.

What Do Mental Health Consultants Do?

THE EARLY CHILDHOOD team at GUCCHD has developed an initial list of activities that early childhood mental health consultants might perform as part of their work with early childhood professionals and parents (see Table 1). Although the model of ECMHC that GUCCHD faculty have articulated and promoted is based on consultation in early care and education programs, many of the underlying practice-based principles and activities are consistent across settings and are being used to plan new initiatives in home visiting, primary care,

Table 1. Georgetown Early Childhood Mental Health Consultation Model

| Early Childhood Mental Health Consultation Sample Activities in an Early Care and Education (ECE) Setting | |
|--|---|
| Clarify Purpose | Meet with ECE Director/Principal, review or share: philosophy, process, range, and scope of services. |
| Introduction/Orientation | Offer opportunities to meet and get to know families, community members, and new staff. Spend time being available and accessible to staff and families (consider what hours are most accessible for families). Spend time in classrooms, on home visits, in staff meetings, in parent meetings, and in parent socialization groups. |
| Align Expectations | Negotiate and establish mutual expectations regarding: duration and intensity of consultation, responsibilities, methods, focus, how information will be exchanged between consultant and various staff members, needs, goals, working style, procedures, meeting schedules, and how crisis or new concerns or priorities will be handled. |
| Informally Assess and Determine Needs | Conduct observations and schedule time for one-on-one discussions with a variety of staff, families, and community members. Be available to listen at various staff, family, and community meetings. Be sure that administrators understand and support consultation. |
| Short-Term Problem Solving | Identify and prioritize immediate needs. Determine initial effective strategies to reduce "crises." |
| Systematic Assessment | Use standardized tools to gather data to identify issues and contextual influences as well as strengths (related to child-focused issues, programmatic issues, or both). |
| Long Term Problem-Solving | Work collaboratively with staff and family members to select culturally competent, effective, and feasible strategies along with action steps, indicators of success (formal and informal), and time frame to achieve goals. |
| Develop Written Plans | Create concrete action steps, hold face-to-face meetings, and provide regular feedback to Director. |
| Implement Strategies | Model effective strategies and provide materials to support implementation. Team members, the family, or both try out recommended strategies and approaches. Provide coaching and support, monitor progress, and assess fidelity to plan frequently. Team, family, or both evaluate whether strategies are meeting needs by examining outcomes and indicators. Celebrate progress in action steps and other achievements. |
| Identify Community Resources | Identify range of possible supports within and outside the program to address child, family, and staff mental health needs. |
| Link to Community Resources | Contact, inform, and seek resources from relevant community systems and organizations as needed. |
| Support Implementation of Evidence-Based Practices/Curriculum | Provide instrumental and emotional support to staff and families as they implement evidence-based interventions or curricula (e.g., Incredible Years, Second Step, The Teaching Pyramid developed by the Center for Social Emotional Foundations for Early Learning, Parent Child Interaction Therapy). |
| Revisit and Update Plan | Collaboratively reflect on and assess changing priorities and also consider new strategies and action plans as needed. Complete documentation of progress and changes in plan. |
| Maintain and Build Team Efficacy and Cohesiveness | Frequent meetings with team to support and hone skills, determine satisfaction and commitment of team, and evaluate success of consultant-staff relationship. |
| Transition Plan | Review strengths and any on-going needs. Identify strategies to meet post-transition challenges with action steps, responsibilities, and linkages to resources. (Transition may be from a more intensive dosage of consultation to a less intensive level of consultation or an ending to a short-term consultation arrangement with the hope to reconnect when or if the need for additional support is identified.) |
| Support Sustainability | Consultant works to identify supports needed to sustain behavioral changes in staff, child or family, and program. |
| Follow-Up | Periodic check-in, including the possibility of helping address newly developed needs. |

and in homeless shelters (Ash, Mackrain, & Johnston, this issue, p. 28). These activities will also vary across settings on the basis of a number of factors including, but not limited to, the population served, type of setting or agency, mission of the program, funding, and length of time the consultant has worked or will work in the setting. This list is meant to illustrate the types of activities a consultant may engage in rather than represent an exhaustive list of activities that each consultant must do.

The activities listed in Table 1 illustrate how a consultant might begin a consultation relationship with a program. The list can also be useful for programs that have had a long-standing relationship with a consultant. For example, every year or at least every couple of years it is advisable that programs with long-standing relationships with consultants clarify their purpose and review their philosophies, scope of services, and processes. Similarly, activities such as informal and more formal or systemic assessments may be activities conducted yearly or even throughout the year to evaluate and guide the effectiveness of the consultant's work. Activities such as an introduction or orientation may take place in the beginning of a new consultant relationship with an organization or orientation and introductions may be take place throughout the year as a consultant meets new staff and new families enrolling in a program.

Early childhood mental health consultants come to the work from a variety of different backgrounds. In addition to the unique needs of the setting and the population, the consultant's discipline (e.g., social work, psychology, psychiatry, special education, counseling), orientation, training, and previous work and life experience all contribute to the activities they engage in and how they prioritize their work (Johnston, Steier, & Heller, this issue, p. 52). For example, a child psychologist with a specialization in child development may spend time reviewing individual children's screening or assessment results to guide the program in developing strategies to help specific children. A mental health consultant with a background in family therapy and parent training may spend more of her time offering training and consultation to parents. A mental health consultant with a background in workforce development or program development may focus more time and energy on developing programs to enhance the program's overall climate or morale. Answering the question, "What does the consultant do?" results in a variety of answers. However, regardless of where the consultant works, what specific activities the consultant engages in or how the consultant prioritizes her time, the consultation work uses reflection and problem solving to build capacity of others who provide care



PHOTO: KIVI STREET STUDIOS

Early childhood mental health consultation (ECMHC) is a strategy that is increasingly being used to promote children's healthy social and emotional development in a variety of settings.

and service for very young children and their families. The consultant is also guided by universal practice principles that transcend specific settings, discipline, and activities.

The articles in this issue of the *Zero to Three* Journal reflect this rich interdisciplinary foundation of ECMHC. The article by Hepburn and colleagues (this issue, p. 10) provides a summary of the evidence-base for ECMHC, showcasing the findings from seven recently completed statewide evaluations. Next, Heller, Steier, Phillips, and Eckley (this issue, p. 20) articulate the important role that reflective supervision plays in supporting the work of early childhood mental health consultants in the field. They share concrete strategies for creating and sustaining a culture of reflectiveness and describe the many functions of reflective supervision—including promoting the parallel process and consultative stance. Ash and colleagues (this issue, p. 28) elaborate further on these latter points as they share a series of vignettes that illustrate how ECMHC is being implemented in a variety of settings. Through these vignettes, the authors demonstrate the 10 elements of the consultative stance that distinguish ECMHC from other kinds of consultation. A view from the field is provided by Mackrain and Mytton-Ortega (this issue, p. 34)—who use an extended vignette to showcase how ECMHC is being integrated into a home visiting program serving high-risk families. Next Connors-Burrow and

her coauthors (this issue, p. 38) highlight efforts underway in Arkansas and Arizona to adapt ECMHC for the special needs of young children in foster care. The ECMHC efforts in Louisiana share a common foundation, and Boothe and Nagle (this issue, p. 45) share their experiences integrating ECMHC into the state's Quality Rating and Improvement System. The article by Johnston, Steier,

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Early childhood mental health consultants come to the work from a variety of different backgrounds.

and Heller (this issue, p. 52) describes the historical roots of ECMHC and summarizes the state of the collective knowledge about core competencies for ECMH consultants. These authors point to the future directions that the field needs to consider as ECMHC moves forward. And finally, Duran, Kaufmann, Irvine, Hunter, and Horen (this issue, p. 61) share the results of a national scan of how states and communities are paying for ECMHC—highlighting efforts to use a diverse array of federal, state, and local funding streams, including the Child Care and Development Fund, and quality set-aside dollars. Together, these articles document where ECMHC has been, where it is now, and some future directions for the field. §

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home visiting programs, and WIC. She is the principal investigator on two home visiting studies, including the evaluation of the competitive Maternal, Infant, and Early Childhood Home Visiting Program grant awarded to the Washington, DC, Department of Health in 2012. Dr. Perry also serves as a technical assistance specialist for Project LAUNCH—a Substance Abuse and Mental Health Services Administration effort focused on mental health promotion and prevention for young children and their families.

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Unravel the Complexities of Child Care Consultation



Mental Health Consultation in Child Care

Transforming Relationships Among Directors, Staff, and Families

KADIJA JOHNSTON and CHARLES BRINAMEN

As young children spend more and more time in child care programs, those programs have an increasingly significant effect on their healthy social and emotional development. In *Mental Health Consultation in Infant–Toddler Child Care*, Kadija Johnston and Charles Brinamen review current theory and offer practical suggestions for improving relationships between program

directors, staff, parents, children, and mental health consultants to help identify and remove obstacles to quality care. This practical guide also offers real-life examples of effective programmatic functioning, interstaff and parent–staff relationships, and direct child interventions. ■ 2006. 320 pages. Paperback.



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Early Childhood Mental Health Consultation as an Evidence-Based Practice

Where Does It Stand?

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The current era of evidence-based practices demands that programs document that they are making a difference in the lives of infants, toddlers, and their families. As states and communities make difficult decisions about how to allocate limited resources to address growing needs of vulnerable families, policymakers are asking program managers one fundamental question: “Does it work?” Two published reviews of the state of the evidence for the impact of early childhood mental health consultation (ECMHC) provided some basis for believing the answer was “yes” (Brennan, Bradley, Allen, & Perry, 2008; Perry, Allen, Brennan, & Bradley, 2010). But these reviews also pointed to some of the limitations in the available studies—including few randomized controlled trials, lack of comparison groups, and reliance on measures that were not developed to test the effects of ECMHC on teachers, children, and classrooms.

Since the publication of those two reviews, a growing number of researchers have partnered with states and communities who are implementing ECMHC within early care and education settings to gather more rigorous data to address this question. A group of providers, researchers, and evaluators associated with several ECMHC programs met in Arizona in June 2012 (See box Statewide Early Childhood Mental Health Consultation Programs) to share their interest in and current efforts to contribute to the evidence-base for

ECMHC. This article draws upon some of the findings from seven statewide programs and their evaluation to provide the field with a snapshot of where we are in assessing the effectiveness of different ECMHC programs.

Does ECMHC Work?

GILLIAM & LEITER (2003) articulated a series of important questions that underscore the complexity hidden behind that seemingly simple question posed by policymakers. To really answer the

question “does ECMHC work” requires a clear understanding of:

1. what ECMHC is;
2. what is the theory of change about how ECMHC leads to improved outcomes;
3. which outcomes can be expected to change if ECMHC is implemented well; and
4. what are the best measures of those outcomes?

Abstract

This article reviews the current evidence base for the effectiveness of early childhood mental health consultation (ECMHC). Comprehensive program evaluations of ECMHC include a number of elements such as a theory of change, a defined program logic model, and tools to measure outcomes at multiple levels: child, teacher, classroom, program, and family levels. Seven statewide programs with strong program evaluations illustrate current research efforts and contributions to the evidence base.

STATEWIDE EARLY CHILDHOOD MENTAL HEALTH CONSULTATION PROGRAMS

Seven statewide early childhood mental health consultation programs share evaluation data on the effectiveness of their services. These programs, listed by state and program name, include:

- Arizona: Smart Support
- Arkansas: Project PLAY
- Connecticut: Early Childhood Consultation Partnership
- District of Columbia: Healthy Futures
- Louisiana: Quality Start Early Childhood Mental Health Consultation
- Maryland: Maryland Early Childhood Mental Health Consultation Project
- Michigan: Child Care Expulsion Prevention

We address each of these in turn in this article and then synthesize some of the findings from the evaluations of these programs.

Is There a Commonly Agreed Upon Definition of ECMHC?

A widely disseminated document, *Early Childhood Mental Health Consultation* (Cohen & Kaufmann, 2000, rev. 2005) put forth a definition of ECMHC, which was derived from a consensus-building meeting that engaged a variety of practitioners, policymakers, and leaders in the fields of early childhood and mental health. The definition emphasized the ongoing, collaborative relationship between a mental health consultant and caregivers (i.e., early childhood staff and family members) and identified two types of consultation—child- or family-centered consultation and programmatic consultation. In both types of consultation, the goal is to build the capacity of staff, families, and programs to support the social-emotional development of young children, address concerns about an individual child, or improve practices that affect more than one child and family. This definition has been widely used to guide the early and ongoing development of ECMHC programs. (See Kaufmann, Perry, Hepburn, & Hunter, this issue, p. 4, which reviews the evolution of this definition during the past decade.) This definition can also inform the development of a theory of change for ECMHC.

What Is an ECMHC Theory of Change?

Carol Weiss (1972) popularized the term *theory of change* as a way to describe the set of assumptions that explain both the steps that lead to the long-term goals of interest

ARIZONA'S THEORY OF CHANGE FOR SMART SUPPORT

Arizona's Smart Support evaluation team, led by Dr. Eva Marie Shivers at the Indigo Cultural Center, worked in partnership with the program developers at Southwest Human Development. The team designed their research on the basis of the program developers' theory of change and child care research on effective early childhood mental health consultation (ECMHC) models (Duran et al., 2009; Florida State University, 2006; Gilliam, 2007; Green, Everhart, Gordon, & Gettman, 2006; Johnston & Brinamen, 2006). In alignment with their approach to collaborating in research with community partners, evaluators at the Indigo Cultural Center assumed that Smart Support leadership team and staff as well as key stakeholders are experts with important knowledge and perspectives and needed to be engaged in the evaluation process. At the beginning of the project year, the Smart Support leadership team convened to develop a theory of change for the Smart Support Program. The Smart Support leadership team included the Smart Support project director, project coordinator, senior managers, and the evaluation partner. The evaluation partner for Smart Support, Indigo Cultural Center, uses a community-based participatory approach to research and evaluation, and helped facilitate a conversation about the theory of change in conjunction with the development of the Smart Support logic model—as recommended in the ECMHC Evaluation Toolkit (Hepburn et al., 2007). The Smart Support leadership team came up with the following theory of change based on their program's framework, rooted in attachment theory and the parallel process:

Through the development of trusting relationships with early childhood administrators and staff, we hope to change professional thinking and practice to the benefit of the children in their care.

Through the experience of a supportive, dependable relationship with the mental health consultant and the development of a shared language, we believe child care providers will be better equipped to adopt a stance of:

- Curiosity about the meaning of children's behaviors;
- Flexibility in thinking about young children's needs;
- Emotional availability to the children in their care;
- Openness to new information;
- Respect for self as a professional. (Johnston & Brinamen, 2006)

and the connections between program activities and outcomes that result. A theory of change describes the mechanisms that undergird the intervention's impact on proximal and distal outcomes. A well-articulated theory of change enables researchers to develop research questions and identify variables that need to be measured in order to support or refute hypothesized links among inputs and outcomes.

For ECMHC, many of the theories of change are undergirded by other broader theories and constructs from psychology and education such as:

- attachment theory;
- clinical and therapeutic intervention (e.g., parallel process, internal representation, building reflective capacity);
- organizational psychology;
- family systems; and,
- adult learning principles and skill acquisition.

Having a theory of change makes it easier for researchers to test their hypotheses and guide assumptions about how and why

they think ECMHC is effective (or not). From a practical point of view, going through the exercise of developing, refining, and promoting a theory of change enables program leadership and staff to articulate the “what,” “why,” and “how” of ECMHC. See box Arizona's Theory of Change for Smart Support for an example of a theory of change.

Often people have trouble distinguishing a logic model from a theory of change. Both are helpful tools for evaluators, their program partners, and other stakeholders in the community in structuring how the evaluation and ECMHC program staff work toward measuring effectiveness. In its simplest form, a logic model is a tool that graphically depicts the connections between and among a program's goals, participants, intervention activities, short-term outcomes, and long-term outcomes. Common components of a logic model include: a description of the target population, guiding assumptions, program activities, and outcomes (Hepburn et al., 2007; Perry, Woodbridge, & Rosman, 2007). The theory of change is often depicted as the arrows in a logic model—connecting intervention elements to changes



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Studies investigating job-related stress found an association between early childhood mental health consultation and a reduction in job-related stress for teachers.

in knowledge, attitudes, or behaviors of teachers, which then lead to changes in children's behavior.

What Outcomes Can Be Expected to Change, and How Are They Measured?

Comprehensive program evaluations of ECMHC usually measure outcomes at multiple levels: child, teacher, classroom, program, and family levels. During the last decade, the majority of ECMHC evaluations were conducted in early care and education settings; as a result, many of the outcomes were measured for individual teachers or children who received ECMHC. More recently, researchers have broadened their focus to also examine the impact of ECMHC on the quality of the child care classrooms. In this same time frame, research on child care organizational quality has linked the quality of the organization's functioning at the administrative level with classroom-, teacher-, and even child-level outcomes (Bella & Bloom, 2003; Bloom & Sheerer, 1992; McCormick Center for Early Childhood Leadership, 2011).

Collecting outcome data at each level in a child care organization demonstrates that ECMHC is most effective when delivered at multiple levels. For example, a director's understanding of early childhood mental health principles impacts how supportive she is of her staff as they work to implement strategies and recommendations of their mental health consultant. In addition, the emotional climate of a classroom (something

which mental health consultants work on directly in programmatic consultation) can impact teachers' cooperation with one another and their emotional availability and capacity to develop harmonious relationships with children. When teachers and administrators work well with families, children are the ones who ultimately benefit. By measuring outcomes at all these levels, researchers can start to develop a more nuanced understanding of how and why ECMHC is effective as well as the barriers that can emerge in having the desired impact.

Identifying measures for outcomes at all these levels can be challenging. Ideally programs will use standardized measures—those that have the best reliability (yield consistent results without much error) and validity (accurately reflect what is being measured; Hepburn et al., 2007). Consideration must be given to measures that are compatible with the setting where ECMHC is being delivered (e.g., early care and education, home visiting), and the participants in the program (e.g., age, language, culture). Strong evaluations often

combine a variety of measures including: implementation or process data, as well as outcome or impact measures; and these may be either qualitative (open-ended) or quantitative (statistical) in nature. Finally, the ideal condition is where the evaluation measures are completely (and seamlessly) integrated into the ongoing operations of the program—such, so-called “green evaluations” provide the consultants and program staff with information that informs their interventions while also providing the evaluators with data to measure change over time in implementation and outcomes.

As ECMHC evaluators and program managers better articulate their theories of change, there is a need to expand the types of measures used to assess important constructs. For example, when program leaders at Arizona's Smart Support program articulated the teachers' internal representation of the child as a critical target of the ECMHC work with the teacher, they had to find a reliable and valid way to measure this construct (see box Innovations in Measurement of Early Childhood Mental Health Consultation).

INNOVATIONS IN MEASUREMENT OF EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

Brennan and her colleagues (2005) noted that there are few reliable and valid tools available to measure the pathways through which mental health consultation may affect children's behaviors, such as the quality of the relationship between the teacher and the child or the teacher's internal representation of the child. Arizona's Smart Start program adapted the Working Model of the Child Interview (WMCI; Zeanah, Benoit, Hirshberg, & Barton, 1993) to measure these pathways and its use is described below.

The WMCI (Zeanah et al., 1993) is a structured interview that was originally designed to assess parents' internal representations or working models of their relationship to a particular child. The WMCI has been used for clinical and research purposes in the U.S. and other countries. It is most often used with high-risk samples, but it has proven widely applicable from low-risk to clinical populations. Because of its relevance to tapping into internal representations of relationships, Smart Support leadership saw a direct connection with its own theory of change and developed an adaptation of the WMCI for child care providers and preschool teachers (with permission from Dr. Zeanah).

Smart Support mental health consultants conduct the WMCI during their first 6 weeks of consultation. Consultants make every effort to provide a setting for the interview that is comfortable enough to allow for attention to the questions posed and a relaxed atmosphere that permits teachers opportunity for reflection. The WMCI typically takes about half an hour to complete.

Part of the original WMCI protocol that was retained includes teachers' descriptions of the (focus) child through the provision of five adjectives, and teachers' descriptions of their relationship with the (focus) child through the provision of an additional five adjectives. Although the WMCI is primarily a clinical intervention tool, Smart Support mental health consultants are instructed to record and turn in the two sets of adjectives describing the child and the teacher's relationship with the child. The WMCI is then repeated after 6 months of Smart Support services and then again after 12 months of Smart Support services. Adjectives are recorded and turned in to the evaluation team at those time points as well. The working hypothesis is that the tenor of the adjectives will change over time and will be associated with other variables in the evaluation. The Smart Support evaluation team is currently developing a coding scheme for analyzing the adjectives collected at the three different time points.

How Is ECMHC Being Implemented and Evaluated

IN ORDER TO address the questions of which outcomes to target and how to measure those outcomes, we turn to the literature of already completed evaluations of ECMHC. In 2009, Duran and colleagues conducted a national survey that documented more than half of all states reported having ECMHC services available throughout the state. Since the publication of that survey, other states have started statewide ECMHC (e.g., Arizona) and efforts to expand ECMHC to other settings and sectors through federally funded initiatives such as Project LAUNCH. Funded by the Substance Abuse and Mental Health Services Administration, Project LAUNCH supports community and state efforts to enhance early childhood mental health promotion and prevention—including the implementation of ECMHC. Many of these efforts have evaluation components and are adding to the collective knowledge about the impact of ECMHC.

Below are descriptions of seven statewide ECMHC programs, each with a strong evaluation partner. A list of the resources associated with each program is provided in the Learn More section on page 17.

ECMHC Statewide Program Snapshots

Arizona's Smart Support launched its services with funding from Arizona's early childhood and health system—First Things First. The program, administered by Southwest Human Development, delivers consultation services to 13 regions in the state with support from the local First Things First Regional Partnership Councils. The two main goals of Smart Support are: (a) to improve the overall quality of early care and education settings so that they are able to help support the social and emotional development of all children in their care, and (b) to increase the capacity of early care providers to address the mental health needs and challenging behaviors that place particular children at risk for negative outcomes in the early years of life. The evaluation design can be described as primarily a summative outcome evaluation.

Arkansas' Project PLAY began as a state-initiated pilot demonstration project in and over time, expanded from three regions to six regions (statewide). Funded by Arkansas' Department of Humans Services, Division of Child Care and Early Education through their Child Care Development Fund, Quality Initiative, Project PLAY facilitates collaboration between community mental health centers and early education programs through consultation services. The primary goals of this project are to (a) enhance the capacity of child care centers and teachers to

prevent and manage mental health problems in children and (b) improve the outcomes of children enrolled in child care. This two-phase intervention model, research, and evaluation design can be described as quasi-experimental involving intervention and comparison sites, using pre- and post-intervention assessments.

Connecticut's Early Childhood Consultation Program (ECCP) was created through a combination of public and private funds, but it is now funded almost solely by the Department of Child and Families, the state's child protection agency. Services are provided on request and free of charge to any early care and education program serving children birth to 5 years old anywhere in the state of Connecticut. ECCP is managed by Advanced Behavioral Health, a nonprofit behavioral health management company, using a centralized information management system. Services are manualized and menu-driven, and they focus on both classroom- and child-specific consultation provided during a 3-month period of service. The goal of ECCP is to reduce suspension and expulsion rates of young children by building the capacity of caregivers and parents to create together socially and emotionally healthy environments for young children. ECCP has been evaluated in one statewide random-controlled trial, and data from two additional random-controlled trials (one with preschool settings, one with infant-toddler settings) are currently being analyzed.

The District of Columbia's Healthy Futures program was initiated by a white paper commissioned by the Mayor's Advisory Council for Early Childhood Development

which led to a plan for ECMHC developed by the Department of Mental Health. Initial funding for the program came from two sources: the Deputy Mayor of Education's Office and the federal Mental Health Services Block Grant. A partnership with the Department of Health accessed federal grant dollars from the Substance Abuse and Mental Health Services Administration through Project LAUNCH. Healthy Futures offers ECMHC services to 24 child development centers throughout the District of Columbia. The primary goals of this project are to promote child care quality, child development, and school readiness. Healthy Futures' evaluation relies on a quasi-experimental design using pre- and post- (year-end) assessments.

In Louisiana, Tulane University's Quality Start Mental Health Consultation Program was initiated and implemented as an integral part of the state's Quality Rating System for child care. Funded through their federal Child Care and Development Fund, the project is designed to assist all children in center-based care through (a) promotion of the social and emotional health of young children, (b) support for teacher's promotion of healthy child development within classroom settings, and (c) referral for treatment or design interventions for children exhibiting behavioral problems. The research and evaluation design can be described as quasi-experimental, comparing two groups of study participants using pre- and post- intervention assessments.

Maryland's ECMHC Project began as a 3-year pilot program in Baltimore City and on the Eastern Shore. On the basis of the pilot project's success as shown in the program evaluation, the Maryland State Department



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During the last decade, the majority of early childhood mental health evaluations were conducted in early care and education settings.

of Education funded the expansion of the ECMHC Pilot Project statewide to the 12 child care licensing regions. The Project's goals are to: (a) promote positive social-emotional wellness practices in early childhood settings; (b) identify and work proactively with children who may have developmental, social, emotional, or behavioral concerns; (c) refer children and families in need of more intensive mental health services to appropriate support or clinical programs; (d) help children remain in stable, quality child care arrangements that support their individual needs; (e) increase teacher confidence and competence dealing with challenging behaviors; and (f) build close partnerships with local community resources. Maryland's research and evaluation design can be described as a quasi-experimental mixed-methods design. Within the evaluation, there were three unique studies: Service Description Study, Impact Study, and an Exit Study, which explored factors related to expulsion.

Michigan's Child Care Expulsion Prevention program was established by the Michigan Department of Community Health with the support of funding by the Michigan Department of Human Services in the late 1990s. The program grew to serve 31 of Michigan's 83 counties with the intention of becoming a statewide program. Managed by the Michigan Department of Community Health, and funded with Child Care Development Funds, Child Care Expulsion Prevention services have been supported and delivered by Community Mental Health Services Programs. The primary goals of this program are to (a) reduce expulsions, (b) improve the quality of child care, and (c) increase the number of parents and providers who successfully nurture the social-emotional development of infants, toddlers, and preschoolers. The program's evaluation consisted of a mixed-method evaluation design. Methods include: A longitudinal study, a quasi-experimental comparison study, case studies, and an on-line cross-sectional survey.

How Are ECMHC Outcomes Being Measured?

THE SEVEN EVALUATION teams associated with the programs described in the previous section used the constructs and measures to examine the impact of ECMHC outlined in Table 1. The table indicates the level at which the measure was used, the measure name, and a brief description of the measure.

Outcomes of ECMHC

THE EVALUATION REPORTS produced by each of the seven programs described above were reviewed to examine the

Table 1: Evaluation Constructs and Measures

| | ECMHC Programs | Measured By |
|----------------------------|-----------------------|--|
| Children's Behavior | | |
| | AZ, AR, DC MD, MI | Devereux Early Childhood Assessment (DECA; LeBuffe & Naglieri, 1999; DECA-IT; Mackrain & LeBuffe, 2007; DECA-C; LeBuffe & Naglieri, 2003) is a series of instruments that measure the mental health of infants (1–18 months old), toddlers (18–36 months old), and preschoolers (3–5 years old) in the areas of initiative, self-regulation/self-control, and attachment. |
| | MI | The Behavior Assessment System for Children, Second Edition (BASC-2; Reynolds & Kamphaus, 2004) is a teacher- or parent-administered instrument examining a child's observable behavior, including both adaptive and problem behaviors as well as internalizing and externalizing problems. |
| | CT | Conners' Teacher Rating Scale–Revised Long Form and Conner's Parent Rating Scale–Revised Long Form (CTRS, CPRS; Conners, 1997) are teacher- and parent-rating forms that measure externalizing behaviors associated with oppositional behaviors and hyperactivity, internalizing behaviors associated with anxious-shy behaviors and perfectionism, and social problems. |
| | CT | Preschool Social Behavior Scale (PSBS; Crick, Casas, & Mosher, 1997) is a 19-item teacher-report scale used to measure relational aggression in preschoolers. |
| | CT | Social Skills Rating System (SSRS; Gresham & Elliot, 1990) is a teacher- and parent-rating scale that measures both behavior problems (externalizing and internalizing) as well as social skills (cooperation, assertion, and self-control). |
| | CT | Infant-Toddler Social Emotional Assessment and Brief Infant-Toddler Social Emotional Assessment (ITSEA and BITSEA; Carter & Briggs-Gowan, 2006) measure externalizing, internalizing, dysregulation, and competence behaviors in young children 12–36 months old. |
| | MD | The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) This instrument is a brief screening questionnaire completed by parents or teachers examining a child's emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior. |
| Internalizing | MI | BASC-2™ (see description above) |
| | CT | CTRS, CPRS (see description above) SSRS (see description above) |
| | CT | ITSEA and BITSEA (see description above) |
| Prosocial Skills | AZ, AR, DC, MD, MI | DECA, DECA-IT, DECA-C (see description above) |
| | DC | Ages & Stages Questionnaires®: Social Emotional, (ASQ-SE; Bricker & Squires, 1999). This parent-completed screening tool is designed to identify children who may be at risk for social or emotional difficulties using questions related to a child's behavior and social interactions. |
| | CT | SSRS (see description above) |
| | CT | ITSEA and BITSEA (see description above) |
| Expulsions | | |
| | AZ, CT | Preschool Expulsion Risk Measure (Gilliam, 2010): This instrument measures risk for expulsion on the basis of the teacher's perception of how a specific child's behavior impacts the teacher's work and the perceived likelihood that the child's behavior can improve. |
| | CT, DC, MD, MI | Exit Interviews, Expulsion Tracking and Analysis developed by the evaluation teams. |

Continued

Table 1: Evaluation Constructs and Measures *Continued*

| Teachers' Beliefs, Feelings, and Behaviors | | |
|---|-------------------|--|
| Efficacy/ Confidence | AZ, LA, MD, MI | Teacher Opinion Survey (Geller & Lynch, 1999): This self-reported attitudes and beliefs survey examines teacher's perceived skills at managing difficult behavior and sense of hopefulness about their role as teacher. |
| Behavior Management | MI, DC, MD, LA | Goal Achievement Scale (Alkon, Ramler, & MacLennon, 2003): This self-report instrument used by center administrators or teachers includes 13 items that examine behavioral changes in a teacher's ability to manage children (especially with challenging behavior) and work with families as well as assess changes in center or classroom climate. |
| Stress | AZ, CT, DC | Child Care Worker Job Stress Inventory (Curbow, Spratt, Ungaretti, McDonnell, & Breckler, 2000): This self-reported survey examines a child care worker's stress including the worker's perceptions of job demands, job control, and job resources that may help contribute to a worker's job satisfaction or positive feelings about his own work. |
| Depression | CT | Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) : The CES-D is one of the most widely used self-report measures of depressive symptoms in adults. It has high known-group and concurrent validity, and support has been found for its use across groups of different ethnicities. |
| Interaction | AR, CT | Arnett Caregiver Interaction Scale (Arnett, 1989): This scale, used by an outside observer to rate a caregiver's attitudes toward children and their behavior in interactions with children, examines positive interaction, punitiveness, detachment, and permissiveness. |
| Perceived Interaction | AZ | Pianta's Student-Teacher Relationship Scale (Pianta, 1992) measures teacher-perceived teacher-child interactions. The two constructs that the STRS measures are closeness and conflict. |
| Classroom | | |
| Social- Emotional Climate | AZ, CT, DC, MD | Preschool Mental Health Climate Scale (PMHCS; Gilliam, 2008) : This instrument, used by an outside observer to evaluate the mental health climate of preschool classrooms, examines child care quality on the basis of multiple environmental dimensions including transitions, directions and rules, staff awareness, staff affect, staff cooperation, teaching feelings and problem-solving, individualized and developmentally appropriate pedagogy, and child interactions. |
| | CT, DC, LA | The Classroom Assessment Scoring System™ (CLASS™ PreK, 2; Pianta, La Paro, & Hamre, 2008) This instrument, used by an outside observer to assess teacher-student interactions in early care and education settings, examines teacher sensitivity, emotional support, classroom organization, and instructional support that include multiple dimensions such as positive climate, negative climate, teacher sensitivity, and regard for student perspective, behavior management, productivity, and instructional learning. |

patterns in the findings. These reports are listed in the Learn More section on page 17. This research and two other published reviews of the ECMHC identified the following outcomes for ECMHC programs:

Reductions in Children's Challenging Behaviors

One of the most consistent findings in Perry and colleagues' published review (2010) of the ECMHC literature was that ECMHC was associated with reductions in externalizing behaviors. This was true whether the children's challenging behavior

was reported by the teachers or rated independently by an external observer. In the more recent studies we identified for this review, this finding was repeated. In the Michigan Child Care Expulsion Prevention program, using the DECA, DECA-IT (LeBuffe & Naglieri, 1999; Mackrain & LeBuffe, 2007), and subscales from the BASC-2 (Reynolds & Kamphaus, 2004) as measures, they reported a decrease in children's hyperactivity and attention problems. The results for children served in the Connecticut ECCP, District of Columbia Healthy Futures Maryland Early Childhood Mental Health Project,

and Project PLAY programs were similar. Their outcomes showed decreased behavior concerns for those children identified with problem behaviors measured by DECA scores—including children with identified individual concerns in the clinical range using the DECA-C. The Maryland evaluation also reported that beyond any individual child, the impact of the intervention also reduced the overall level of problem behaviors in the classroom, measured by Strengths and Difficulties Questionnaire (Goodman, 1997). This measure was completed by teachers who reported on the behavior of all of the children in their classroom as a whole group; the children were not identified as individuals. Rather, the teacher rated each child anonymously at baseline and 4 months later—indicating which children were exhibiting behaviors that interfered in her ability to teach. And after receiving 4 months of on-site consultation, the teachers' perceptions of the rates of problem behaviors in these classrooms decreased significantly.

Perry et al. (2010) found that far fewer studies looked at internalizing behavior as a main outcome for ECMHC—in part perhaps because it is children who are acting aggressively who are more likely to be referred for child-specific ECMHC. The recent studies continued this trend. The majority of the studies that looked at child-level outcomes were using one or more forms of the DECA (LeBuffe & Naglieri, 1999, 2003; Mackrain & LeBuffe, 2007). And while the DECA instruments do gather information about internalizing behaviors, most evaluation studies did not report outcomes specific to internalizing behaviors. It could be that there were too few children who scored in the clinically significant range to warrant reporting these scores. This continues to be an area where increased outreach to teachers and families is warranted to alert them to the importance of attending to the concerns of young children who are excessively anxious, withdrawn, depressed, or any combination of these.

Improvements in Children's Pro-Social Behaviors

In addition to reductions in challenging behavior, Perry et al. (2010) reported that ECMHC was associated with increased positive social and emotional outcomes for young children. More than half of the studies reviewed in that synthesis reported positive pro-social behaviors including social skills, communication, social interactions, cooperation, self-control, play and leisure time, coping skills, interpersonal relationships, initiative, and attachment. Three of the recent studies, in Michigan, Maryland, and the District of Columbia, also reported increases

PHOTO: MARILYN NOLT



Many programs have been concerned about the disproportionate rates of expulsion from preschool classrooms.

in social skills, social-emotional functioning, and protective factors for children who received consultation intervention. These outcomes were measured by DECA (LeBuffe & Naglieri, 1999, 2003; Mackrain & LeBuffe, 2007) scores collected for children who were receiving child-specific ECMHC.

Reduced Expulsions

Many programs have been concerned about the disproportionate rates of expulsion from preschool classrooms documented in the landmark study by Gilliam (2005). Data from this study estimated the national rate of expulsions as 6.7 per 1,000 served in pre-kindergarten and served as a catalyst for many ECMHC programs across the country. Gilliam and Shahar (2006) found an association between ECMHC and reduced rates of expulsions. Similar positive outcomes were reported by three of the recent studies. Expulsions were tracked in Michigan, Maryland, and the District of Columbia. In both the District of Columbia and Maryland, programs tracked the number of children who were expelled from child care programs receiving ECMHC; and for both programs, the number of children expelled per number served by the ECMHC project was below the national average published by Gilliam in 2005. Maryland and the District of Columbia also conducted qualitative studies of some of the factors associated with expulsion; and they both reported that these children are far more likely to have complicated family lives, with mental health, substance abuse, and

incarcerated parents being identified as risk factors.

Improvements in Teachers' Efficacy/Confidence

Teacher self-efficacy is defined as perceived operative capability (Bandura, 2007) or a teacher's confidence in her ability to work with children in their classroom, even those with difficult behavior, and perform her job as a teacher. Brennan et al. (2008) reported that the studies they reviewed showed an improvement in teachers' attitudes and self-perceptions when they received ECMHC. Teachers indicated an increased confidence in addressing the social-emotional needs of children, working with children and families, and managing their duties. Teacher efficacy and confidence was a focus of three of the recent studies with similar results in Arizona, Louisiana, and Michigan. Using measures such as the Goal Achievement Scale (Alkon et al., 2003) and the Teacher Opinion Survey (Geller & Lynch, 1999), these studies found that ECMHC increased teacher efficacy and teacher competence in the areas of social-emotional development and ability to respond to children and deal effectively with conflicts.

Improved Teachers' Skills

In addition to self-reported confidence in their ability to do their job, Brennan et al. (2008) noted that teachers reported specific skills and behavior changes associated with receiving ECMHC. Teachers reported

positive results in the areas of improved skills in classroom management, interactions with children and parents, and increased parent involvement in improving their child's behavior. These results were echoed in the statewide evaluations reviewed for the current synthesis. Teachers reported increased awareness of social-emotional aspects of development, being better able to manage challenging behaviors, and increased knowledge and comfort with referring children and families for mental health services. In Louisiana, teachers reported being better able to support children's social-emotional development as a result of ECMHC services, regardless of teacher, consultant, or center characteristics. In Michigan, providers reported being better able to recognize early warning signs of developmental, social-emotional, and behavioral concerns as a result of higher dosage (more hours) of ECMHC services. In the District of Columbia, child care center directors reported that classroom staff had an increased ability to manage challenging behavior and an increased positive attitude about working together with parents.

Reduced Teacher Stress and Turnover

Previous studies investigating job-related stress found an association between ECMHC and a reduction in job-related stress for teachers, and research has shown that teacher job stress is a strong predictor of expulsion rates (Gilliam & Shahar, 2006). In their published review, Brennan et al. (2008) reported teachers receiving ECMHC report feeling less stressed and lower levels of burnout. A related finding noted that consultation was also associated with reduced numbers of staff leaving programs and a lower level of staff turnover. In addition, one study reported that higher self-reported levels of staff wellness were associated with higher quality relationships with consultants and more frequent program and individual consultation (Green et al., 2006). Arkansas and the District of Columbia's evaluations both examined the impact of ECMHC services on teacher stress. Both evaluations found results that were consistent with the previous research synthesis: teachers who received ECMHC reported feeling less stress from baseline to follow-up. In addition, in Arkansas researchers found that teachers who received ECMHC reported a decreased intention to leave the profession of child care.

Teacher-Child Interactions

Arizona and Arkansas included teacher-child interaction measures to track changes in relationships over time. Arizona's evaluation used Pianta's Student Teacher Relationship Scale—Short Form (1992) to measure

teachers' perceptions of their relationships with focus children. This teacher-report measure blends attachment theory with research on the importance of early school experiences in determining concurrent and future success in school (Pianta & Nimetz, 1991). The Arizona evaluation team reduced items on the Short Form to two commonly published subscales: Closeness and Conflict (Pianta, 1992), and found increases on the Closeness subscale and decreases on the Conflict subscale after 6 months of ECMHC intervention. The Arkansas evaluation team used independent raters and the Arnett Caregiver Interaction Scales (Arnett, 1989) to assess several dimensions of teacher-child interactions. They reported strong positive effects including significant reductions in punitiveness and detachment, and improvements in positive interactions associated with ECMHC.

Improved Classroom Climate

Early studies that attempted to link the improvements in the quality of child care to ECMHC relied on the Early Childhood Environmental Rating Scales (ECERS; Harms, Clifford & Cryer, 1998). The findings were mixed, perhaps in large part because of the fact that this tool was not sensitive enough to assess some of the changes that are thought to occur through the work of a mental health consultant. As a result, Gilliam (2008) developed and pilot-tested a new measure that was designed specifically to tap the domains that ECMHC impacts through consultation work. On the basis of this foundational work, many evaluators requested permission to use the Preschool Mental Health Climate Scale (PMHCS) including Arizona, the District of Columbia, and Maryland. All of the research teams reported consistent, strong positive results using this observational instrument. Teachers improved in their interactions to support social and emotional development, showed increased teaching about feelings and emotional problem-solving skills, and other interactions related to classroom quality.

Another important measure of the quality of the classroom climate is the CLASS (Pianta et al., 2008) used to assess teacher-child interactions and examine teacher sensitivity, emotional support, and classroom organization that impact the social, emotional, and educational experience of young children. This measure was used in Louisiana and in the year 2 evaluation in the District of Columbia and administered by a trained research assistant not associated with the child care program or the provision of ECMHC. Both evaluations reported significant improvements in the many of the domains included in the emotional support and classroom organization subscales.

Learn More

These resources provide additional information about the seven early childhood mental health consultation programs highlighted in this article. There are also links to the evaluation reports, where available.

Arizona

SMART SUPPORT PROGRAM

www.swhd.org/training/early-childhood-training/smart-support
www.IndigoCulturalCenter.org

SMART SUPPORT: ARIZONA'S EARLY CHILDHOOD MENTAL HEALTH CONSULTATION SYSTEM—YEAR 1 EVALUATION REPORT, 2010–2011

E. M. Shivers (2012)

Phoenix, AZ: Institute for Child Development Research & Social Change, Indigo Cultural Center, Inc.

Arkansas

PROJECT PLAY

<http://familymedicine.uams.edu/ProjectPLAY>

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION: PROMOTING CHANGE IN THE QUALITY OF TEACHER-CHILD INTERACTIONS

<http://onlinelibrary.wiley.com/doi/10.1002/imhj.21358/>

IMPROVED CLASSROOM QUALITY AND CHILD BEHAVIOR IN AN ARKANSAS EARLY CHILDHOOD MENTAL HEALTH CONSULTATION PILOT PROJECT

<http://onlinelibrary.wiley.com/doi/10.1002/imhj.21358/abstract>

Connecticut

EARLY CHILDHOOD CONSULTATION PARTNERSHIP RESULTS OF A RANDOM-CONTROLLED EVALUATION: FINAL REPORT AND EXECUTIVE SUMMARY

www.chdi.org/download.php?id=76

District of Columbia

HEALTHY FUTURES: YEAR ONE IMPLEMENTATION AND EVALUATION

http://dmh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Healthy_Futures_Year_One_Report.pdf

Louisiana

QUALITY START EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

www.qrslouisiana.org/child-care-providers/child-care-center-mental-health-consultation

IMPLEMENTATION OF A MENTAL HEALTH CONSULTATION MODEL AND ITS IMPACT ON EARLY CHILDHOOD TEACHERS' EFFICACY AND COMPETENCE

<http://onlinelibrary.wiley.com/doi/10.1002/imhj.20289/abstract>
<http://onlinelibrary.wiley.com/doi/10.1002/imhj.20289/abstract>

Maryland

MARYLAND EARLY CHILDHOOD MENTAL HEALTH CONSULTATION PROJECT

www.marylandpublicschools.org/MSDE/divisions/child_care/program/ECMH and <http://theinstitute.umaryland.edu/topics/ebpp/ecmhc.cfm>

MARYLAND'S EARLY CHILDHOOD MENTAL HEALTH CONSULTATION EVALUATION: FINAL REPORT

<http://theinstitute.umaryland.edu/topics/ebpp/docs/ECMHC/ECMHC%20Final%20Report.pdf>

Michigan

CHILD CARE EXPULSION PREVENTION PROGRAM

www.michigan.gov/mdch/0,4612,7-132-2941_4868_7145-14785--,00.html

AN INTERDISCIPLINARY EVALUATION REPORT OF MICHIGAN'S CHILDCARE EXPULSION PREVENTION (CCEP) INITIATIVE

<http://outreach.msu.edu/cerc/research/ccep.aspx>



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Teachers receiving consultation reported positive results in the areas of improved skills in classroom management and in interactions with children and parents.

Conclusion

THERE IS A growing number of states around the country that recognize that supporting children's social and emotional development is a vital component to school readiness, and that ECMHC is an effective strategy in enhancing children's social and emotional functioning (Gilliam & Shahar, 2006). On the basis of this current review of existing evidence on ECMHC, it appears that current models of ECMHC are effective at improving outcomes for early education classrooms, teachers, and children and are consistent with previous research findings about ECMHC effectiveness. The findings reviewed from the seven states featured in this article provide additional evidence that the investment states have made in supporting child care mental health consultation is paying dividends.

It is important to continuously revisit and share ECMHC research and evaluation findings so that researchers and program leadership can not only stay up to date on the latest findings, but so they can also develop evaluation designs that align with common frameworks and measurement approaches that other ECMHC researchers are using. This alignment can lead to a more unified and

efficient way to build the evidence base. With further collaboration among ECMHC states and their research partners, and continued funding of rigorous evaluation and research, there can be a continued enhancement of the efficacy of services and an establishment of long-term sustainability for this emerging evidence-based practice. ♣

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The Building Blocks for Implementing Reflective Supervision in an Early Childhood Mental Health Consultation Program

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Given that early childhood mental health consultation (ECMHC) has its roots in infant mental health and relationship-based practice, many practitioners view reflective supervision not only as an ideal but also an essential tool to support and sustain both the consultant and the consultation program. This article focuses on how the processes of reflective supervision are well matched to many of the unique values of ECMHC and will provide various strategies for creating and sustaining reflective practice in an ECMHC program.

Rebecca Shamoan-Shanok (2009) eloquently defined *reflective supervision* as “a collaborative relationship for professional growth that improves practice by cherishing strengths and partnering around vulnerabilities to generate growth” (p. 8). In regards to ECMHC, reflective supervision aims to create a relational climate between the supervisor and consultant that allows the needs of both the child care provider and the consultant to be considered with the overall goal of

optimizing the effectiveness of both the consultation program and the child care program. By adhering to the three key components of reflective supervision—reflection, collaboration, and regularity (Fenichel, 1992)—a partnership is created in which the supervisee never feels alone, is not overwhelmed by fear or uncertainty, and feels safe to express her thoughts, feelings, and reactions. This allows the supervisee to learn more about herself, the client

Abstract

The capacity for thoughtful consideration of multiple perspectives, including one's own felt experience and actions, is an essential component of early childhood mental health consultative practice. Reflective supervision offers a powerful opportunity to support this capacity. This article discusses the importance of integrating a reflective supervision model into an early childhood mental health consultation program, including: hiring staff inclined toward reflection, working with staff who have limited or no experience with reflective supervision, combining reflective and administrative supervision, and adjunct experiences that support reflective functioning.

(e.g., center, teachers, children, parents), coworkers and colleagues, and the work. Reflective supervision has been well defined and described in the literature. For more information on this model of supervision, see the Learn More box for a list of annotated references.

Reflective Supervision and ECMHC

THE USE of reflective supervision, as a means to support, sustain, and maintain consultants and their relational and reflective stances, has been widely adopted throughout the field of ECMHC (Duran et al., 2009). In “What Works? A Study of Effective Early Childhood Mental Health Consultation Programs,” Duran and colleagues (2009) reported that the majority of the effective ECMHC programs they reviewed used reflective supervision to support their staff, defining it as a supervisory approach that “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” (p. 52).

Johnston and Brinamen (2006) described the consultative stance, a central tenet of mental health consultation, as a way of being that communicates a willingness to think with another about a concern (see Johnston, Steier, & Heller, this issue, page 52, for a description of the 10 Elements of an Effective Early Childhood Mental Health Consultative Stance). This way of being can also be considered one of the essential features of a reflective supervisor. These elements, which are reflective in nature, are supported, enhanced, and maintained through reflective supervision and reflective practice within the ECMHC program.

Centrality of Relationships and the Parallel Process

A compelling finding in the body of research on effective ECMHC is the link between positive outcomes and the teacher-consultant relationship. A study by Green and colleagues (2006) concluded that “the single most important characteristic of mental health consultants is their ability to build positive collaborative relationships with program staff members” (p. 142). Duran and colleagues (2009), in their study of effective ECMHC programs, identified five programmatic elements as essential for producing positive outcomes. One of the five elements was the quality of the relationships between and among consultant and consultee. In addition, this relationship variable was one of two programmatic elements considered to be a “catalyst for success” (p. 4) of the consultation.



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Reflective supervision supports the consultant’s ability to develop positive relationships with child care providers through a parallel process.

Reflective supervision supports the consultant’s ability to develop positive relationships with child care providers through a parallel process. During supervision, the consultant experiences what it feels like to have his feelings held, and to be heard and supported in his work by a supervisor who is emotionally available on a consistent basis. As a result of this experience, the consultant may listen with empathy, communicate with authenticity, and collaborate with child care providers in a similar way. This relational way of being is then transmitted to the child care provider’s relationship with the children in her care and their families. The parallel process of passing the emotional experience from one relationship to that of another is a crucial ingredient for consultation to achieve its “primary goal” of increasing “the teacher’s awareness and understanding of each child’s experience” (p. 26). The warm and accepting relationship the consultant experiences in supervision supports the consultant so that he is able to hold the child caregiver’s emotional experiences without becoming overwhelmed or feeling pressured to provide a quick fix to complex problems. This sense of support the child care provider experiences during consultation allows the provider enough emotional “breathing space” to consider children’s behaviors in a new light. As a result of this process, providers begin to respond to the children in their care with increased empathy, warmth, and understanding. Jeree Pawl (1995) summed up the parallel process best in what has become a mantra of the reflective stance: “Do unto others as you would have others do unto others” (p. 43).

The parallel process also offers an opportunity for consultants to help providers learn new skills. The experience of having been heard, held, and understood may be a new one for the child care provider. In typical child care settings, providers have limited opportunities to reflect upon their work or to consider their own emotional responses to it. The learning that occurs through the consultative relationship transmits information about new skills, but not didactically (Johnston & Brinamen, 2006). Rather, it is through the experience of the reflective relationship that the child care provider learns new social and emotional skills that will benefit her in developing more meaningful relationships with children, coworkers, and families. Ultimately, providers will become increasingly reflective, rather than reactive, to the challenges of their profession. Reflective supervision can help the consultant recognize when this process has occurred with providers and supports the consultant in thinking about how his own interactions within a child care setting might increase the likelihood for this form of experiential learning to continue to develop and expand.

Avoiding the Position of Sole Expert

The art of both reflective supervision and mental health consultation is to share expertise without diminishing the expertise of the other and without being prescriptive or controlling. Reflective supervisors take care to listen to the meaning behind supervisees’ words and to consider the possible impact of their own words before making suggestions. This same expectation extends to the



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In typical child care settings, providers have limited opportunities to reflect upon their work or to consider their own emotional responses to it.

consultant's interactions with child care providers. Novice consultants, in particular, often misunderstand and struggle with the caveat to avoid the position of expert. Essentially, consultants should avoid creating or communicating differences in power or relative value of input, such that the consultant risks injuring the relationship with the consultee or limiting the opportunity to benefit from the consultee's contribution. Although some consultants are inclined to jump hastily to giving suggestions or direction, others may attempt to avoid being the expert to the extent that they do not offer needed or requested resources or information. This reluctance to offer expertise can be just as detrimental as rushing in too quickly, leaving the consultee frustrated or confused. To effect change and then sustain and generalize it, the consultant needs to rely on shared expertise with children's caregivers. Reflective supervision provides the space for the consultant to safely and regularly consider how she manages the expertise she has, within each center and within each interaction.

Authentic interest is an important tool that helps both the reflective supervisor and consultant to avoid assuming the expert role unintentionally. Authentic interest can create a space for collective reflection to occur and takes the form of thought-provoking inquiry rather than inquisition (Johnston & Brinamen, 2012); it also supports the mutuality of interest element of the consultative stance. Gaining a better understanding of the issue or concern through observation and query opens the door for true understanding and collaboration. Creating a space for wondering, musing, and hypothesizing often

takes longer than simply providing advice and can produce anxiety for the novice consultant. However, slowing down and truly listening leads to shared understanding and a greater likelihood that any information transmitted will be useful, heard, and applied. By doing so, the consultant avoids the position of being sole expert yet still provides needed expertise. The reflective supervisor not only models this process in reflective supervision with the consultant but can also help the consultant as she struggles with adhering to the consultative stance. Such modeling is critical as it often takes patience (another consultative stance element) and a recognition not only of the centrality of relationships to effect change but also of the idea that creating genuine relationships takes time. This can be difficult as, especially to the novice consultant, it can feel like nothing is occurring in the consultative visit; here is a situation in which having a reflective space where the consultant can safely share any uncertainty can be vital to supporting a consultant's use of the authentic voice.

Isolation and Autonomy

ECMHC professionals find they spend much of their time away from their peers, supervisors, and the familiar environment of professional offices. The consultant spends most of her working hours with providers in either a home care or child care center setting. Working alone, the consultant enters each child care system as an outsider, providing service to clients or conversing with collaborators who often do not understand the reasoning behind a consultative—versus a more directive—stance, nor the relevance of

a mental health perspective. The consultant wonders about whether or not she is doing good work and meeting the needs of the providers and children on her caseload (Johnston & Brinamen, 2006). She may wonder whether she is doing consultation the right way and may question the slow pace of change she sees in her daily work. The consultant may feel “unseen and unknown”; that is, having only herself as a reference for what makes good consultation on a day-to-day basis, she has no one physically present with whom to share her fears or celebrate her successes. The consultation elements of patience and holding hope are truly tested in such circumstances, and at that point the reflective supervisory relationship can be a critical source of support.

The reflective supervision relationship offers a lifeline to the professional experiencing isolation because of the autonomous nature of consultation work. As the supervisor provides a “safe, protected, reliably recurring space” (Shahmoon-Shanok, 2009, p. 8) for the consultant, through regular supervision, the consultant is able to use this secure base to trust his own abilities, maintain patience against the pressing urge to fix problems now, and hold hope that his efforts are indeed impacting positive change. The Circle of Security “hands” diagram, illustrating the role of caregiver as both a secure base and safe haven, translates effectively in describing the role of the supervisor for the consultant who spends his days out in the field (Marvin, Cooper, Hoffman, & Powell, 2002, p. 110). The consultant, especially early in his relationships with centers, must try new strategies to help develop a trusting relationship with the director and staff that will allow him to co-create supportive strategies to address challenges identified by the child care staff. This can be more challenging for new consultants, who are operating in a new environment and using skills of which they may not yet feel confident. The reflective supervisor is consistently supportive and nonjudgmental, able to listen to the vulnerabilities expressed by the consultant without becoming emotionally activated herself. It is this tone that creates a safe holding space or secure base from which the consultant can explore and experiment with different ways of being and of interacting with child care staff. Equally important, the consultant knows he can turn to this co-created supervisory space as a safe haven during times of difficulty. Within the secure space of the supervisory relationship, the consultant can share his vulnerability and know he will be heard and understood.

The reflective supervisory relationship provides a place to turn for safe haven and

sense of comfort during times of distress. However, uncertainty, frustration, fear, and confusion may arise during the consultant's working day without an opportunity to quickly seek out the supervisor, either in person or by phone. Here, the consistent, regular, and collaborative nature of the reflective supervision relationship benefits the consultant. Through the development of the trusting relationship, the consultant begins to experience what Jerree Pawl called being held in the mind of another (1995). The consultant may not be able to speak to her supervisor to discuss the difficulty in the moment. In fact, quite often the consultant will need to work through the challenge immediately. It is then that the benefits of the co-created secure space or relationship are effective. The consultant has come to feel "respected, nurtured, remembered and safe" (Shahmoon-Shanok, 2009, p. 18). Through the supervision relationship, the consultant develops an internal model of the "holding environment" that helps her contain her uncertainty about the work, reduces her affective response, allows her to slow down and make considered choices about how to manage the challenging situations she faces daily in her work as a consultant, and, above all, trust her own abilities.

Multiple Perspectives

Working alone, the early childhood mental health consultant first brings his own perspective to any consultation experience. This is informed by his lifetime experiences, both personal and professional. His perspective, however, is naturally limited by the nature of his own experiences in the world. Reflective supervision supports and enhances the consultant's capacity to consider multiple perspectives; that is, to strive to achieve the consultative stance elements of understanding another's subjective experience, to consider all levels of interest, and to hear all the voices. During the reflective supervision session, both the consultant and supervisor can use their combined experiences to consider the teacher-child relationship from a variety of angles. They can explore and share thoughts on varying perspectives, experiences, or relationships that may be affecting the teacher and child's relationship. They can hold the perspective of the child's parents in mind as well. By collaborating, the consultant and supervisor can encourage one another to consider their own experiences and differences as well as reflect on the perspective and voices of other key players (e.g., parent, director, teacher, child) to inform their discussion about how the consultant might work within the child care center. This process not only helps the consultant to practice holding the perspective and interests of others in mind,

but also enhances the consultant's ability to help others (e.g., teachers, administrators, parents) to do the same.

The following example illustrates the limits of a consultant's individual perspective and how reflective supervision supported the consultant to allow her to feel safe to explore the potential perspectives of others.

Working in a classroom of young 3 year olds, the consultant noticed that the teacher seemed particularly annoyed by the demands of a smaller boy who was new to the class. The child was easily frightened, especially by change, and often cried and clung to the teacher as she attempted to move through the daily routine. The teacher would typically ignore the child until he reached a level of great distress. The consultant, having a more introverted and sensitive stance in the world herself, began to feel a growing resentment toward what she saw as the teacher's abrupt and sometimes hostile response toward the little boy.

During reflective supervision, the consultant's feelings of anger toward the teacher made it difficult for her to think about how she might begin to address the situation with the teacher. The supervisor listened empathically as the consultant expressed her thoughts, feelings, and frustrations with the situation. Once the consultant felt heard and understood, the intensity of her emotions subsided and she was able to think together with the supervisor about other points of view that might be helpful to consider in this difficult situation. The consultant could well describe what she imagined it felt like to be the child in relationship to that teacher. What, the supervisor gently probed, might it feel like to be the teacher in relationship to that child? What might it feel like to be the parent dropping off and picking up the child in that classroom? Multiple perspectives. Each examined. Each honored.

Both the supervisor and consultant can bring their own life experiences to the discussion and, as a result, brainstorm differing views and expand potential solutions to dilemmas. With joint attention and individual differences, the supervisor and consultant should also consider factors that affect individuals' subjective experiences and perspectives. Common influences to consider include: whether the center's beliefs are influenced by a rural or urban setting, whether the center's values are based on a religious belief system or a secular one, whether the center promotes academic achievement or uses a developmental approach to child care, whether there are ethnic differences (e.g., between consultant and provider, between administration and staff, between children and staff) and how (or whether) these differences contribute to an individual's



PHOTO: KIVI STREET STUDIOS

It is through the experience of the reflective relationship that the child care provider learns new social and emotional skills.

perspectives and experiences. Given all of this information, how might any of these differences affect the way the consultant sees the teacher—and the way the teacher sees the child?

Reflective supervision provides an important opportunity for the consultant to "create a pause" to consider the various perspectives of all of the parties involved. Through the careful work of reflective supervision, the consultant comes to see that he has a uniquely informed perspective, based on his education, experience, and personal background. Similarly, he has the opportunity to think about how the others involved have also have very individualized perspectives on the situation. Together, the supervisor and consultant have the chance to consider how these perspectives affect the situation and consider how to support teachers, administrators, and parents to safely acknowledge the perspectives of others and use this enhanced understanding to support positive change.

Through the reflective supervision process the team of supervisor and consultant can wonder together about perspective—how that perspective is influencing behavior or concern in a relationship. Once they have considered things carefully, they may find themselves on different plateaus of understanding and can be more deliberate in choosing how to proceed. The consultant might see, after considering all perspectives carefully, that it is best to wait and see or purposefully do nothing in



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Reflective supervisors take care to listen to the meaning behind supervisees' words and to consider the possible impact of their own words before making suggestions.

order to gather more information, and with the support of her reflective supervisor, remain patient even against her own urge to push forward and fix things. Or perhaps the reflective process will help her identify a point of entry that will not isolate the teacher but rather invite her to see others' perspectives (e.g., the challenging child) and collaborate with the consultant on a solution. Through reflective supervision, the consultant has the opportunity to deconstruct the problem and move forward with thoughtfulness. And it is this very process that the consultant hopes to see happening eventually with the teacher (child care administrators and parents) as she considers a child in her care.

Quality Assurance and Fidelity to the Model

ECMHC programs operate in differing capacities in many states (Duran et al., 2009), making the development of a common fidelity measure challenging (Kaufmann, Perry, Hepburn, & Duran, 2012). Fortunately, a recent cross-site analysis identified six common components and processes that can be used to assess fidelity among ECMHC programs across the United States (Kaufmann et al., 2012). It is interesting to note that developing positive relationships among consultants and consultees was one of the three process components identified. Beyond supporting the development and maintenance of positive relationships, the reflective supervisor can use the reflective process as a tool for

staff development, program improvement, and quality assurance.

Many ECMHC programs use a model of supervision that blends the functions of mentoring and monitoring within a single supervisor. In this model, the supervisor seeks to provide a safe and nurturing environment that promotes learning and growth and also holds the consultant accountable for the quality of his work through administrative oversight (Bertacchi & Gilkerson, 2009; Heffron & Murch, 2010). In a blended model, the supervisor strives to incorporate performance standards into daily program routines by providing an understandable structure. Suggested ways to do this include reviewing standards regularly and using self-assessment as well as formal performance tools. Providing regular feedback that addresses strengths and struggles and developing opportunities for learning are key to maintaining fidelity to any model of ECMHC.

Individual and group reflective supervision and regularly held team meetings also serve the goals of ensuring quality of services and managing the tendency to drift from the program's consultation model or various policies or procedures. Supervisors can listen for misunderstandings or deviations from the program's expectations and can set about understanding and addressing discrepancies from the same curious, nonshaming, partnering stance they are hoping consultants hold with their child care consultees. In some cases, the need to clarify or modify a policy may come to light. Other times, it may be that one or more consultants require additional training or coaching. Regardless, when the supervisor takes the time to pause, wonder, listen, and reflect, any changes that need to be made are more likely to be embraced by staff and implemented to the benefit of the program's quality and fidelity to the service delivery model.

Integrating Reflective Supervision Into an ECMHC System

AMONG THE CHALLENGES of integrating reflective supervision into a system such as an ECMHC system, in contrast to adopting it in individual practice, is that of establishing and preserving an overall culture of reflection. Programs that are successful in this endeavor set a crucial context for high-quality service provision and professional growth. As noted earlier, although the work of ECMHC can be isolating and anxiety-arousing, it can also be compelling and gratifying. The balance may be tipped toward more positive experiences when consultants regularly return from fieldwork to a home base that values and supports reflective practice and in which they may develop the expectation, if they are disposed to doing so,

that they do not have to bear the difficulties of their work alone. Peers and supervisors may be counted on for empathy and a willingness to think together about consultative predicaments. This is no less true for supervisors in the ECMHC system, who may feel free to rely on collegial relationships and their own reflective supervision for help considering clinical and supervisory predicaments, managing intense emotions, and learning.

There is wide agreement that reflective practice is a hallmark of competence within the infant mental health arena (Heffron & Murch, 2010; Johnston et al. this issue, p. 52; Shahmoon-Shanok, 2009). The cohesiveness of a program's larger system requires reflection to be "in the air and water," that it be the norm. Opportunities to establish and reinforce this norm begin at the hiring phase and continue throughout the employee's tenure, in both obvious and subtle ways.

Hiring Staff Given to Reflection

It is, of course, desirable to hire supervisors and consultants who are inclined—and specifically not disinclined—toward reflection. This desire sometimes competes with the program's need and pressure to quickly fill open positions. To the extent that a program's administrators can refrain from acting out of desperation and rather from a position of choice, their hiring decisions will then be likely consistent with the program's intentions and ambitions. Working toward that goal sometimes requires that the ECMHC program's leadership challenge their beliefs about scarcity ("Do we really think that we will not be able to hire a qualified person in the next month?") and think creatively about the allocation of resources (e.g., adjusting supervisor or consultant caseloads) while waiting for the best candidate.

The initial interview for consultant or supervisor positions offers an important opportunity to consider an applicant's potential "goodness of fit" in the system. In addition to learning about her relevant training, work experience, and content expertise, this first encounter can provide a window into the applicant's inclination toward reflection, tolerance for complexity, ambiguity (e.g., the "not knowing" of consultative work), and orientation to the use of supervision. To that end, the interviewers may pose a variety of questions and solicit information related to working with young children and their caregivers and to participating in supervision. For example, the applicant might be asked for an anecdote that illustrates work that went well. What qualified the experience as a success, from the applicant's perspective? Even so (the interviewer may continue prodding), in retrospect, is there anything that she would

have done differently? Asking applicants to recount work experiences with which they were satisfied or dissatisfied or to grapple with vignettes that typify consultation situations and dilemmas provides rich opportunities to listen for capacities that are at the heart of consultation work. Such capacities include self-reflection and an openness to change (e.g., “I didn’t know then, but I realize now...”), readily extended empathy to adults and to children, self-regulation and restraint in the face of challenge, the capacity to consider multiple meanings of and influences on behavior, thoughtfulness around how to broker relationships and repair breaches, and use of supervision.

Center staff can learn more about what motivates an applicant and about his views on supervision, his approach to working out problems, and his capacity for perspective-taking by asking the applicant how he managed disagreements or disappointments with a supervisor, for example, or by asking him to speculate about what it is like to supervise or be supervised. Such a process offers clues about an applicant’s use of supervision as a secure base and a safe haven, or for his wish that something on that order had been available for support and collaborative problem-solving. Center staff also should be alert to signs that applicants show a preference for longstanding autonomy in their work, particularly if there are indications of equating supervision with regressive dependence (e.g., “I go to my supervisor when I have to, but I’m good at figuring things out for myself.” or “My supervisor had an open-door policy, but I didn’t need to go through the door very often.”).

In addition, interviewers would do well to clearly and thoroughly detail for applicants the reflective supervision model that the ECMHC program embraces and the attending expectations for all staff. It is useful to highlight the fact that reflective supervision is a core component of the program and a regular event in the week of consultants and supervisors—not a strategy first deployed when staff are having trouble or performing inadequately. Such explicit discussion in the initial interview has the potential to dissuade applicants who know they would be especially uncomfortable with, or otherwise ill-matched, to the program’s reflective emphasis.

Many applicants for positions in ECMHC will not have the full array of skills and competencies necessary to do the work well. The initial interview and other contacts in the period before hiring can be maximized to “stack the deck” in favor of bringing in new staff who will benefit from and contribute to the culture of reflective practice, and thereby

In consultation, the goal is to build the capacity of staff, families, and programs to support the social–emotional development of young children, address concerns about an individual child, or improve practices that affect more than one child and family.

stand to develop their expertise over time in a condition of supported practice.

Developing and Maintaining a Programmatic Culture of Reflection

Beyond hiring professionals with reflective capacity and ensuring that the program’s leadership is notable both for their vision and provision of reflective supervision, program staff can call upon a variety of experiences to develop and maintain a programmatic culture of reflection. Of course, the key to reflection—slowing down—is also difficult to achieve. Consultants often say they have difficulty finding time for thoughtful conversation, collaboration, and even commiseration with child care and preschool providers. Encouraging such a climate in early childhood settings cannot happen if ECMHC programs are not able to secure it for the consulting staff who influence those settings. One of the first opportunities for staff to take a stand in favor of a reasonable pace starts with establishing caseloads for consultants and supervisors. In ECMHC systems throughout the United States, caseloads and models of service delivery (e.g., time-limited vs. open-ended) vary, but it is clear that programs and funders must grapple with the question of how many relationships can be “held” in a meaningful way at any given time by supervisors or consultants.

In a similar way to individual supervision, consistently scheduled group meetings can serve as anchors for the ECMHC system’s overall reflective sensibility. It is important to establish cues to participants that they are in a safe space intended for their full presence and thoughtful attention. Such an atmosphere need not preclude, and in fact is likely to promote, proceeding with purpose, moving through an agenda, or achieving a specific goal, although program staff may prefer to separate out addressing administrative issues from more in-depth discussions of the work. In any case, it is useful to convene a meeting

with deliberateness, rather than find that it has launched by virtue of a side conversation. Some creative ways to convene include: going around the room to check in with each person, beginning the meeting with the vibration of a singing bowl, engaging the group in a “mindfulness exercise” (e.g., grounding their feet and watching their breath), and greeting the group and declaring, “Let’s start.” Whether the steps are elaborate or simple, the intention is for everyone in the room to “get there” before beginning. Likewise, ending the meeting at the designated time is preferable to having it peter out as participants, one by one, slip away to their next appointment.

Group meetings remind staff that, although they carry on independently during much of their work time, they are, in fact, part of a team and part of a larger effort on behalf of young children and their nonparental caregivers. When gathered as a group, consultants have the chance to share their experiences—often finding surprising commonalities with their peers—hear administrative updates, and have questions answered and misperceptions clarified. They may participate in group–case consultation or cover a training topic. Supervisors have the chance to notice group dynamics, appraise their team’s morale, and, as noted earlier, assess and address issues related to quality of consultation services and fidelity to the consultation model.

Gathering the members of a team together—and, when possible, the full staff—provides a potent opportunity to convey the program’s commitment to the relationship base of the work. The acknowledgment of birthdays, comings and goings of staff, and successes as well as struggles communicates that “we are all in this together” and that the staff members value relationships. Period. Relationships are not valued only for young children or only in early childhood settings. In Arizona’s Smart Support ECMHC system, for example, each of the teams in regions around the state has a monthly book club meeting. Participants may gather at a coffeehouse or over lunch. All of the groups read the same book, which is selected to increase knowledge and thoughtfulness on topics relevant to ECMHC. Such topics have included the consultative stance, child development from an infant mental health perspective, attachment relationships in the classroom, and negotiating adult conflict. A set of discussion-guiding questions developed by Smart Support’s director and program managers are sent to each team’s supervisor in a sealed envelope, to be opened during the meeting. The dramatic revelation is meant to be an injection of humor, and the overall experience is intended to be both stimulating and fun. The book club meetings also serve as a strategy for reinforcing the cohesiveness

of a large ECMHC system. In any given month, the program administrators can be certain that staff on teams throughout the state are reading the same material, selected to be relevant to the work and consistent with the program's philosophies, and are

having something approximating a similar conversation.

Conclusion

ECMHC that is grounded in the principles of an infant mental health perspective

embraces reflective supervision as a primary mechanism for supporting consultants and enhancing their skills and effectiveness. It is an elegant opportunity because it offers as much implicitly as it does explicitly. The reflective supervision conversations that

Learn More

PROMOTING PROFESSIONAL AND ORGANIZATIONAL DEVELOPMENT: A REFLECTIVE PRACTICE MODEL

A. Copa, L. Lucinski, E. Olsen, & K. Wollenburg (1999). *Zero to Three*, 20(1), 3–9. The authors describe three phases of the reflective practice model. It provides descriptions of these phases, including vignettes, as well as strategies for incorporating reflective practice into an organization. The authors describe a nice model for presenting cases.

MENTAL HEALTH PRINCIPLES, PRACTICES, STRATEGIES, AND DYNAMICS PERTINENT TO EARLY INTERVENTION PRACTITIONERS

G. Costa (2006)

In G. M. Foley & J. D. Hochman (Eds.), *Mental Health in Early Intervention: Achieving Unity in Principles and Practice* (pp. 113–138). Baltimore, MD: Brookes. In this chapter, the author discusses integrating infant mental health into early intervention programs. Reflective practice (including reflective supervision) and relationship-based intervention are emphasized as two key concepts integral to infant mental health work.

IRVING B. HARRIS DISTINGUISHED LECTURE: REFLECTIVE SUPERVISION IN INFANT–FAMILY PROGRAMS: ADDING CLINICAL PROCESS TO NONCLINICAL SETTINGS

L. Gilkerson (2004). *Infant Mental Health Journal*, 25, 424–439.

The author describes implementation of reflective process in two settings: a neonatal intensive care unit and an early intervention program. Provides a brief description of reflective supervision and its use and importance in nonclinical settings that serve very young children. A brief outline and description of different parts of a session are also included.

REFLECTIVE SUPERVISION IN INFANT, TODDLER AND PRESCHOOL WORK

M. C. Heffron (2005) In K. M. Finello (Ed.), *The Handbook of Training and Practice in Infant and Preschool Mental Health* (pp. 114–136). San Francisco, CA: Jossey-Bass.

This chapter presents a wonderful overview of reflective supervision. The author describes the qualities necessary for the program and supervisor to possess. Myths or misconceptions regarding reflective supervision are also discussed.

FINDING AN AUTHENTIC VOICE. USE OF SELF: ESSENTIAL LEARNING PROCESSES FOR RELATIONSHIP-BASED WORK

M. C. Heffron, B. Ivins, & D. R. Weston (2005). *Infants & Young Children*, 18, 323–336.

Focuses on the “use of self” construct used in reflective practice. The authors present the theoretical background of the term. Several concepts or processes of reflective practice are presented in great detail and used to operationalize the term. Clinical vignettes are provided to better illustrate the concepts.

REFLECTIVE SUPERVISION AND LEADERSHIP IN INFANT AND EARLY CHILDHOOD PROGRAMS

M. C. Heffron & T. Murch (2010). *Washington, DC: ZERO TO THREE*

Illustrates the foundations and frameworks of reflective practice and outlines ways to support reflective supervision in a wide variety of work settings. Other highlights of the book are a discussion of the roles of the reflective supervisor; knowledge and skills needed for reflective supervision; tips for providing group reflective supervision; and vignettes outlining common supervisory dilemmas.

A PRACTICAL GUIDE TO REFLECTIVE SUPERVISION

S. S. Heller & L. Gilkerson (Eds.) (2009). *Washington, DC: ZERO TO THREE*

Written to help guide administrators and professionals who provide reflective supervision to launch a reflective supervision program in their organization. Each chapter addresses a critical question that will help guide his process (e.g., What is reflective supervision?; How can administrative and reflective supervision be combined?; and How do I introduce reflective supervision to my program?).

STARTING WHERE THE PROGRAM IS: THREE INFANT MENTAL HEALTH CONSULTANTS DISCUSS REFLECTIVE PRACTICE

S. S. Heller, F. Jazefowicz, R. Redmond, & J. Weinstock (2004). *Zero to Three*, 24, 10–19.

Three infant mental health consultants discuss how they helped incorporate reflective practice into three Early Head Start programs. Each of the three programs presented incorporated reflective practice and supervision into their program in different ways.

LOOK, LISTEN, AND LEARN: REFLECTIVE SUPERVISION AND RELATIONSHIP-BASED WORK

R. Parlakian (2001). *Washington, DC: ZERO TO THREE*

This publication is intended to help program leaders promote high-quality services to young children and their families by providing both the rationale and techniques for creating supportive supervisory practices and in turn effective staff–parent relationships. It provides specific tools and techniques for using reflective supervision effectively. Contents also include information on relationship-based organizations, the Look-Listen-and-Learn model, and effecting organizational change as well as an organizational assessment and group exercises.

THE POWER OF QUESTIONS: BUILDING QUALITY RELATIONSHIPS WITH FAMILIES

R. Parlakian (2001). *Washington, DC: ZERO TO THREE*

This resource focuses on direct service work with parents and children. It explores how leaders and staff can use the reflective approaches of the Look, Listen, and Learn model to establish high-quality relationships with families. This workbook presents strategies for boundary-setting and managing one's reactions to families to staff who face complex problems on a daily basis.

REFLECTIVE SUPERVISION IN PRACTICE: STORIES FROM THE FIELD


R. Parlakian (2002). *Washington, DC: ZERO TO THREE*

Highlights four infant–family programs that implemented reflective supervision. Key elements of the transition and the outcomes experienced are discussed. Tools designed to present reflective supervision to staff members are also presented.

BEING IN CHARGE: REFLECTIVE LEADERSHIP IN INFANT/FAMILY PROGRAMS

R. Parlakian & N. L. Seibel (2001). *Washington, DC: ZERO TO THREE*

This resource explores the experience of being a new leader in an infant–family program, focusing on reflective leadership—using self-awareness, observation, and flexible responses as tools to manage stress and increase on-the-job effectiveness. Numerous leadership concerns are discussed: how to individualize one's relationship with staff members, encourage collegial work, and learn from conflict. And it describes how leaders can use self-awareness, observation, and flexible responses as tools to manage stress and increase on-the-job effectiveness. Tools provided include a staff development questionnaire and a self-assessment of leadership style.

occur relate to the children who are struggling in the classroom setting and the adults who are struggling with them or perhaps with each other. These conversations have to do with identifying what is in place that may promote growth and change, and what may impede or derail it. Often, the conversations include guided or supported self-reflections on the consultant's feelings, perceptions, and the ways in which the consultant influences and is influenced by others. The invitation is there. Unstated much of the time but palpable in strong supervisory relationships is the communication to the consultant that "you are not alone, and through this patient process in which we are engaged, you will find your way." Reflective supervision, in its function as secure base and safe haven, offers ECMHC consultants the opportunity to feel welcomed, understood, respected, and refueled. 

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Errata

The second paragraph on page 25 in this article should read as follows:

Hiring managers can learn more about what motivates an applicant and about his views on supervision, his approach to working out problems, and his capacity for perspective-taking by asking the applicant how he managed disagreements or disappointments with a supervisor, for example, or by asking him to speculate about what it is like to supervise or be supervised. Such a process offers clues about an applicant's use of supervision as a secure base and a safe haven, or for his wish that something on that order had been available for support and collaborative problem-solving. Hiring managers also should be alert to signs that applicants show a long-standing preference for autonomy in their work, particularly if there are indications of equating supervision with regressive dependence (e.g., "I go to my supervisor when I have to, but I'm good at figuring things out for myself." or "My supervisor had an open-door policy, but I didn't need to go through the door very often.").

Early Childhood Mental Health Consultation

Applying Central Tenets Across Diverse Practice Settings

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Four-year-old Adam, 3-year-old Blake, and their 8-month-old sister, Cassie, wait in an exam room for Cassie's well-child check-up as their mother, Christina, 22 years old, sits slumped in a chair. When the nurse practitioner arrives, the boys appear to be on the verge of really hurting each other as they wrestle on the floor, Cassie looks solemn as she sucks on her pacifier, and Christina lethargically remarks that she's been having a hard time lately because the boys are so aggressive at preschool they are about to get kicked out. The family recently moved because "the fighting got pretty bad with the boys' daddy" and they are now sleeping on a friend's couch. Mom thinks "some lady from the health department" has been trying to see them, but she's missed two appointments recently. With some gentle questioning, Christina reveals that she "just got her kids back" and that she has a social worker she is supposed to see every 2 weeks.

Adam, Blake, and Cassie are children who are at risk for health and developmental problems due to their aggressive behavior, homelessness, history of domestic violence, and need for child protective services. They are at risk for school failure, for out-of-home placement, and for entry into the juvenile justice or mental health systems. They are at risk of disrupted relationships, of having poor adult role models, and of having their potential left untapped and unrealized. Young children with behavior challenges such as aggression are expelled from child care and preschools settings at rates 3 times that of children in public schools (Gilliam, 2005). Once expelled from child care, not only do these children tend to have other events of expulsion (Gilliam & Shahar, 2006), but these suspensions and expulsions are among the leading indicators of dropping out of school altogether (Losen & Gillespie, 2012). Rates of out-of-home placement are high for children

like Adam, Blake, and Cassie with histories of neglect and particularly if parental substance abuse is a factor in their care (Office of Child Abuse and Neglect, 2009). Young children exposed to domestic violence risk repeating the interpersonal violent acts that they witnessed, being victim of further violence, as well as exhibiting slower cognitive development, lower problem-solving abilities and lack of conflict resolution skills (Child Welfare Information Gateway, 2009). As adults, they are overrepresented in the justice system, a sad fate that in itself has numerable negative consequences.

Christina, an overwhelmed mother with challenging life circumstances, may indeed be showing signs of depression. If left untreated, her children can expect lower levels of physical care, fewer responses to their bids for emotional nurturance, and inconsistent engagement as depressive symptoms wax and wane (Harmon, 2010). The accumulation of

adverse early experiences has been linked to adult physical and mental illness and to early death (Felitti et al., 1998). Less frequently measured but equally powerful is the imagined experience of a life unlived: a child with great potential in the arts whose lack of confidence inhibits her creativity, or her brother who has the dexterity and mathematical

Abstract

Early childhood mental health consultation (ECMHC) is an important and burgeoning approach for building front-line staff capacity to recognize, interpret, and support young children's and family's social, emotional, and behavioral health care needs across early childhood systems. ECMHC helps prevent longer-term negative impacts to physical and mental health. The application of ECMHC may differ in scope across settings, however, there are central tenets of the consultative stance that are critical to building staff capacity and positive child and family outcomes. The authors use vignettes to illustrate how ECMHC may be practiced in an early care and education setting, a domestic violence shelter, and pediatric primary care.

capacity to make important technological discoveries but whose sense of wonder has been crushed by low expectations and lack of a close relationship with even one caring adult.

And yet, for Adam, Blake, and Cassie there is also great hope. Development is on their side with its combination of biologically driven imperative and mastery motivation to propel both chronological maturity and psychological growth forward. A safe environment that presents just the right degree of stress to engage their interest, kindle their senses, and challenge their cognitive processes will ensure that the necessary stimulation occurs to build a flexible yet strong neurobiological architecture. Their paths are not yet fixed, and there are sensitive phases into which support, contingent responsiveness, and safe limits can be instilled. At the core of successful early intervention will be the relationships with the adults in their lives. Fostering nurturing relationships with adults that are respectful, culturally resonate, and predictable can serve as the template for Christina and the children's other caregivers to carry forward into their interactions with the children. Relationships are the vehicle through which psychological protection and inoculation from life's hardships are delivered. Early childhood mental health consultation (ECMHC) is one of the vehicles that can help identify and address the challenges and strengths of vulnerable families across a diverse array of settings.

The Potential of ECMHC

ECMHC IS AN important mechanism for building front-line staff capacity to recognize, interpret, and support young children's and family's social, emotional, and behavioral health care needs. ECMHC, long cultivated with early childhood professionals and families of young children in early care and education settings, is now gaining traction with other service providers that come into contact with families in a wide range of settings including health care programs, home visitation, child welfare settings, domestic violence venues, primary care, and homeless shelters.

Conceived of more than 20 years ago and used successfully since then (Johnston, 1990), implementation of ECMHC in early childhood settings has grown nationally particularly over the last 5 years. While there are states that have only a few ECMHC programs in some regions and limited availability, other statewide initiatives have broad reach into most if not all communities within the state. ECMHC services differ across programs, and one such difference is the range of organizations housing and delivering ECMHC, from community mental health centers to state agencies to university-based programs. Each

of these home agencies has its own requirements around hiring, training, and support for the consultants providing the service, as well as how often a consultant visits a setting, how many hours per visit, and for what duration or service length.

Given this diversity among programs, practitioners are attempting to define the elements of ECMHC, beyond frequency and duration of services, which are important for a program to be effective. Understanding these elements of practice can help to design effective ECMHC programs across diverse settings.

ECMHC in Diverse Settings

ECMHC IS EXPANDING into new types of settings that serve infants, young children, and their families, such as domestic violence shelters, home visitation programs, primary care offices, and other child-serving organizations. Although these settings have long been staffed by social workers, nurses, doctors, and case managers, newly defined collaborations with early childhood mental health consultants offer an approach that emphasizes the capacity of the caregiver to understand and respond to the unfolding needs of the young child. The consultants focus on the relationship that supports and sustains this growth. ECMHC has helped parents understand what to expect from their young child and understand the frustrations of parenting, and it provides emotional support to the parents. (Kaplan-Sanoff, Lerner, & Bernard, 2000). Buchholz and Talmi (2012) suggested that the trained infant mental health specialist who consults in a pediatric practice not only supports the early identification of developmental and mental health concerns, but also helps physicians provide better services by impacting the quality and content of the visit, covering a broader range of developmental topics including parental well-being and the socioemotional health of babies and young children.

Unifying Principles of Practice

In order to bring ECMHC from child care settings into other venues, it is important to first understand the values and goals guiding the professionals delivering this approach. These goals and values contribute to a unifying set of principles that shape the work across settings. The ways that consultants approach the work can transcend the setting to provide the practitioner with a sense of direction, a package of core beliefs, and the mechanism through which services can be delivered. For example, the consultative stance (Johnston & Brinamen, 2006, 2012), provides 10 elements that set the stage for collaborative, relationship-based work



PHOTO: KIVI STREET STUDIOS

Early childhood mental health consultation is an important mechanism for building front-line staff capacity to recognize, interpret, and support young children's and family's needs.

that is co-created between consultant and consultee and is the central contributor to positive change (see Johnston, Steier, & Heller, this issue, p. 52, for a description of the 10 Elements of an Effective Early Childhood Mental Health Consultative Stance). The 10 elements of the consultative stance are:

1. Mutuality of endeavor,
2. Avoiding the position of the expert,
3. Wondering instead of knowing,
4. Understanding another's subjective experience,
5. Considering all levels of influence,
6. Hearing and representing all voices—especially the child's,
7. The centrality of relationships,
8. Parallel process as an organizing principle,
9. Patience, and
10. Holding hope.

Integration of ECMHC within new settings allows for natural ports of entry for families seeking support. Families accessing these types of services are often in need of assistance outside the scope of the original intent of the visit, such as a well-child checkup or a bed in an overnight shelter. The front-line workers in these agencies are often turned to as trusted professionals but may be



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Relationships are the vehicle through which psychological protection and inoculation from life's hardships are delivered.

unprepared to meet the complex concerns of families. ECMHC can be effective at helping families identify their needs and strengths and in fostering positive relationship between the family and the worker.

ECMHC in Early Care and Education

The vignette below guides the reader through several elements of the consultative stance illustrated through Christine and her children's experience of consultation within an early care and education setting. Christine has recently been told that Adam and Blake's child care provider is considering expelling the boys because of their challenging behavior.

Arriving at the children's child care to pick them up after a long shift at work, Christine felt that familiar anxiety stirring in her stomach. The child care director, Ms. Darlene, had asked Christine if she was open to meeting with someone called a "social-emotional" consultant. The consultant, Mr. Lee, was waiting by the entry when Christine arrived and reached out his hands to greet her with a smile, "So glad you could meet. I know from our phone call that your time is limited, and you have a lot going on."

Christine and Mr. Lee went into the director's office and sat side by side. Mr. Lee shared that Ms. Darlene wanted to build a good relationship with the boys and she needed some help in understanding how to do it. She wanted them to be safe at the center and, right now, she felt her efforts were not working. Mr. Lee explained that his job was to support everyone working together to figure out what the boys were trying say with their behavior. He went on to say,

"You are the most important person in the lives of your children, and you are important to this process. I am wondering if I can hear more about what you feel the boys are trying to tell us..."

Christine was quiet for a moment as she wondered about the aggression the boys were showing. How much of the fighting had they seen and heard between herself and their dad? She could not handle their father and now she could not handle the boys either. Why couldn't they just behave? Couldn't they see she needed them to be "good?" How do I share this?, Christine wondered. Christine looked up and Mr. Lee said, "It seems you have a lot on your mind, I wonder how you are getting by." Christine began to tell her story, and Mr. Lee just listened. After a while Christine was tired and looked down. Mr. Lee sat in silence for a bit with Christine and then said, "You are carrying many difficult experiences from your past into your daily life now, and I wonder if Adam, Blake, and Cassie are also carrying some difficult experiences?"

Christine looked up and nodded. Together Christine and the consultant had shared an important experience and Christine found herself feeling supported. Maybe things would get better. She went to pick up the boys early at their classroom and knelt down and listened—really listened—to them talk about their day.

Christine was looking forward to her next meeting with Ms. Darlene and Mr. Lee. They met every week to share thoughts and ideas for the boys. She wondered if her ideas to help Adam and Blake talk about their feelings by using stories from the library would help. Ms. Darlene said she would try the stories and would spend more one-on-one time with the

boys. Mr. Lee called Christine after visiting the classroom that week and said all of the children had fun with the stories and wanted Ms. Darlene to read them three times. He shared that Blake gave Ms. Darlene a hug as they worked on a project together later that day and that her ideas were really helping Ms. Darlene. Christine felt a sense of safety with this team who supported her and her children. She felt hope, something that had not been there in a long time.

Mr. Lee is setting the stage for mutuality of endeavor as he works to understand Christine's experiences and perspective and as he shares the child care provider's hope for the children.

As Mr. Lee and Christine engage in safe, open dialogue, connecting with one another, they are building a trusting relationship that will serve as the foundation for the consultation process. Mr. Lee's ability to listen and validate Christine's experiences illustrates the parallel experience he hopes to foster between Christine and her children. As Mr. Lee acknowledges and facilitates Christine and Ms. Darlene's unique ideas and perspectives, he is building their capacity for change through everyday experiences, taking the role of a supportive partner and avoiding the position of expert.

ECMHC in a Domestic Violence Shelter

In the vignette below, Shelly and her children are living at a domestic violence shelter where the consultant helps the family and staff so that together they can reflect and grow. This vignette illustrates how the support of an early childhood mental health consultant can benefit both the families in need and the staff members who serve them.

Liz, a staff person at a domestic violence shelter, sits down at her weekly meeting with Marcella, a mental health consultant whose predictable presence Liz has come to count on. Liz anxiously asks Marcella for help with a referral. A mom, Shelly, and her three children arrived yesterday at the shelter at which Liz works. Liz is concerned about the behavior of the oldest child, Gabriella, and wants her assessed by the early childhood mental health consultant. Having Shelly's permission to speak with Marcella, Liz is hoping to move quickly.

Because Liz is usually relaxed and reflective, Marcella asks about her urgency. Liz is calmed by the inquiry. "Wow, until you asked I hadn't even noticed I was agitated." Liz identifies that her impatience is an expression of anxiety. Although the younger children seem okay, Gabriella is wild. As Liz helped the family get settled last night, Gabriella jumped on and off the bed shrieking and bellowing all night. Convinced that concentrating expressly

on Gabriella, let alone offering a referral, would be of little use, Marcella asks about factors contributing to Liz's worry and request. As they attempt to parse out the reasons, it becomes clear that several factors are conspiring. Given Gabriella's rambunctiousness, Liz is certain she will be found out and reprimanded for allowing a family with three children to stay, when the limit at the shelter is two. On top of the concerns about program policy, Liz is feeling unsettled by Gabriella's actions. Supported by Marcella's gentle but incisive probing, Liz realizes and reveals that Gabriella reminds her of her sister. Having grown up with a sibling with developmental delays, Liz imagines Gabriella's "feral" behavior indicates a cognitive deficit.

Appreciating that the domestic violence shelter provides a service aimed at addressing adult needs and staff are not trained in typical child development, Marcella asks if her direct involvement with the family might be useful. After a few visits with Shelly and her children and an equal number of talks with Liz, some hypotheses about Gabriella's behavior are developing. The consultant gives voice to the collectively created ideas. She posits the possibility that trauma along with the recent changes Gabriella and her family have experienced could account for her deregulated behavior. Initially it is difficult for both Shelly and Liz to consider the effects of violence and instability on Gabriella or her siblings, but Marcella's support is instrumental in helping Liz be more effective in her role and in helping Shelly understand her children's needs.

Held within a trusting relationship, Marcella's well-placed wondering instead of knowing affords a space for self-reflection and exploration of the consultee's currently held explanations and affect. Rather than rushing into action, the consultant focuses on subjective experience, thereby eliciting attitudes and beliefs that, if unattended, would have obstructed Liz's ability to usefully respond to the needs that Gabriella's behavior expressed. Recognizing that perceptions are determined by a multiplicity of factors, the consultant considers all levels of influence. First, they discuss Liz's reasoning for making an exception to a shelter rule. The two then explore how feelings of responsibility for and resentment toward her sister might play a role in Liz's request for a referral. The consultant compassionately and patiently persists in representing the children's voices. Avoiding the pull to prematurely offer advice, the consultant collaboratively seeks and finds meaning in behavior. Offering new perspectives, Marcella helps Liz and Shelly understand and respond to the needs of Gabriella and her siblings.



PHOTO: ©ISTOCKPHOTO.COM/CHRISTOPHER FUTCHER

Early childhood mental health consultation can be effective at helping families identify their needs and strengths.

ECMHC Within Primary Care

In the vignette below, the early childhood mental health consultant works with a family over time during well-child visits at the pediatrician's office. With the patience and hopefulness of the consultant along the way, Tamika is able to receive the support she needs to be the best parent she can be for her children.

Tamika arrived at the health clinic with her two children in tow. She was happy both her kids could get their well-child check-ups on the same day. That meant a few less bus rides. The kids ran across the waiting room to play with the books and toys. Tamika rested her head in her hands; she was feeling tired, more than usual. She had missed the last appointment at the clinic because she just could not get out of bed in time.

Ms. Jennifer, the mental health consultant at the clinic, waved at Tamika through the glass as she headed out to greet her and the kids. Jennifer sat down next to Tamika and said, "I am so glad you are here today—the kids sure look busy! I have a few forms for you to fill out from our Family Wellness Packet so I can gather some information for Dr. Jenkins." Jennifer brought them into the exam room and everyone sat down. The kids began to play again while Tamika and Jennifer talked. "How are things, Tamika?"

Tamika began her story. "I know we usually meet about the kids, but I wondered if I could talk to you about something else." "Of course," Jennifer said. "So much is going well and I feel like I should be fine too—but I am not sleeping and I still find myself feeling panicked and irritated most of the time." Tamika went on to

share more of her feelings, and Jennifer used eye contact and periodically nodded to convey her understanding. Jennifer had so many ideas she had been thinking about for this family since the last time they had been together for the baby's well-child check-up. They needed so much but she held back, waiting for the place in the conversation where there was a mutual understanding of need.

Jennifer makes a gentle comment to Tamika. "You have shared your stories with me, and you have experienced some very scary and challenging situations. I wonder how you are managing and caring for yourself. I noticed on the form you completed on your own well-being that you reported feeling down most of the time." "Yes, that is true; I don't know what to do. You know me, Jennifer; I am usually not this bad." Jennifer pauses for a moment and says, "I wonder if you might want to take some time for yourself to get support, just as you have done for William and Sarah? We offer a parent group here at the clinic that meets every week and offers child care." "What kind of parent group?" Tamika asks. "It's other moms who have young children and have been through some difficult situations. They share their strength and hopes together. If you like, I could meet you for your first group and introduce you to Ms. Johnson, the leader. I notice you are observant and like to sit back to get comfortable. Ms. Johnson seems like she would be a good fit for you—she is very gentle and has experienced some hardships herself as a young mom." Tamika thinks for a bit and then responds, "Yes, I think I am ready..."

Jennifer's ability to be available over time for Tamika and use patience versus trying to

solve Tamika's problems immediately allows them to work together in partnership toward a more positive future and allows Tamika the opportunity to take the time she needs to feel ready for change. As Jennifer waited until Tamika was open to further support, she held on to the hope that Tamika would be able to recognize the possibilities for her own future and be willing to take action.

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About the Consultative Stance

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C. Brinamen, A. Taranta, & K. Johnston. (2012)
Infant Mental Health Journal, 33, 283–293.

WORKING ACROSS BOUNDARIES: MAKING COLLABORATION WORK IN GOVERNMENT AND NONPROFIT ORGANIZATIONS

R. M. Linden (2002)
San Francisco: CA, Jossey-Bass.

INTEGRATING AND ADAPTING INFANT MENTAL HEALTH PRINCIPLES IN THE TRAINING OF CONSULTANTS TO CHILDCARE

K. Johnston & C. Brinamen (2005). *Infants and Young Children*, 18 (4), 269–281.

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Report of the Task Force on Early Mental Health Intervention (2003)
<http://apa.org/pi/cyf/emhireport.pdf>

Conclusion

As ECMHC MOVES into new settings where professionals support families and children, the essential elements of the consultative stance provide a framework for how to integrate the consultation into these new systems. These elements set the stage for services that are relationship-based, individualized, and more likely to engage partners and families. To be most successful, consultants must seek to learn as much as possible about the culture of the setting and the factors that influence practice including the roles and responsibilities of those they support. The influential organizational features that early childhood mental health consultants need to consider include the history of the service and the setting, bureaucratic and programmatic pressures, and program philosophy. Additional influences are interpersonal. Paying close attention to how staff interact with and speak to one another, how the hierarchies of authority and responsibility operate, and informal ways of getting things accomplished assists the consultant in establishing what to do in each setting, while the consultative stance supports how the consultant should be. The consultant can then make adaptations based on the careful understanding of the setting and shifts his own practices as a result.

Typical shifts in practice include: offering more didactic instruction in early development and the effects of trauma for staff whose work centers primarily on adult needs; communicating recommendations in a more directive manner in response to fleeting contact with families and changes in the pace and priority of consultation activities in places that attend to the immediate and crisis needs of families with infants and young children. Being able to adapt is critical as there are inevitably challenges to the delivery of ECMHC in these new setting. In pediatric primary care settings, for example, there may be extremely limited time for each visit, compressing the opportunity to reflect with medical practitioners on how best to support each family. Billing and reimbursement for ECMHC within a medical practice is fraught with barriers. In settings serving domestic violence survivors, staff are typically well versed in the aftermath of adult trauma but are not be trained in the effects of trauma on early childhood development and thus may miss opportunities to understand the needs and behaviors of the young child client. Rules and protocols may exist that compete with fostering consistent, predictable

relationships. The consultant who anticipates such challenges and is able to make the necessary practice shifts will ensure that the central tenets of the work of ECMHC remains steadfast in new, diverse service settings. ♠

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MARY MACKRAIN, MEd, IMH-E® (IV), is a technical assistant specialist with Education Development Center where she supports grantee-related cross-agency and systems work to meet the unmet mental health needs of children and families, birth to 8 years old. As a national infant and early childhood mental health consultant, Mary engages in the development of research informed and promising practice resources and approaches that foster positive early childhood mental health outcomes for young children and families, including extensive experience with early childhood mental health consultation across diverse settings.

KADIJA JOHNSTON, LCSW, is a licensed clinical social worker and the director of the Infant-Parent Program, at the University of California, San Francisco. She helped to develop the Program and, since its inception in 1988, oversaw the early childhood mental health consultation (ECMHC) component of the Program which now serves as a model for other organizations, locally and nationally. Ms. Johnston designed a training program in ECMHC which she and her colleagues have been implementing for the past 15 years. Ms. Johnston writes and presents nationally on ECMHC. Her recent articles on the subject have appeared in the *Infant Mental Health Journal* and *Infants and Young Children* and a chapter in the 3rd edition of the *Handbook of Infant Mental Health*. Ms. Johnston co-authored *Mental Health Consultation in Child Care: Transforming Relationships With Directors, Staff, and Families* with Dr. Charles Brinamen, published by ZERO TO THREE.

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Enhancing Home Visitation With Early Childhood Mental Health Consultation

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Estimates indicate that more than 400 publicly and privately funded home visitation programs provide services for at least 500,000 children in the United States (Johnson, 2009). This number is expected to increase over the next 5 years as states expand their evidence-based home visiting programs with funding provided by the Patient Protection and Affordable Care Act, legislation that will bring \$1.5 billion in new federal dollars for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.

Home visiting programs can be staffed by paraprofessionals (e.g., Parents as Teachers and Healthy Families America), by nurses or social workers (e.g., the Nurse Family Partnership), or by other professionals. In many cases, these models differ in target population (e.g., first-time mothers), as well as staff qualifications, yet they all recognize the critical importance of supporting parents as a means to improve a wide array of child health and development and parenting outcomes (Gomby, 2005). Home visiting services typically begin at the prenatal stage and continue through the child's second birthday, but some models (e.g., Home Instruction for Parents of Preschool Youngsters) begin after the child's second birthday (Stoltzfus & Lynch, 2009). Working with parents in their homes, home visitors support parenting skills and family functioning, emphasize safety in the home, promote maternal and child health, and ensure referrals and access to needed services.

Home visitation programs primarily serve families living in poverty and at high risk for child maltreatment, which often coincide with a higher incidence of maternal depression, substance abuse, and domestic violence. These family challenges can have a grave impact on parents' ability to support children's development, and they may contribute to behavioral problems among children as young as 3 years old (Whitaker, Orzol, & Kahn, 2006). In addition, these factors, if left unrecognized, predict early school failure, later school failure, and more serious mental health problems such as depression, anxiety, and conduct disorders, which are expensive and difficult to treat (Raver & Knitzer, 2005).

Home visitors often do not know how to address such psychosocial issues while providing families with basic information on infant nutrition, parenting skills, home safety, and maternal health (Gomby, 2005). Furthermore, home visitors report feeling unequipped to deal

with families' mental health issues, because of lack of education, training, and support. Home visiting nurses in one maternal health program said they struggled with how to minimize the impact of mental health problems on the mothers' and babies' functioning (Zeanah, Larrieu, Boris, & Nagle, 2006). Through a systematic review of scientific evidence of the

Abstract

Early childhood home visitation programs must be able to meet the mental health needs of families with complex risk factors such as substance use, mental illness, and domestic violence. However, many home visitors report feeling unequipped to meet these psychosocial needs, and working with at-risk families often leads to high levels of stress and burnout. This article illustrates one home visitation program's efforts to integrate early childhood mental health consultation (ECMHC). In a case study, the authors highlight the consultant's role in supporting the home visitor through reflective case consultation and collaboration to strengthen the family in need.

effectiveness of early childhood home visitation, Bilukha et al. (2005) found that because of the complexity of family circumstances and needs, home visitors may require more intensive training and supervision in order to provide quality services to families.

Because many home visitation programs have reported that mental health issues are paramount with at-risk families and that home visitors are underprepared to provide comprehensive support, researchers have begun to document the success of augmenting home visitation programs with early childhood mental health consultation (ECMHC). ECMHC involves a professional consultant with early childhood mental health expertise working in partnership with early childhood programs, staff, and families to (a) enhance the mental health climate of the environments in which children learn and grow and (b) build professionals' capacity to recognize, interpret, and support the individual mental health needs of children and families in their care (Cohen & Kaufmann, 2005). A number of studies found that home visitors with access to an experienced mental health consultant had decreased levels of stress and lessened rates of burnout, and they reported increases in professional growth (Boris et al. 2006; Fox, Gresl, & Mattek, 2012; Wasik, 1993). Boris et al. (2006) reported that collaboration between home visitors and an early childhood mental health consultant increased nurses' comfort in dealing with the complex issues their families presented and decreased their levels of personal stress.

Home Visiting and ECMHC: A View From the Field

A NONPROFIT HEALTH care provider serving families in Wisconsin is enhancing several home visitation programs with ECMHC, targeting an urban location burdened by elevated teen pregnancy rates, unemployment, and poverty. The approach used to integrate ECMHC includes a masters'-prepared mental health consultant providing ongoing reflective and clinical supervision to home visitors to increase their capacity to recognize and support families' mental health needs. The consultation also minimizes the effects of secondary traumatic stress on home visitors that may result from their efforts to support families through ongoing crises.

A case study illustrates how several of the core tenets of ECMHC—relationships, reflection, and the parallel process—can be integrated within a home visitation program. In this case, a primary care provider referred a mother, Nan Na, and her children, who were 4, 3, and 1 year old, to the local home visitation program. The family is originally from Burma and came to the United States 3 years ago

after living in a refugee camp in Thailand; they speak Burmese at home. When the home visitor, Donna, experienced challenges she could not overcome alone, she called in a mental health consultant: the second author, Paula, who narrates the following case study.

Our First Meeting

I would never have thought my work in mental health consultation would lead me to the Milwaukee Zoo. However, there I was, near the lion cage, waiting to meet a family referred to me for ongoing mental health consultation. Donna, a nurse, was the home visitor who had called me in; she was encountering levels of complexity in her work with this family that she needed my help to confront.

Donna was concerned about the family's history of trauma, one of many issues she had hoped the family would eventually discuss with the two of us. My role in this case would be different from my role offering therapy in my office—it would be to support Donna, and to help her understand and interact with the family. We planned this first casual encounter at the zoo for me to meet the mother and her children, Zarni, Raju, and Victoria. Nan Na knew I was a team member of Donna's and a specialist in child social-emotional development.

Magical Moment of Connection

During the zoo trip, I developed a strong relationship with one of the children, Zarni, who had gently held my hand as Nan Na looked on and approved of these first interactions. A few weeks after this visit, Donna asked me to join her in meeting with the family again. Nan Na had started talking about parts of her life at a refugee camp and seemed open to including me in further conversations about her experiences. This was a very different experience than I had ever had before as a consultant, which had been consulting mostly with Hispanic and African American families. Now we sat in a room together in Nan Na's home: a nurse who is Caucasian, Nan Na and an interpreter who are Burmese, and me, a mental health consultant who is Hispanic.

Our conversation that day began with Donna and me greeting the family and talking with Nan Na about her children, her life before the refugee camp, and her life in the United States. Nan Na shared some of her fearful memories of hiding in a cave so soldiers would not find her. She talked about soldiers hitting her father and taking away some of their animals. She described her father as the protector of her family.

Nan Na went on to say that even though life is better in America, she still misses her family and her friends. She has limited communication with her family, and that makes her worry about them. She expressed her



PHOTO: ©ISTOCKPHOTO.COM/MACHINEHEADZ

Home visiting services typically begin at the prenatal stage and continue through the child's second birthday.

difficulties with learning a new language and how frustrated she feels when she struggles to communicate. I disclosed to her that I did not know English when I moved to the States, but I was able to learn it after going to school. I remember this next part well: Nan Na looked right at me, and we shared a magical moment where we connected—we had something important in common. We are both from a different country, we both struggle to communicate at times, and at some points, we both sorely miss our family and friends.

A Lot of Questions, But No Answers, Yet

I now knew some of the traumatic events that Nan Na experienced. I did not think that my office, where I was used to seeing families, would be the best environment in which to continue our talks. We did not want to create more stress for Nan Na; going to different areas of the city could create anxiety due to transportation and language barriers.

This mother needed to feel safe and comfortable to continue her process of opening up. Her home allowed her to have control over the situation.

Would Nan Na benefit from seeing a therapist in an outpatient clinic? Would the therapist be culturally sensitive? How could we include an interpreter? Was Nan Na willing to talk to someone else about this? Was she ready for such a big step? I had a lot of questions and no answers, yet.

Trouble at Home

I came back with Donna 2 weeks later to see how the family was doing, and to try to find

answers to some of the questions about Nan Na's mental health needs and care. When we returned for this visit, we found the family had moved to a different house. Nan Na claimed the move was due to difficulties between her brother and her husband. The new house was infested with cockroaches and mice, so we were not invited in, but the day was unpleasantly hot and humid. We settled onto the porch for our visit, feeling the weight of how uncomfortable the family's life must be.

Nan Na told us about her relationship with her husband and how upset and irritated he gets. I gently asked if this was the first time these difficulties had arisen. She explained that issues with her husband started when they were living at the refugee camp. They had fought very badly while living there, and once he threatened her with a knife. Donna informed Nan Na that this is not appropriate behavior, and that here in America that sort of action is punishable by the law. To this, Nan Na responded, "My father defended me from the soldiers. My husband is not going to be the one to hit me. I won't ever let him hurt me again."

I asked Nan Na what would happen if she decided to take action if her husband threatened to hurt her again, and she replied, "What can I do?" Together, Donna and I explained what domestic violence is, and that Nan Na has the right to be safe and protected. We told her she could call the police and that her husband could be arrested. She told us that it would not happen again, so we left it there for the time being.

Feeling the Heaviness

After the visit, Donna and I talked. Donna had not known about Nan Na's domestic violence issues with her husband. She said she was feeling overwhelmed and exclaimed, "That is one *more* thing we need to work on!"

Learn More

HOME VISITATION WITH PSYCHOLOGICALLY VULNERABLE FAMILIES

B. J. Harden (2010y). *Zero to Three*, 30(6), 44–51.

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION (BRIEF 1)

National Center for Mental Health Promotion and Youth Violence Prevention
Education Development Center (2012)
<http://projectlaunch.promoteprevent.org/resources/brief-1-early-childhood-mental-health-consultation>

SUPPORTING BABIES AND FAMILIES WHERE THEY LIVE

ZERO TO THREE. (2007)
<http://projectlaunch.promoteprevent.org/resources/supporting-babies-and-families-where-they-live>

Home visitors report feeling unequipped to deal with families' mental health issues, because of lack of education, training, and support.

I gently suggested we have patience. I told her that clearly Nan Na was not ready to continue the conversation about domestic violence, and that we need to give her some time. While we waited, we would work on some possible solutions to other problems the family was facing.

As we talked about some of the other issues, I started feeling the heaviness that Donna was feeling. We wanted to help this family get to a comfortable place where they could really begin to dream and hope. We found ourselves asking, "What is the best thing to do in this case?" Referral is so often the answer for a mental health consultant, but I knew referral was not right for Nan Na and her family right now. Nan Na was just starting to feel comfortable talking about some of the different situations taking place in her home, and I had the feeling that while I was telling Donna that we needed time, I was also telling myself not to rush with them. I had to respect Nan Na and her process. I also knew Nan Na had developed a strong relationship with Donna and she trusted her; it was because of that relationship that I was allowed into the home. I was not sure that Nan Na would be willing to meet with somebody in an unfamiliar office, a setting that might feel strange for someone who came from a refugee situation. Rather than take things out of Donna's hands, I needed to continue supporting her so she could continue to be a presence for the family.

Small Steps Forward With Mother–Child Relationships

We continued to meet on and off during the summer, and we continued to get to know the children. Nan Na shared some concerns about Zarni, her 3-year-old son, and his behavior. She shared that she felt uncomfortable because her husband's sisters were dressing her son as a little girl. She asked them to stop and they refused. She also said that Zarni was not listening to her. He would argue and say he did not love her. To this she would reply, "I do not love you either." We explained that children sometimes say things they do not really mean. I offered another strategy to try when he says this to her, to say, "Mommy loves you. I understand that you are upset now, but Mommy still loves you." I asked her to try it as an experiment and see what happened. A few

weeks later, Nan Na was excited to share how Zarni's behavior was improving.

Cold Weather Comes, and More Challenges

As the cold weather arrived, we moved our visits to a local coffee shop. During one visit, it was very crowded, and there was no place to sit inside. It was sunny out, but still chilly and windy. Nan Na was not wearing warm clothes and did not have boots, a hat, or gloves. She said she was fine to sit outside and talk—she wanted the visit to go on. "It's a sunny day," she said.

On this particular visit, we talked about Victoria, her 1-year-old baby. Victoria was not yet talking, and the *Ages and Stages Questionnaire* (Squires & Bricker, 2009) indicated caution in this particular area. We discussed Victoria's speech issues with Nan Na, but she did not see a problem. Donna and I shared information on how children develop language. We all wondered together about which of her children was the most talkative and how old the other children were when they started talking.

At this time, the conversation turned again to Zarni. Nan Na shared that he started talking late, and that his language was delayed. She then began to share more about Zarni's development. We let her talk and just listened. She shared that Zarni was very quiet, and quite scared of his father; sometimes he hid under the table when his father screamed and got upset. Nan Na wanted to protect him. We drew the connection with Nan Na and her own father. I said, "You had your father to help protect you. Zarni has you." Nan Na seemed comforted by this.

Digging Deeper Into the Past

Donna and I knew we needed some reflection time. We wanted to know more about Nan Na's past. We thought knowing more of her history, such as where she grew up and under what circumstances, might shed some light on her present relationships. I remember wondering aloud, "What would life feel like for someone who had to hide in a cave? What would it be like to know you needed to be quiet, or risk being found? What importance would a person who has been through all of that put on talking?"

I invited Donna to think about how people construct reality and how that affects their lives, perceptions, and experiences. I said, "Think about what happened to Nan Na when she was a baby. What horrible things has she seen in her life? How are her reactions to traumatic events different from yours or mine?" I pointed out that Donna had reacted quite strongly when Nan Na told us a story of how her uncle cut her finger with a knife. In contrast, Nan Na had barely any reaction at all.

Donna was comfortable with me inviting Nan Na to think about how life is different for everybody, and how those experiences shape peoples' minds and souls. How could we help this mother to find her childhood that was lost in Burma? How could we help her find her voice? How could we help her be heard by us, by her in-laws, by her children, and by her husband? More questions loomed—in need of important and life-changing answers.

An “Aha!” Moment

After our reflective time together, Donna went back to Nan Na's house to work on some Parents as Teachers (Parents as Teachers National Center, 2002) activities with the two youngest children. She noticed that Nan Na did not get involved while she was engaged with the children, and had an “aha!” moment. Donna remembered that while Nan Na was growing up, she spent a lot of time hiding in a cave, being quiet. There were likely no games, no puzzles, not much interaction or talking. Donna realized that Nan Na probably did not know how to play—her childhood was not like Donna's, or like mine.

Donna gently invited Nan Na to join the play. She taught her what to do. Donna shared with me, “I just needed to change my approach with her. I was expecting her to know how to do things that she had never experienced before. That was not fair to Nan Na, and she was getting frustrated.”

Ongoing Support: Offering Hope

Now Donna is finding more joy in her work with this family. She is helping them learn about safety, as well as exploration. Although progress has been made, the family still has many pending needs. Donna will continue to work with Nan Na for another year, helping


prepare her for various situations she might encounter in her new country.

Final Reflections

The home visiting program Donna works with provides prenatal care and follow-up until the children turn 3 years old. I feel blessed to consult for this program, and to be able to help support the families it serves. In offering support to this home visitor, I was able to help her understand the unique mental health needs of the family. At times, I was there to physically and emotionally connect with the family. At others, I could help guide moments of reflection. Taking time to pause, dig deeper, and ask ourselves tough questions about the family helped Donna and me to work together to provide the best service possible for this client. Furthermore, Donna and I had built a relationship of trust; she opened her mind to my ideas and she trusted me, so that in turn I could help her tolerate and express difficult emotions—and thus be better equipped to help the family manage their own challenges and triumphs. Donna has been able to look for the strengths of this family, to help them realize their own strengths, and to help them reinforce those strengths and build additional ones. Sometimes, consultants enter into a new relationship not knowing what they are going to find. My journey with this consultation experience began at the zoo with wonder and worry. As I, the family, and the home visitor reflected, using patience and listening, our path turned to one of hope.

Summary and Implications

INTEGRATING ECMHC WITHIN natural settings, such as home visitation, where children grow and learn is a promising

practice that is important to early childhood planning efforts at the national, state, and local levels. The burgeoning federal investment in home visitation programs serving at-risk families will allow for greater study of the potential benefits of enhancing home visitation models with ECMHC. Such study should include the specific impact of ECMHC on home visitors' knowledge and skills to identify, interpret, and support child and family mental health; the retention of families within programming; the retention of quality home visitation staff; and the efficacy of evidence-based models. 

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A New Focus for Mental Health Consultation

Increasing Child Care Quality and Stability for Young Children in Foster Care

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Young children in foster care have experienced the trauma of abuse, neglect, or loss and have had their most important early relationships disrupted. It is not surprising that these young children are at increased risk for developmental delays and problems with mental health and behavior (Melmed, 2011; Mennen & O'Keefe, 2005). These vulnerable children need sensitive, nurturing caregiving, hence finding appropriate placements is a key task of the child welfare system. Many parents of young children work outside the home, and child care is a necessity. As a result, many young children spend the majority of their waking hours in the child care setting (National Research Council & Institutes of Medicine, 2000). Foster children are no different. Experiences in the early years shape the development of the brain—for better or worse (National Research Council & Institutes of Medicine; Zeanah, 2009); therefore, the hours spent in child care matter. In this article, we will argue that greater attention must be paid to both the quality and the stability of the child care experience for foster children, and we will describe multiple ways that early childhood mental health consultation (ECMHC) can help.

High-quality child care is beneficial to all children, and for vulnerable children it holds a particularly urgent opportunity. Research shows that high-quality child care can help children with risk factors catch up developmentally, but low-quality child care is associated with children falling further behind their same age peers (National Research Council & Institutes of Medicine, 2000). Low-quality care impedes children's

cognitive, social-emotional, and language skills (Cohen, Cole, & Szrom, 2011; National Research Council & Institutes of Medicine, 2000). Children in low-quality care are more likely to experience stress and behavior problems (Bradley & Vandell, 2007).

In addition to quality, foster children need stability in their child care placement. Children in foster care, like all children, fare best when they have nurturing relationships

with stable, consistent adults. A key developmental task of infancy is forming an attachment to at least one primary caregiver (Ainsworth, 1979; Bruskas, 2010). Children in foster care, by definition, have had their primary relationships disrupted, and attention to children's attachment is essential for improving outcomes for children in protective services (Mennen & O'Keefe, 2005).

Abstract

High-quality and stable child care can be an important support for young children in foster care. Unfortunately, many children are placed in low-quality care and have frequent disruptions to their care. This article describes how early childhood mental health consultation (ECMHC) to child care programs serving foster children can support children and their caregivers. The authors illustrate how system-level ECMHC can support child welfare staff members in their efforts to develop trainings, policies, and practices to increase quality and stability in child care.

Evidence suggests that secure attachment with teachers or caregivers offers advantages as well. Babies who are securely attached to their child care provider explore, play, and interact more than babies who experience frequent changes in caregivers (National Research Council & Institutes of Medicine, 2000; Raikes, 1996). However, frequent moves between foster homes or child care hampers the child's ability to develop secure attachment (Dupree & Stephens, 2002; Melmed, 2011).

High-Quality Care for Foster Children

THERE IS LITTLE information available to measure how successful states are in connecting foster children to high-quality, stable child care. We wanted to explore whether foster children in Arkansas experienced quality and stability in their child care placement. What we found was disheartening (see box Foster Children in Early Care and Education: A Look at the Numbers), and so we sought to learn why more foster children are not in high-quality child care placements and to begin to address those barriers.

There are several reasons that the majority of Arkansas foster children are not enrolled in quality child care. One reason is that some child welfare workers may not yet fully recognize the value of high-quality child care for children involved with the child welfare system. A 2012 survey of a statewide sample of child welfare workers in Arkansas suggested a need to build awareness about how to identify quality care (Lloyd, 2012). Of 207 survey respondents, only 3% of child welfare workers reported they were "very familiar" with the state's quality rating system, and 27% reported being "familiar." Further, only 23% of the child welfare workers knew of a quality rated facility in their area (although there are quality rated facilities in all regions of the state). Finally,

the vast majority (75%) reported the foster parent usually made the decisions about child care. While we do not have comparable survey data for foster parents, in trainings with foster parents we ask for a show of hands from those who have heard of the quality rating systems, and invariably fewer than 10% raise their hands. When we ask how they make decisions about child care, most foster parents note the importance of a convenient location and an immediately available child care slot. Among both foster parents and child welfare staff there appears to be a widespread misconception that licensed care is equivalent to quality care, and there is a lack of awareness of variations in quality and how those variations impact children.

The limited evidence available suggests several additional barriers in access to Head Start and similar high-quality early childhood programs for foster children. In Arkansas, Head Start and other high quality child care programs fill up (often with a waiting list) during the enrollment period and drop-outs are relatively few so there are limited opportunities to enroll children who enter foster care at other times of the year. Anecdotally, we learned in our discussions with child welfare workers that many had stopped recommending Head Start programs to foster parents because they were usually full. For others, limited hours (e.g., closing at 2:30 p.m.) and summer closures were a barrier.

Information on child care stability for foster children was even harder to come by. Although official numbers related to child care placement changes for foster children are not available, Arkansas staff members working in the child care voucher program voiced concerns about the frequency of changes. Children in foster care are likely to experience one or more placement changes during their stay in foster care (Barth, Lloyd, Green, James, Leslie, & Landsverk, 2007). For young children in foster care, the practical



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High-quality child care is beneficial to all children.

consequence of a home move is usually a change in child care placements as well. With careful planning, the child care placement could be a point of stability for the child even during changes in the home placement.

In many states, like Arkansas, it may be difficult in the short-term to ensure that all foster children are consistently enrolled in high quality settings. ECMHC programs can draw attention to this important problem and help their state and local policymakers design solutions. Wherever these children are enrolled in child care, staff from ECMHC programs are a potential support for both teachers and children.

ECMHC for Child Welfare and Child Care Systems

WHILE WE HAVE used data from Arkansas to illustrate the challenges of ensuring high-quality care for foster children, many states face the same challenges. Fortunately, many states may find potential solutions in their ECMHC programs. We will highlight efforts in two states to use ECMHC programs to support foster children. Like many states, Arkansas and Arizona both have ECMHC programs designed to partner with child care centers to build the capacity of teachers and staff to support children's social-emotional development and manage challenging behaviors. In the sections that follow, we will describe three approaches used by the ECMHC programs in Arkansas and Arizona to support young children in foster care. Specifically, we will describe how ECMHC

FOSTER CHILDREN IN EARLY CARE AND EDUCATION: A LOOK AT THE NUMBERS

Of 1,376 foster care vouchers paid to Arkansas child care centers in August 2011, only 29% went to facilities participating in the states' Quality Rating Improvement System (unpublished report, 2011). In addition, for 2011–2012, only 75 children in foster care were enrolled in Head Start (U.S. Department of Health and Human Services, 2012c). That is 2.2% of the 3,317 Arkansas children less than 6 years old who were in foster care that same year.

Nationally, there were 19,434 foster children enrolled in Head Start during the 2011–2012 school year (U.S. Department of Health and Human Services, 2012b), compared to 151,699 total foster children less than 6 years old in the U.S. at that time (U.S. Department of Health and Human Services, 2012a). Head Start and Early Head Start deliver the family-centered, quality, holistic services these children need and prioritizes placement of foster children (they are eligible regardless of family income). Increasing the percentage of foster children enrolled in Head Start is a goal of the Office of Head Start and the Administration on Children Youth and Families (U.S. Department of Health and Human Services, 2010).



PHOTO: ©ISTOCKPHOTO.COM/LOKIBAH

Children in foster care, like all children, fare best when they have nurturing relationships with stable, consistent adults.

programs can provide (a) programmatic consultation to child care programs that serve foster children, (b) child-specific consultation to support teachers in working with an individual foster child, and (c) systems-level consultation to help the child care and child welfare systems work together to meet the needs of young foster children.

Programmatic Consultation to Child Care Programs

To begin to address the needs of foster children in their child care settings, the Arkansas ECMHC program (Project PLAY) partnered with leaders of the two divisions of the Arkansas Department of Human Services responsible for child care for foster children: The Division of Child Care and Early Childhood Education and the Division of Children and Family Services (DCFS). In initial meetings we explored the best way for Project PLAY to become involved. Given the relatively small size of our ECMHC program, we worried that Project PLAY would quickly become overwhelmed if we focused on the needs of individual children. Instead, we decided to prioritize services for child care programs in which foster children were naturally clustering, offering programmatic consultation to those centers to increase their capacity to offer high-quality and supportive services to the foster children they serve. By examining data from the voucher system that provides payment for child care for foster children, we were able to identify child care programs serving the most foster children and reach out to offer our support. The following vignette highlights how centers

serving foster children can benefit from consultation, even in challenging circumstances (all names and other significant details have been changed).

Precious People Childcare serves many foster children. When Project PLAY called, the director (Anne) was excited at the offer of support for their center. Anne openly shared her concerns about the foster children they serve, the other needs of the center, and how Project PLAY could help. At the time, foster children made up almost one third of the enrollment at this small center, partly because the center had developed relationships with several foster parents who were “repeat customers.” Anne said that her biggest concern about their foster children is that often the teachers can tell that children are struggling, but they don’t know much about their background and it is hard to know how to help.

Anne says they learn a lot about the problems in the family from the children. For example, one preschool age child told her that his stepdad went to jail for beating up his mom. Other children act out things that they have seen, like smoking, drinking, and fighting. There are problems with aggression, and the staff is having difficulties managing some of the challenging behaviors. Anne says that training on challenging behaviors is a top priority. The work environment is stressful, and they struggle with staff turnover—in fact, they just had to let two staff members go because they didn’t have the skills they needed.

When the consultant visits, she notes several positives about the center. There is a lot of space, and the director has invested in nice equipment in the classrooms and on the playground. However,

it is quickly apparent that teacher turnover is a huge problem in the center. Most of the teachers are new and haven’t yet settled into a regular daily routine. During the first few weeks of consultation, there is a new toddler teacher in the classroom almost every week, as a series of teachers quickly quit or are fired. The problems of the surrounding neighborhood also create stressors for the staff. Issues with substance abuse, crime, and violence are too common, and many families are struggling financially. Anne cares deeply for the families in her community and tries to help where she can. This creates financial pressures when she serves children whose families cannot pay their child care bills. It also takes an emotional toll, as she struggles to know how to support families facing homelessness, domestic violence, and other serious problems.

The consultant spends several long sessions with Anne, serving as a sounding board for Anne’s frustrations. Anne feels that the center has become chaotic and is frustrated at the staff turnover. The consultant thinks with her about strategies that might increase stability and reduce the chaos. They decide that providing some immediate training opportunities for staff might be helpful for the new staff, as most have never worked in child care. The consultant begins to provide trainings during naptime. She also begins working closely with the teacher in the preschool room, who is inexperienced but very receptive. The consultant helps her with a daily schedule and helps her think of ways to engage the children in play activities, which tended to get out of control quickly with several high-energy boys in the class. The teacher seems uncomfortable joining in play, and so the consultant models different ways of engaging in play. The teacher is also reluctant to touch or nurture the children, expressing concerns that this will make the children more clingy. She and the consultant discuss this possibility, and the consultant models ways to nurture the children and attend to those who are distressed. The teacher is receptive, and begins to ask the consultant for more suggestions. The consultant finds opportunities to offer support in the infant room, but struggles to connect with teachers in the toddler classroom who continue to come and go over the first few months of consultation.

After 6 months, progress can be observed in a number of areas. The toddlers’ class has stabilized and they have maintained the same teachers for more than 3 months. The preschool classroom is a happier place, and the teacher is finding ways to nurture the children more often. With the help of the consultant, each teacher made a picture schedule for the classroom and that has helped the teachers settle into a daily routine that works better. The teachers are reporting less aggression in the classroom. The director is still stressed by problems in the neighborhood and financial difficulties. This was made real for the consultant during one of her final visits to the child care

center, when a mother from the neighborhood sought refuge at the center after having been beaten by her ex-husband. While these challenges remain, Anne is encouraged by the progress they have made. While there is still room for growth, it seems clear that the overall climate has changed for the better.

Our experience in centers serving foster children has been quite variable, but this vignette summarizes some of the issues that consultants have encountered. In many settings, consultants have encountered teachers with very little training and support, chaotic classroom environments without appropriate schedules and routines, centers that are under financial pressure, and high teacher stress and turnover rates. Although the consultants have many successes in these partnerships, it has been difficult for consultants to focus specifically on the needs of foster children and children that have experienced trauma. Often other issues with the basics of quality child care are more pressing. We had originally hoped to more frequently share information about the impact of trauma on children and families, signs and symptoms of trauma, and strategies for working with children that have experienced trauma. We continue to think together with our state agency and other partners about how to work with centers at all levels to help them reach their goal of providing the best possible care for children in foster care.

This vignette also highlights another lesson learned, which is that problems with child care stability for foster children are not just the purview of the child welfare system. When teacher turnover rates are extremely high, even when children remain in the same setting, they miss out on the ability to develop meaningful relationships with their caregiver that could support them through this difficult time.

Child-Specific Consultation

Arizona is fortunate to have a large ECMHC program called Smart Support, available to provide both programmatic and child-specific support to child care programs around that state. Whereas the Arkansas ECMHC program has taken the approach of providing primarily programmatic support to child care programs where foster children naturally cluster, Arizona's Smart Support consultants have been available to support individual foster children in their child care setting. The following vignette provides an example of this support.

When 4-year-old Tony's preschool teacher, Miss Melanie, turned for help to Rich, the early childhood mental health consultant who supported her school, she admitted that she was



PHOTO: © STOCKPHOTO.COM/MARKGODDARD

Among both foster parents and child welfare staff there appears to be a widespread misconception that licensed care is equivalent to quality care.

at an utter loss for how to manage the behavior of this little boy. Miss Melanie painted a vivid picture of a child who could turn her classroom upside down with little or no provocation. He hit and kicked other children, took their toys, and ran from her when she tried to intervene. Rich learned that Tony was in foster care, but Miss Melanie knew little about his life outside of her classroom other than the fact that his foster mother indicated that he was similarly challenging in her home.

In his initial conversations with Miss Melanie, Rich listened empathically to her feelings of frustration and helplessness, which were all the more vexing for her because she was an experienced teacher! She wanted to know what to do to change Tony's difficult behaviors. Rich was hoping they could take time to think together about what might be driving Tony's difficult behaviors. He was heartened by the fact that although she viewed Tony as interfering with her ability to teach effectively, to control her classroom, and to allow the other children to learn, Miss Melanie was not in fact considering expelling him. When all was said and done she declared, "I'm not giving up on him."

Teacher and consultant agreed that it was important to include the foster mother, beyond just obtaining her informed consent, as they tried to better understand Tony. They learned that Tony had been removed from his biological parents for neglect related to their substance abuse, and he had been in several foster homes prior to hers. In his short life, he had had little stability, predictability, or security, and he had been scared. Miss Melanie felt compassion for Tony, but Rich could see that she did not make a connection

between his traumatic experiences and his difficulties in her classroom. He set about to help her "hold in mind" Tony's life experiences and perspective as she observed and interacted with him each day. When she described a challenging behavior or troubling incident, he mused out loud, "Hmm, I wonder what he was feeling in that moment?" He asked the teacher to speculate about the meaning of Tony's behavior—"What's your thought about why he did that?"—taking a collaborative stance and honoring the teacher's long experience. He gently but persistently drew parallels between Tony's history of undependable care from adults and the challenges he posed to Miss Melanie caring for him.

Rich helped recast many of Tony's disruptive behaviors as ways of showing the fear and distress he had experienced and continued to experience in his life. They each brought to their conversations observations they made about Tony.

In one crucial conversation, Rich observed for Miss Melanie that although Tony often failed to comply with her requests, he simply behaved better when he was physically close to her. Had she noticed that? She had not. "I wonder what that means to him" he asked, "I wonder how that makes him feel, particularly given the experiences he's had with adults?" and ultimately, "I wonder how he could get more of that?" The teacher determined to be more mindful of Tony's proximity to her and to create opportunities for him to be close to her, other than when he was "in trouble." Over the next few weeks, Miss Melanie noted with surprise the calming influence of just her nearness to Tony. She felt she had underestimated her importance to him because he had not seemed



PHOTO: ©ISTOCKPHOTO.COM/JATIHBOGA

There is wide variation in the level of training among teaching staff in licensed child care centers.

Learn More

ARKANSAS CHILDCARE AND CHILD WELFARE PARTNERSHIP TOOLKIT

www.projectplay.uams.edu
Click on “foster care” tab to download toolkit and other educational materials.

THE NATIONAL CHILD TRAUMATIC STRESS NETWORK

www.nctsn.org
The National Child Traumatic Stress Network was established to improve access to care, treatment, and services for traumatized children and adolescents exposed to traumatic events. Their Web site includes resources for parents, caregivers, and professionals.

PROTECTING THE YOUNGEST: THE ROLE OF EARLY CARE AND EDUCATION IN PREVENTING AND RESPONDING TO CHILD MALTREATMENT

S. Christian & J. Poppe (2007)
Washington DC: National Conference of State Legislatures.
Available at: www.ncsl.org/print/cyf/protectingyoung.pdf

CENTER FOR EARLY CHILDHOOD MENTAL HEALTH CONSULTATION TUTORIALS

www.ecmhc.org
The Center for Early Childhood Mental Health Consultation has developed a Best Practice Tutorial Series. This series is designed to enhance professionals’ skills and knowledge around how to implement effective mental health consultation. For information on working with children that have experienced trauma, see Tutorial 7: *Recognizing and Addressing Trauma in Infants, Toddlers and Young Children*.

interested in her and had so strenuously challenged her authority.

As he worked with Miss Melanie on addressing Tony’s specific needs, Rich simultaneously considered the overall classroom environment. What was and was not in place for all the children, from the standpoint of the physical environment, the structure of the day, and the quality of teacher–child relationships? In truth, it was quite chaotic. The noise level was very high, there were few routines, and there were long periods of waiting between activities without any teacher engagement. As she prepared the next activity, Miss Melanie tended to tune out the children, and as they stood around without direction from her or a sense that she was “with them” they tended to get into fights with each other. Rich talked with Miss Melanie about the value of routine and predictability for children’s feelings of safety and security and their development of self-regulation. She could see that for a child like Tony, who had had the chronic experience of not knowing what’s coming next, a sense of predictability at school was especially important. Rich offered a variety of concrete strategies to institute more rhythm and routine in the classroom.

Over time there was a noticeable shift in the classroom climate toward greater structure and calm. After many weeks of deliberate investment in her relationship with Tony, Miss Melanie saw his challenging behaviors diminish greatly. She reported feeling closer to him and could describe ways in which he indicated that he felt secure with her. She understood better the impact of trauma on children’s development and could more readily hold it in mind as she considered Tony’s behavior, his assumptions and expectations of relationships, and how she interacted with him.

This vignette illustrates some themes that Smart Support consultants have found to be common in their work with foster children. Some foster children can exhibit very challenging behaviors, but their teachers don’t always have the information that they need to connect their traumatic life experiences with their behavior. Like Miss Melanie, many teachers’ empathy is deepened when they are able, with the help of a consultant, to “connect the dots.” Often this gives teachers renewed energy to try new strategies to support a difficult child. This vignette also illustrates how the lines between programmatic and child-specific consultation often blur, as there are often issues in the classroom environment and routines that need to be addressed. These changes benefit all children but can be especially beneficial to children that are struggling in the classroom environment.

Systems-Level Consultation

Project PLAY began its intentional partnership with the child welfare system (the Arkansas DCFS) at about the same time that local university partners were awarded an “infrastructure building” grant from the Children’s Bureau. The purpose of the grant was to support collaborative initiatives between child welfare and early childhood systems to maximize enrollment, attendance, and supports for infants and young children who are in foster care in comprehensive, high-quality ECE programs. Working together with state agency personnel, court personnel, child welfare training partners, and others, the state has made great strides toward putting into place supports for child care quality and stability for foster children. Below we highlight some of the outgrowths of this systems-level consultation and teamwork.

PROMOTING INFORMATION SHARING BETWEEN CHILD CARE AND CHILD WELFARE TEAMS.

We contacted 45 child care centers that served multiple foster children and interviewed the program directors. Several themes emerged from these discussions, but one of the most consistent themes was a lack of communication with the child welfare agency. Many child care directors expressed concerns about having minimal information on the children, including difficulties accessing developmental evaluations and medical records. Directors also expressed concerns about lack of planning for transitions (children “disappearing” from the center) and frequent disruptions to the child’s daily schedule (e.g., visitation scheduled during naptime). In response to feedback from child care providers who felt in the dark when working with foster children, we developed a communication toolkit designed to promote information sharing that is in the best interest of the child (see Learn More). The toolkit

includes a format for two-way information sharing, as well as a booklet for child care providers with strategies to support children who have experienced trauma.

SUPPORTING CHILDREN THROUGH TRANSITIONS. DCFS partnered with Project PLAY to develop a practice guideline for child welfare staff on minimizing child care transitions and supporting children through unavoidable transitions. The guidance is designed to help staff promote stability in care and decrease trauma associated with unplanned moves (e.g., loss of teacher and friends). Comparable suggestions for child care providers are available as part of the communication toolkit.


SUPPORTING CHILD CARE STABILITY BY REVISING EDUCATIONAL STABILITY POLICIES. The Fostering Connections to Success and Increasing Adoptions Act (2008) requires states to keep children in the school of origin when they are placed in custody or move to a new foster care placement, unless doing otherwise would be in the child's best interest. While the legislation does not specifically address the needs of children less than 5 years old, the Arkansas child welfare leadership team agreed that stability is important for children of all ages, making explicit that Arkansas educational stability policies extend down to birth to 5 years old.

STAFF TRAINING ON CHILD CARE QUALITY AND STABILITY. Arkansas DCFS leadership realized that their current training processes for both staff and foster parents did not adequately address quality and stability in child care, including why quality and stability are important, how to identify a high-quality setting, and what each team member can do to promote stability. We developed training materials and have begun trainings for DCFS staff and foster parents.

OBSERVING IN CENTERS THAT SERVE FOSTER CHILDREN. After learning more about the variance in quality among child care centers that accept vouchers for foster children, the Arkansas DCFS leadership required their county supervisors to visit each child care program in their county that serves foster children. During these visits they focused their observations on the nature of the interactions between teachers and children so that they can identify centers most ready to nurture young children in foster care.

Lessons learned in Arkansas and Arizona suggest that both the child welfare and ECE systems must work together to improve child care experiences for foster children. Unfortunately, high-quality child care is not always prioritized when children are removed from their homes by child protective services (see box Child Care as a Part of the Child Welfare Case Plan). The negative impact of sudden and frequent changes

in caregivers is too often ignored. On the child care side, there is wide variation in the level of training among teaching staff in licensed child care centers. Even teachers with higher levels of training and education are too often missing information that would allow them to better meet the needs of foster children and other children that have experienced trauma. Naturally, many child care training programs emphasize normative developmental experience, and information about the sequelae of maltreatment and trauma in young children is often missing. The consequence is that child care teachers and other providers are not prepared to best understand and respond to children who have been maltreated.

The good news is that our shared experience suggests a number of ways that ECMHC can help bridge the gap between the child welfare and child care systems. Early childhood mental health consultants can provide information that can encourage the child welfare system to prioritize child care quality and stability. The Arkansas Safe Babies Court Team provides an example of how all parties can work together in the case planning process to ensure high-quality and stable child care during the foster care placement and after reunification. Consultants can also work to raise the quality of care in centers where foster children are already placed and work with individual teachers and children to address the specific needs of children that are struggling. Working together, we can achieve our vision of a nurturing child care environment that is a consistent daily comfort for a child whose home life has been disrupted. 

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CHILD CARE AS A PART OF THE CHILD WELFARE CASE PLAN

The Arkansas Safe Babies Court Team project is a pilot project in the 10th Division Circuit Court in Pulaski County, Arkansas. It is designed to improve outcomes for maltreated infants and toddlers and to reduce the recurrence of substantiated reports of abuse or neglect of infants and toddlers in the courts' jurisdiction. In partnership with Project PLAY, the staff of the Court Team has changed the way they approach discussions about child care. Decisions about child care are made thoughtfully as part of the case planning process, with considerations about what is in the best interest of each individual child, and with a goal that the first child care placement should be the last. Two key questions guide the discussions: Can the child stay at home with a foster parent, and if so, does this meet their cognitive and social development needs? How can we enhance the child care experience for children who need to be in child care? When child care is needed, Court Team staff engages both the foster and biological parents in identifying a quality care setting (providing education about how to identify quality) that is acceptable to both in hopes that the child will remain there regardless of the success of reunification efforts. Once a child care program has been selected, the Court Team uses the Child Care–Child Welfare Partnership Toolkit (see Learn More) to ensure that child care program team members become an important part of the case planning team.

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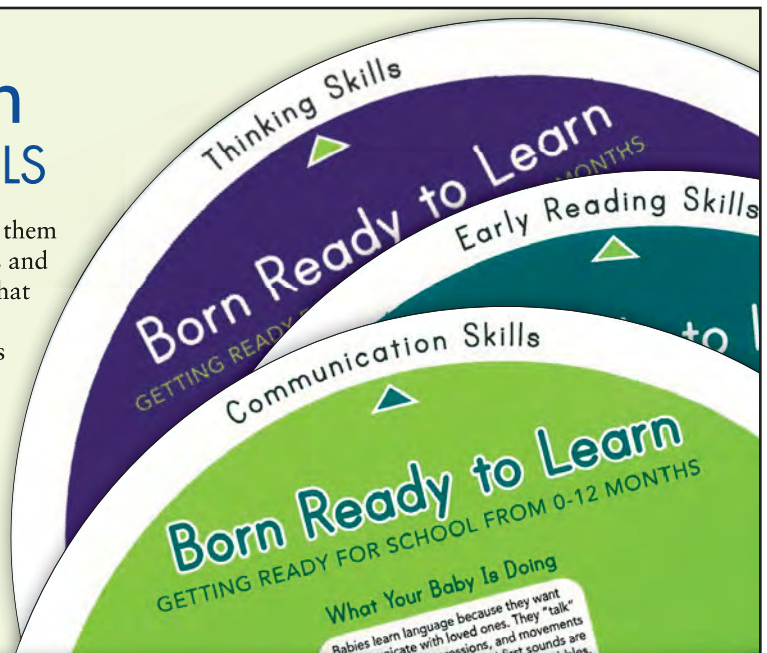
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A Quality Start in Louisiana

Early Childhood Mental Health Consultation as a Primary Support in a Statewide Quality Rating and Improvement System

ALLISON B. BOOTHE

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Young children develop in the context of their relationships with their primary caregivers. When these attachment relationships are strong and secure, the caregiver will be the most important factor in a child's ability to successfully navigate the demands of development, achieve positive outcomes, and recover from traumatic experiences (Zeanah & Zeanah, 2001). Children who do not have strong, secure, and ongoing attachment relationships are at risk for a variety of negative outcomes, including social and emotional difficulties, behavioral problems, and even learning delays (Dicker & Gordon, 2004; Melmed, 2011). The early childhood mental health consultation (ECMHC) model developed by the Tulane Institute of Infant and Early Childhood Mental Health (the Institute) is founded on the principle of supporting the establishment of healthy relationships between young children and their caregivers and teachers as well as parents.

In Louisiana, during the years 2003 and 2004, the Institute worked to educate state government leaders about the critical needs of young children less than 5 years old, especially those in foster care, who spent a significant amount of time in child care settings. The goal was to have state leaders recognize that young foster children had great vulnerability because of the abuse and or neglect that they had experienced and were in need of higher quality child care (Connors-Burrow, Patrick, Steier, & Lloyd, this issue, p. 38).

However, many of Louisiana's children, including many children in foster care, were not in high-quality child care settings. With

no quality rating system in the state, the only way to convey to government leaders the type of child care that children were experiencing was to observe the children in their child care settings. The Institute arranged a series of site visits for small groups of state leaders to observe foster children in their daily child care experiences. After each site visit, Institute faculty met with the state leaders to debrief them about what they had seen. These site visits proved invaluable as the lack of quality child care these children were experiencing was easily conveyed upon simple observation. The feedback the state leaders gave after the site visits included

statements such as, "There was so much noise and chaos that I can't stop shaking," or "The children had nothing to do but watch television." Because of these visits, state leaders were becoming open to the idea that the quality of child care mattered.

A parallel effort by the Institute in 2004 and 2005 was to advocate for a statewide quality

Abstract

Recognizing the economic impact of the child care industry and based on the needs of at-risk young children, Louisiana policymakers and stakeholders reorganized the child care industry after Hurricanes Katrina and Rita and developed a quality rating system using early childhood mental health consultation (ECMHC) as a primary support. Child care programs have embraced the ECMHC model, reporting positive subjective changes, and objective changes on the Classroom Assessment Scoring System have been observed. The ECMHC model developers are working to adapt to the ongoing changes in early education in Louisiana so that all young children are ready for school.

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Young children develop in the context of their relationships with their primary caregivers.

rating system for child care centers. Child care rating systems were new at the time, and only a handful of states had fully implemented them. North Carolina, building from its Smart Start efforts, had a rating system in place that became the model that the Institute pursued. The Institute presented the concept of the rating system at various community meetings of child advocates and child care providers. The concept was met with lukewarm reaction from the child care community. The advocates questioned the funding that would be available to pay for the quality demanded by such a system, and the provider community voiced a deep distrust of state regulations and intentions.

Economic Impact of the Child Care Industry in Louisiana

IN FEBRUARY 2005, the Institute and the Louisiana State University Division for Economic Development and Forecasting completed a report that documented the economic impact of the child care industry in Louisiana. The study computed the short-run economic impact of the child care sector by applying standard input-output analysis to federal funds for child care injected into the Louisiana economy. Using methodology developed at Cornell University (Liu, Ribeiro, & Warner, 2004), the report documented conservative estimates of the size of the Louisiana child care sector as 12,701 businesses employing 22,644 workers, serving more than 149,000 children and 136,000 working parents and generating approximately \$658 million in gross receipts. In addition, for every dollar that was spent in the Louisi-

ana child care sector, \$1.72 was returned into the economy. Similarly, for each new child care job that was created, 1.27 jobs were created in the larger economy. At the time, the state contributed \$40 million dollars into child care (including prekindergarten), which helped leverage \$251.7 million federal dollars into the child care system. In turn, this \$251.7 million had a total impact of \$433 million to the Louisiana economy. One of the concluding recommendations of the economic impact study was that quality ratings could guide consumer demand when choosing programs and thereby pressure the child care market to improve quality. The Louisiana Advisory Council on the Child Care and Development Block Grant joined in echoing this recommendation and used the findings of the economic impact study to call for additional supports for the child care sector (Advisory Council on Child Care & Development Block Grant, 2005).

Hurricanes: The Ultimate “Game-Changers”

IN AUGUST 2005, Louisiana was struck by Hurricane Katrina and, 1 month later, by Hurricane Rita. These two storms completely disrupted the status quo. By January 2006, attention had shifted to rebuilding, and the Institute’s prehurricane focus on quality child care and a child care rating system had assisted in paving the way for a new course of action. With this new focus came a unique willingness and receptiveness, inside and outside of state government, to start the process of designing and implementing a quality rating system. In effect, active planning for the

rating system became part of the rebuilding effort, as there was an opportunity to infuse greater quality in the child care sector as it was re-established across much of the state.

In February 2006, the Louisiana Department of Social Services (now the Department of Child and Family Services) convened a statewide meeting with early education providers (e.g., prekindergarten, Head Start/Early Head Start, child care) and experts from three states that had implemented quality rating systems. The goal of the meeting, attended by approximately 200 people, was to decide whether to move forward with the development of a rating system. The meeting was positive and productive, and—on the basis of the presentations from Tennessee, Pennsylvania, and North Carolina—Louisiana made the decision to move forward. What had begun in 2003 as an effort to improve the quality of child care for children in the foster care system had, in combination with many other factors, led to the formal planning of a quality rating system to support high-quality child care for all children.

Quality Rating System Planning

LED BY THE state child care administrator in the Louisiana Department of Social Services, a Quality Rating System Steering Committee was convened with 39 members. Over the next several months, the committee developed the Louisiana rating system, subsequently named Quality Start. All of the details of the system are beyond the scope of this article, but a general ethos was embraced early on that the system should be focused on the social and emotional needs of children. The rationale for this approach was the belief that the literacy and numeracy needs of young children are already widely accepted and often emphasized; conversely, the social and emotional needs of children are seldom recognized as critical components of child development in these formal systems. This focus on social and emotional development was embraced and influenced how ratings would be earned and what supports that the state would provide to child care centers.

The Louisiana Quality Start assessment rates child care centers on a scale ranging from one to five stars.

- One star – The one-star rating indicates that the center has a license in good standing and no outstanding deficiencies.
- Two stars – The two-star rating indicates that the center staff has received more specialized training and the center has completed a self-assessment plan.
- Three to five stars – The three- to five-star rating indicates that the center

provides quality child care based on staff qualifications and the Environment Rating Scales (ERS; Harms, Clifford, & Cryer, 2005).)

Louisiana's Quality Start system uses the ERS (Harms et al., 2005) as the observational assessment tool. After the observations, centers receive their scores, which consist of an overall score and six subscale scores. In addition, Louisiana implemented a unique social-emotional (SE) subscale after we consulted with the ERS authors. The SE subscale is defined as a composite of the following subscales: Listening and Talking, Interaction and Program Structure on the Infant/Toddler Environment Rating Scale—Revised (Harms, Cryer, & Clifford, 2006); Language and Reasoning, and Interaction and Program Structure on the Early Childhood Environment Rating Scale—Revised (Harms et al., 2005).

The SE subscale score was given more weight in the determination of star level than the overall ERS score; therefore, providers needed to focus on social-emotional aspects of caring for young children. The SE subscale score became the most critical component of earning points for stars for the majority of centers that achieved three to five stars on Louisiana's five-star scale.

With all of the changes to the child care sector that the new Quality Start system presented, it was expected that there would be confusion, concern, and resistance to the system. The state put in place several technical assistance (TA) mechanisms to assist with many of these issues, but no support has been larger or more sustained than the implementation of a statewide ECMHC program.

The Institute's ECMHC Model

TO SUPPORT CENTERS in increasing the quality of care they provide, with a focus on the social-emotional health of young children, all centers participating in Quality Start are able to access ECMHC services. These services are provided by the state through a contract with the Tulane University Institute of Infant and Early Childhood Mental Health, which subcontracts with six regional nonprofit agencies throughout the state. Quality Start mental health consultation services provided through the Institute are designed to assist all children in center-based care, not only those who are exhibiting behavior problems. The goal is to achieve healthy behavioral, social, and emotional development. This consultation program has three main objectives: (a) to promote the social and emotional health of young children; (b) to support caregivers' promotion of healthy child development within the class-



PUBLIC DOMAIN PHOTO FROM NOAA

In August 2005, Louisiana was struck by Hurricane Katrina.

room setting; and (c) to refer young children exhibiting behavioral problems for treatment or design interventions.

The model merges two types of consultation: child-centered and program-centered (Johnston & Brinamen, 2006). Child-centered consultation focuses on the needs of a specific child: how to intervene to better support that child's development (e.g., classroom behavior management strategies, referral to an external specialist such as speech or mental health; parent support) and how to diminish the negative effect of that child's behavior within the classroom. Programmatic consultation focuses on the child care program as a whole and how factors specific to that child care program affect the social-emotional development of the children enrolled there.

The mental health consultants are on site working with center staff for 1 day every other week or per week (depending on center size) for 6 months. Child care programs with eight or more classrooms are eligible to receive weekly visits. (For more information about the Institute's ECMHC model, please see Heller et al., 2011.)

The model has as its primary underpinning a "curiosity and respect for differences" (Johnston & Brinamen, 2006, p. 7). As consultation work is focused on understanding another's subjective experience, it is necessary to take into account how culture, race, and other individual factors may affect perception. Consultants must consider how culture, race, ethnicity, or other factors influence the approach of both child care center staff and parents with reference to child rearing,

parenting, communication styles, and developmental expectations (Johnston & Brinamen, 2006).

On the basis of input from other ECMHC programs around the country (e.g., Day Care Consultants, a program of the Infant-Parent Program of the University of California, San Francisco), the Institute designed a model tailored to the particular needs of Louisiana. As ECMHC was to be a primary support for early education providers participating in Quality Start, it was important to establish a model that allowed consultants to work with a program long enough to form relationships and support change while also permitting them to work with multiple programs over the course of a contract period (e.g., 18 months). Building relationships with center staff and supporting relationship building between staff, children, and the children's families is a foundation of the Institute's ECMHC model. Moreover, relationships between consultants and center staff have been shown to be a key factor in a successful ECMHC experience (Green, Everhart, Gordon, & Gettman, 2006). A visit schedule of every other week was established, with visits occurring over a 6-month period for a total of 12 visits. We theorized that such a schedule would allow participants time to process, develop, and practice skills between consultation visits while the 6-month time period would allow time for successful relationship development between consultants and staff.

During the first 6 months of piloting the ECMHC model, we learned that, to support change in this relatively short period of time,



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A general ethos was embraced early on that the quality rating system should be focused on the social and emotional needs of children.

the consultant needed a method of training through which she could offer and receive information in a somewhat formal way with several staff members. As several of the TA providers across the state had received training on the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) pyramid model for supporting social and emotional competence in infants and young children, we decided to build upon the CSEFEL language and ideas to which many child care staff may be exposed through TA providers. CSEFEL language and the basics of the pyramid model were incorporated and became the foundation for the ECMHC trainings (Heller et al., 2011).

Consultants use a combination of group process and didactic training techniques when providing these trainings. The sessions serve multiple purposes. Staff members are allowed to discuss their own feelings, concerns, challenges, and triumphs from their classes and can assist each other in solving challenges along with the consultant's support and guidance. The consultant is able to point out positive interactions that had occurred in the center and can support and promote the social-emotional development of young children through the interactions with staff. The trainings are flexible and can be tailored to the unique needs of each teacher, classroom, and center. All ECMHC trainings count toward the continuing education clock hours for child care staff that are required by child care licensing. This assisted consultants in recruiting centers and encouraged participation among staff members.

Beyond the more formal trainings, the bulk of the Institute ECMHC model is built on time spent in classrooms with the teachers and time spent meeting with the director. Activity forms completed daily by each consultant reveal that approximately 67% of a consultant's visit time is spent observing (e.g., watching teacher-child interaction or children's behavior) and modeling in the classroom (e.g., demonstrating developmentally appropriate interactions with children). Approximately 20% of the consultant's time is used to meet with or train teachers individually or within groups, and the final 13% is typically spent meeting with the center director, owner, or both (Boothe & Heller, 2012). The consultants were given the opportunity to provide anonymous feedback about how they made activity decisions. Answers reflected a series of choices. Consultants reported that, first, they typically met with the director to incorporate her thoughts for how the consultant should spend the day. Second, when the consultant entered a classroom, the consultant asked for the teacher's input; and finally, but possibly most important, the consultant worked to address the needs of the children (Boothe & Heller, 2012).

We have received positive feedback from both teachers and administrative staff about the combination of time spent in classrooms observing, modeling, and relationship building and the time spent in didactic trainings. The proverbial "carrot" of free continuing education hours for staff proved to be a selling point for the program while also giving the consultant and staff members time to work together as a group, which may

not have occurred if the training time had not been included.

Statewide Launch of Quality Start and ECMHC

ALL CENTERS ACROSS Louisiana were invited to participate in a Louisiana Department of Child and Family Services, Division of Childcare, training program titled "Foundations, Up," which aimed to provide a base from which programs could enter Quality Start when it began. "Foundations, Up" provided trainings on the ERS (Harms et al., 2005), training specific to Quality Start, and the ECMHC director provided social-emotional development training. This central position in the statewide in-person and televised trainings alerted child care providers that ECMHC was going to be a significant resource.

After approximately 6 months of piloting ECMHC, the Institute moved into a longer term contract with the state to design a method for serving new Quality Start centers once that program was up and running. We spent the next 6 months continuing to hone the ECMHC model further, securing regional subcontracting agencies through which consultants would be hired, and hiring consultants in cooperation with the subcontracting agencies. Appropriately assessing regional need was one of the most difficult aspects for the first 2 years of the program. We calculated the number of consultants to be hired by determining how many consultants were needed to serve 20% of centers in each region over an 18-month contract period. However, as Quality Start began, we also took into account regional participation in the rating system and openness to consultation. With these factors as part of the equation, we settled on a feasible number of full-time equivalent positions per region that allows for the consultants to maintain a small waiting list and consistently serve centers. There has continued to be a small ebb and flow of these numbers over the 5½ years of the program.

Program Challenges

A key challenge during the statewide launch of Quality Start and ECMHC was the difficulty that MHCs had in recruiting centers. Despite the offer of no-cost services, the consultants had to work at finding centers to serve. Several methods of recruitment were used including e-mail blasts from the State Department of Child and Family Services, telephone calls and visits from consultants to child care centers, flyers advertising services handed out at Quality Start trainings, and consultants networking with directors at regional meetings. Supporting quality child care for vulnerable children is a foundation

for our model; therefore, recruitment efforts focused on those centers identified as serving children in foster care. We found that word of successful consultations spread throughout each region, creating a positive climate for recruiting new centers. In addition, as a center completed its consultation cycle, the director was typically interested in receiving consultation again. However, in an effort to reach more centers, repeat centers were given lower priority. Since the beginning of our ECMHC program, consultants have consistently focused on recruiting centers serving children who are in foster care or whose families are receiving child care assistance payment so that those children more vulnerable to risk factors could receive quality care.

From the beginning, a challenge has been securing accessible and appropriate referral sources for young children and their caregivers. In choosing our partner subcontracting agencies, we looked for regional nonprofits that provided therapy services or other community services that support the mental health of young children and families. When administering a program across a wide geographical area, however, there can be gaps in services available. In more rural areas of the state, the consultants struggle to secure appropriate referral sources. In this time of severe cuts in funding, our referral sources continue to dwindle. Now the consultant is often the only mental health professional that children, families, or teachers see as they join long waiting lists to access the limited treatment options available. Directors and teachers have provided consistently positive feedback as to how their consultant was able to support children and families. One director stated that her consultant was most helpful to children and families “by offering our families resources for specific developmental needs, meeting with our parents, and helping these families with answers beyond anything a pediatrician could provide. The families were very open to [the consultant] and her suggestions.”

Program Strengths

Key strengths of the program are the background and training of our consultants and the ongoing reflective supervision they receive. Each is a licensed mental health professional (e.g., licensed clinical social worker, licensed professional counselor) who received intensive training in infant and early childhood mental health during the first year as a consultant. With a graduate degree in a mental health field and experience working with children and families as a mental health professional, the consultants are prepared with a level of clinical acuity that is necessary to provide mental health consultation



PHOTO: MARILYN NOLT

Quality Start mental health consultation services provided through the Institute are designed to assist all children in center-based care, not only those who are exhibiting behavior problems.

services to child care centers. In addition, each consultant receives individual reflective supervision by telephone twice a month and participates in a reflective supervision group through a conference telephone call once a month. Consultants have reported that reflective supervision assists them in maintaining connections to other consultants, as they are primarily working alone in the field. Reflective supervision also gives them opportunities to gain perspective and insight into their centers, which supports their work.

The reflective supervision for our program is provided by four licensed, doctoral-level senior clinicians. Each has extensive experience in infant and early childhood mental health, including clinical and research experience in working with young children and their caregivers. This leadership team also provides preservice and ongoing in-service training for the consultants. Another strength of the program is the subcontracting model. The ECMHC program is able to have a presence in every parish across the state through six regional nonprofit agencies across the state that employ the consultants. The consultants are local to their communities and understand their communities' unique needs. By working through regional agencies, the staff members of those agencies learn about the ECMHC program and its benefits for children, families, and child care staff in its community. In this way, the ECMHC model has gained champions throughout the state and has localized the provision of

services. Consultants are able to capitalize on the unique strengths of their agencies to support early education providers. Child care community members are often more comfortable as they embark upon ECMHC when the provider is employed through a trusted community agency.

The decentralized model of ECMHC employment is balanced with the centralized nature of the ECMHC program administration. As discussed earlier, all supervision and training is provided by the four-member Institute leadership team. Centralized program administration and supervision allows for quality control and program adherence. Moreover, as consultants are typically working in the field, group supervision and in-service training that occur across regions and subcontracting agencies support consultants to operate as a part of the statewide team.

ECMHC Program Evaluation

EVALUATION OF THE Tulane model of ECMHC for the Quality Start program has demonstrated an increase in teacher-reported self-efficacy, or the teacher's belief that he can make a difference in a child's life. This increase was maintained after 6 months (Heller et al., 2011). In addition, there was a significant increase in the teacher's report of his sense of influence (i.e., the teacher's sense that what he does will influence a student in comparison with other factors in the child's life). The

teacher's report of his sense of influence also continued to increase after 6 months (Heller et al., 2011).

More important, observational assessments of teachers who participated in the Quality Start ECMHC program demonstrated significant changes in all seven areas measured on the Classroom Assessment Scoring System: Pre-K (Pianta, La Paro, & Hamre, 2008). These areas were examined across two domains. The Emotional Support (relationship) domain included increases in positive climate, teacher sensitivity, regard for emotional perspective, and a decrease in negative climate. In the Classroom Organization domain, increased scores were observed in behavior management, productivity (i.e., productive use of classroom time), and instructional learning formats. The Instructional Support domain was not assessed in this evaluation, as we did not expect this ECMHC model to affect this more academic domain of the CLASS. The intervention was equally successful across racial groups (e.g., Caucasian and African American participants), socioeconomic groups, and geographic settings (i.e., urban, suburban, and rural settings; Heller et al., 2012).

The success of the model contributes to the evidence base of ECMHC as a primary method of supporting and increasing the quality of child care and supporting healthy relationships between caregivers and young children and their families in early care settings.

Learn More

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**Programmatic
consultation focuses on
the child care program as
a whole and how factors
specific to that child care
program affect the social-
emotional development of
the children enrolled there.**

Where We Are Now

WE ARE CURRENTLY in our 6th year of providing ECMHC services as part of Louisiana's evolving Tiered Quality Rating and Improvement System. Our team size has stabilized, with each consultant serving, on average, 16 centers per year for formal 6-month consultation periods and 11 centers that had previously received ECMHC services for follow-up visits. Most of the consultants maintain an ongoing waiting list with a combination of centers that have not yet received consultation and centers that have requested another round of consultation.

As the Child Care Resource and Referral agencies, which provide TA to child care centers, and the consultants are all working in support of Quality Start, in several regions consultants have informal partnerships with the technical assistants at the Referral agencies. The technical assistants in these regions have become champions of the ECMHC program and often suggest to centers that they request consultation. Likewise, the consultants often suggest that centers reach out to the regional technical assistant for support on those specific child care questions that are outside of the ECMHC domain.

Although it can be somewhat confusing for a child care center at first to have different individuals providing support, when a consultant and a technical assistant can meet with a director together to help work through a difficult aspect of the Tiered Quality Rating and Improvement System, the center and the system are strengthened. For example, in one area, the regional consultant and technical assistants are employed by the same agency and work in the same office. The consultant is often invited to participate in ERS feedback sessions that the technical assistant provides if the consultant has a relationship with the director. The consultant can use her clinical support skills to help ensure that the technical assistant is sensitive but clear in providing the feedback from the ERS assessment. Moreover, the consultant

can support the director in the emotionally charged process of reviewing what she has learned about the strengths and challenges of her center.


Looking Ahead

THERE IS NEW attention in Louisiana on early childhood and how it relates to school readiness. This resulted in legislation being passed in 2012 with the intention of improving school readiness through the creation of a common governance structure across early education programs. The belief on which this is based is that this new structure would use existing state and federal funds for early education programs more efficiently, as there is already enough money in the early education system. On the basis of this approach, Louisiana did not pursue the Race to the Top–Early Learning Challenge grant.

The legislation that passed put the overall responsibility of early education programs under the state board of elementary and secondary education and also requires a letter-grading system for early education providers that receive public funding. The present plan is to have the letter grades determined by child assessments, thereby creating a new high-stakes test for early education providers for children of all ages before kindergarten. Ultimately, these letter grades would affect the ability of a program to receive public dollars and, possibly, whether a provider would be allowed to operate.

With the pending implementation of a new quality system, letter grades, and this high-stakes test, there is great concern about the significance and weight of the test. The challenge is to ensure that such assessments of very young children are appropriately inclusive of social and emotional development and validly measure these domains. This is much easier said than done, especially in a high-stakes structure. Instead, the threat is that the test will push early education providers to emphasize the cognitive skills, such as knowledge of numbers and letters, thereby neglecting the social and emotional needs of children and the fact that competency in these areas is equally as critical to a child's ability to achieve school readiness. What this all means for the ECMHC program remains to be seen.

Public forums have been held throughout the state to gather input from community stakeholders, and numerous surveys have been collected to assist in guiding the implementation of the new law. Feedback from the child care community continues to support the work and focus of the Institute's ECMHC program. With the time the consultants spend in centers, they have become, in many ways, the "faces" of the Quality Start system.

As part of this program, we are examining ways in which we can continue to support early education providers across the state as the new law and system are implemented. As a seasoned participant in the development of a system of quality early care, the Institute will continue its efforts to highlight the importance of social and emotional development as the foundation for school readiness. 

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Toward Common Guidelines for Training, Comportment, and Competence in Early Childhood Mental Health Consultation

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The field of infant and early childhood mental health is inherently eclectic. Practitioners from diverse disciplines engage in a range of services aimed at points along a broad continuum of promotion, prevention, and intervention. The field is united by a shared focus on the social and emotional development and well-being of infants and young children within the context of their culture, community, and relationships. As these defining relational experiences have expanded to include others in addition to parents, so too has the purview of the field and the scope of services provided. Early childhood mental health consultation (ECMHC) is one of these burgeoning efforts. Currently ECMHC is provided primarily in early childhood education settings, however, other venues where young children are cared for or reside are increasingly the recipients of mental health consultation services (e.g., homeless and domestic violence shelters, pediatric offices, residential substance abuse treatment, and child welfare programs).

As the call for ECMHC increases and evidence supporting its efficacy accrues, more practitioners are needed to fill the role. There is currently no nationally recognized set of skills, knowledge base, or professional standards that identifies ECMHC. In the absence of a coordinated system of oversight, specific educational or experientially derived competencies are not required for practitioners who provide ECMHC. Differentiating this specialization

from the expertise of those who provide other types of consultation or coaching is sometimes difficult. There is a clear need to identify the parameters of the position and the preparatory training and experience essential to effective ECMHC for those who wish to or who are providing the service, their instructors, and their supervisors. Equally so, those requesting the service, funders paying for it, and families involved in the endeavor deserve a definition and assurance about

the capabilities and background of those providing ECMHC.

The specialty of ECMHC has its roots in three areas: consultation, mental health, and infant mental health (IMH). Thus, in developing a set of competencies

Abstract

Several states have developed or adopted a compendium of competencies that chart training trajectories, articulate sets of skills, and determine experiential thresholds for practitioners in the broad-based interdisciplinary field of infant and early childhood mental health. As a burgeoning service delivery approach on the continuum of infant and early childhood mental health services, consultation calls for specific capacities and knowledge domains. This article reviews emerging national efforts to define mental health consultation competencies and suggests additional possibilities as to the perspective and abilities a mental health consultant must possess.

for ECMHC, it is useful to examine the knowledge base, skills, and experiential components required to function competently in these three areas.

Building on an Existing Foundation

FROM ITS INCEPTION the term *consultation* has referred to meeting with an expert, such as a medical doctor, in order to seek advice. The aim of the effort was “assisting others with a work difficulty” (Caplan, 1964, p. 232). The consultee’s participation in the process is intended to be voluntary. The consultant is seen to hold an expertise that is distinct from but equally valuable to the consultee’s. Collaboration is considered the hallmark of the service.

Early conceptualizations of mental health consultation were premised on a deficit perspective. The first step in the process was to identify what was lacking, and within whom the deficiency resided—the client or the consultee. Caplan (1964) suggested that consultation should focus first on the patient’s problem but shift to examine and assess the consultee’s skills, knowledge, and professional objectivity when an inadequacy in any of these areas is identified by the consultant.

More recently, consultation that is based on principles of IMH views development as transactional. Therefore dilemmas are conceptualized as developing in the intersubjective space between individuals rather than residing in a static state within someone. Even when the difficulty emanates from one person, it is invariably expressed in the interaction. Alleviating or ameliorating difficulties is also seen as relational. Solutions emerge as transactional tangles are understood and unwound. Applying the principles of IMH, Johnston and Brinamen (2006) offered 10 elements, coined the Consultative Stance, to guide the consultation process (see box 10 Elements of an Effective Early Childhood Mental Health Consultative Stance). In addition to the 10 characteristics of the stance, the authors also stress that consultants must be aware that they lack authority in the system to which they offer services and that the position they hold has meaning in that system. Typically that position is one outside of—and therefore not bound to—the hierarchy of the institution in which consultation is provided. The mental health consultant who acts in alignment with the 10 elements stands not only to effect behavioral change, but to transform how early care and education providers think and feel about the young children in their charge and about themselves as professionals.

10 ELEMENTS OF AN EFFECTIVE EARLY CHILDHOOD MENTAL HEALTH CONSULTATIVE STANCE

An infant mental health approach asserts that effective consultation is premised on the power of the consultative relationship and resides in the consultant’s comportment.

Ten elements comprise the essential core of an effective consultative stance:

1. **Mutuality of endeavor.** Early childhood mental health consultation can be effective only when the consultee contributes to and participates in the process.
2. **Avoiding the position of sole expert.** In accepting that the work is a collaborative effort between consultant, providers, and parents, the expertise of others is valued as equal to the consultant’s own.
3. **Wondering instead of knowing.** “Wondering with, not acting upon” (J. Pawl, personal communication, 1997) the caregivers with whom the consultant is working elicits their involvement in the process and properly preserves the sense of the consultee as the holder of essential information and knowledge and as the agent of change.
4. **Understanding another’s subjective experience.** The consultant introduces the importance of “not knowing” by demonstrating curiosity about the internal experience of the other.
5. **Considering all levels of influence.** In addition to the personal histories of child care providers, there are numerous other influences on their views of a child and on their ability to respond effectively.
6. **“Hearing and representing all voices¹”—especially the child’s.** Eliciting the voices of all child care community members, the consultant is dedicated to hearing about and from each individual.
7. **The centrality of relationships.** Because development is transactional and mental health is promoted through interactions between child and caregivers, the centrality of relationships underlies all beliefs about ECMHC.
8. **Parallel process as an organizing principle.** The consultant’s way of being emanates from her conviction that the ways in which people are treated affect how they will feel about themselves and treat other people.
9. **Patience.** Just as consultants encourage and attempt to foster patience in caregivers’ relationships with children, consultants must also be patient with the caregivers and parents.
10. **Holding hope.** Child care providers often lose hope in the face of daily crises and persistent challenges. The consultant must maintain a belief in change in a slowly shifting system.

¹ Pawl, J. H., & St. John, M. (1998). *How you are is as important as what you do... in making a positive difference for infants, toddlers, and their families*. Washington DC: ZERO TO THREE/National Center for Infants, Toddlers, and Families.

From *Mental Health Consultation in Child Care: Transforming Relationships Among Directors, Staff, and Families* (pp. 14–20), by K. Johnston & C. Brinamen, 2006, Washington, DC: ZERO TO THREE. Copyright © 2006 by ZERO TO THREE. Adapted with permission.

IMH Competency Development

OVER THE LAST decade, professionals interested in identifying guiding principles for IMH training have convened workgroups across the U.S. to define characteristics that correlate to competence in the broad-based interdisciplinary field of IMH. IMH professionals in California, Connecticut, Florida, Indiana, Michigan, and Vermont have created matrices for how practitioners can attain the needed capacities. Several states have adopted one of these sets of guidelines that define the knowledge, skills, and experience that IMH providers

should possess. These guidelines outline criteria and processes for endorsement or certification in IMH practice.

The established guidelines contain much similarity regarding what constitutes competence. Acknowledging the contribution of practitioners from diverse fields, the states’ compendiums of standards all identify core concepts of infant and early childhood mental health and development with which everyone who interacts with children birth to 5 years old should be equipped. The standards all state that practitioners should be well versed in early development; understand



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Currently early childhood mental health consultation is provided primarily in early childhood education settings, however, other venues where young children are cared for or reside are increasingly the recipients of mental health consultation services.

factors that contribute to risk and to resiliency; and be able to skillfully observe, assess, and intervene within the bounds of the practitioner's own discipline.

The guidelines that offer criteria for endorsement in IMH practice distinguish between levels of competency regardless of discipline. The guidelines describe how a practitioner might achieve competence at each benchmark. They recognize that early childhood mental health services should extend across a continuum of promotion, preventive intervention, and treatment. In addition they identify and honor each discipline's specific scope of practice for its unique contribution.

Within the IMH field there is divergence about which disciplines have dominion over various areas of knowledge and the type of services provided. For example, which discipline's scope includes training child care providers to recognize developmental challenges? The field is also undecided about who should oversee and confer status on IMH providers (Korfmacher & Hilado, 2008). Despite differences in the strategies, the states' sets of guidelines for IMH professionals provide a solid foundation upon which to construct competencies specific to ECMHC.

ECMHC's Growing Evidence Base

AT THE SAME time that interdisciplinary groups of infant-family and early childhood practitioners were creating frameworks to confer competence in the broad-based field of IMH, researchers have been collecting proof of ECMHC's effectiveness. Several studies have now

demonstrated that ECMHC is associated with positive outcomes for young children with problematic behavior. Perry and colleagues (Perry, Allen, Brennan, & Bradley, 2010; Perry, Dunne, McFadden, & Campbell, 2008) found ECMHC to be effective in reducing teacher-reported externalizing behaviors (inattention, hyperactivity, aggression, and anger), and in fostering pro-social skills. Access to ECMHC equates to lower expulsion rates from early care programs (Gilliam & Shahar, 2006). In a review article examining staff and program level outcomes, Brennan, Bradley, Allen, and Perry (2008) found support for ECMHC building the capacity of early care and education providers' confidence and competence in coping with challenging behaviors, as well as improved self-efficacy and decreased adult stress and staff turnover.

These encouraging staff and child outcomes are often correlated to characteristics of the consultant and the quality of the relationship she creates with consultees. Focusing on the characteristics of mental health consultation that correlate with effectiveness, Green, Everhart, Gordon, and Gettman (2006) found that the quality of the mental health consultant-staff relationship was the single most salient predictor of perceived efficacy of consultation services. Subsequent studies (Duran et al., 2009; Roeser, 2009; Virmani, 2009; Virmani & Ontai, 2010) have confirmed a link between consultant characteristics, supervision received, and the strength of the consultant-provider relationship with a range of positive program, caregiver, and child outcomes.

The empirical findings echo the sentiments of professionals who believe changes in a child or program that are attributed to ECMHC are primarily caused by the relationship between the consultant and consultee. From these practitioners' perspective, the elements of the stance or disposition are seen as central to imbuing knowledge and creating change in the consultee. The ability to engage all parties in collaborative consideration of a child or family's needs underpins all other efforts. Additional skills include the capacity for self-awareness, the ability to cultivate reflection in the consultee, parameters of the role, and the absence of authority in the system in which the consultant offers services. An aptitude for conveying confidence and competence without acting like the sole expert appears to be associated with positive outcomes. Premised on the psychological concept of parallel process, Johnston and Brinamen (2006) suggested that the consultant's demeanor is the most powerful instrument of change. Parallel process proposes that the characteristics of non-judgment, mutuality, and respect as demonstrated to the consultee encourage a similarly positive stance in that person toward others, specifically children in the case of ECMHC.

The ECMHC literature repeatedly refers to the importance of being relationship-based. Consultants need to be aware of past as well as present relational contributors to a consultee's functioning and view of a child. Another characteristic frequently cited as essential to the consultant's work is knowledge of early development—especially how the child's relationships have an impact on all domains of development. A deep understanding of early development is crucial in consultation. One is called upon to contribute their understanding to consultees who may themselves possess significant knowledge in the area of early development or alternatively have little such knowledge.

Challenges in Developing and Using Guidelines

ATTEMPTS ARE JUST beginning to translate theory into training protocols and to cull the research data for characteristics of effective consultation in order to guide the field and establish common standards for quality (Allen & Green, 2012; Allen, 2008; Duran et al., 2009; Johnston & Brinamen 2012). Academic training in early childhood mental health is still limited. Even fewer opportunities exist for finding coursework specific to the consultation specialization (Cohen & Kaufman, 2005). Intensive practice-based training programs exist, but availability is extremely circumscribed (Johnston & Brinamen, 2005).

A few studies have examined the existing criteria for early childhood mental health consultants and thus serve as a prelude to defining competencies. Conspicuous in this literature is the lack of specificity about disciplines that are qualified to provide mental health consultation. There is also not yet agreement about the qualifications for or knowledge that early childhood mental health consultants should hold. It is astounding that a statewide survey in Florida revealed that neither leaders in the early childhood field nor funders of the effort identified knowledge of early childhood mental health as mandatory for ECMHC (The Florida State University Center for Prevention and Early Intervention Policy, 2007). Struggles also surround the question of academic background. In some states a bachelor's degree is sufficient. If a higher degree is required, the discipline is not always specified. Because ECMHC can span the spectrum of service delivery from promotion to intervention, this lack of a requirement further complicates issues of adequate preparedness. Consultants who are involved in assessing the need for treatment as well as providing promotion and preventive intervention are in some instances mandated to be licensed in a mental health discipline. Seeing consultation as akin to clinical supervision, Michigan has aligned ECMHC with this level of its endorsement system.

Toward Consensus of ECMHC Competencies

THERE IS GROWING momentum around identifying ECMHC as a subspecialization of IMH. It is now understood that the consultative context and parameters of the role require additional and specific instruction (Allen, Brennan, Green, Hepburn, & Kaufmann, 2008). Practitioners are also beginning to identify the distinct and essential contribution of a mental health background (Johnston & Brinamen, 2006).

Several states and many regions are developing guidelines regarding the training, education, skills, and experience needed by an early childhood consultant. The efforts range from one page bullet-pointed lists to detailed descriptions in 100- page documents (Administration for Children and Families, 2011; Cohen & Kaufmann, 2000, 2005; Duran et al., n.d.; Duran et al., 2009; JFK Partners, 2006; Maryland State Department of Education, 2009; Michigan Association for Infant Mental Health, 2010). Despite the variety, all of these documents propose plans that are in keeping with both the broad-based IMH competencies and the characteristics of consultation that have been identified as effective by researchers and practitioners alike. The manuals consistently identify a relational focus applied to a solid knowledge



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Access to early childhood mental health consultation equates to lower expulsion rates from early care programs.

of early development as a hallmark of competence, and they often overtly reference collaboration. Thus familiarity with and the ability to locate and secure referrals is an essential skill connected to collaboration. Two ideas that are not emphasized are that collaboration is an ongoing, integral part of consultation with parents and that providers are the primary collaborative partners.

Most of the training documents identify knowledge of observation, screening, and assessment as important. Rarely do they explicitly articulate necessary adaptations to, or how the knowledge is functionally applied in, consultation. In some instances, they name specific instruments with which consultants should be competent. Despite stressing collaboration in other activities, these documents do not state coordination of assessment efforts as a goal. Implicitly, these reports seem to say that mental health consultants are the people best positioned to organize and integrate information from various sources. Thus according to these documents the mental health consultant contributes discipline-specific assessment and intervention skills and actively advocates a collaborative approach when teaming with other types of consultants or coaches.

There is agreement on the importance of early childhood mental health consultants maintaining sensitivity to and knowledge of unique systems and settings in which consultation is provided. However, the depth of system-based knowledge that is necessary varies between different programs' criteria. Some think a consultant's usefulness is contingent on having experience working in an early childhood setting and in early childhood education (Allen, 2008). Guidelines

created for a particular service sector or geographic location are more likely to view the consultant's awareness of specific regulations, standards, quality initiatives, and rating scales as imperative. Contemporary knowledge is clearly valued over historical understanding of a system's functioning, for example none of the documents assert that a consultant should be acquainted with formative factors of a service setting. Alternatively, the different guidelines reflect an appreciation of historical antecedents to functioning in relation to understanding families and communities and their cultural context. However, the importance of cultural sensitivity is rarely associated with the consultant's consideration of the consultee's experience and perceptions.

Practitioners recognize that ECMHC is an indirect intervention engaged in primarily with adults and thus requires facilitation skills and knowledge of adult learning styles. Despite the fact that all of the competency guides give credence to a relationship-based approach, none extend this view to adult learning. The idea that development continues to occur in a relational context beyond early childhood is not described. Rather, the materials view the consultant in an instructive or problem-solving capacity, and skills in working with adults to those ends are central.

The most comprehensive effort aimed at articulating consultation competencies was produced by the Administration for Children and Families (2011) in collaboration with the office of Child Care and Head Start. *A Guide to Effective Consultation With Settings Serving Infants, Toddlers, and Their Families: Core Knowledge, Competencies, and*



Infant mental health emphasizes the importance of relationships on brain development, attachment, and the regulation of emotions and behavior.

Dispositions describes attributes that pertain to consultants from varied disciplines, rather than solely mental health, working in settings that serve infants, toddlers, and their families.

Competencies as a Reflection of Role, Approach, and Discipline

The *Guide to Effective Consultation* (Administration for Children and Families, 2011) provides useful ways of differentiating between domains of proficiency. In this guide, consultative expertise is associated with a set of dispositions in combination with core knowledge and competencies. The guide also distinguishes between *approach* and *role*. Competence is contingent on role definition. The role that one inhabits as a consultant will to some degree depend on one's discipline. Conversely, an approach to consultation can be adopted regardless of educational background.

Characteristics of the *consultative approach* are applicable to any professional orientation. Skills in the early childhood mental health consultative approach are informed by IMH. They include the use of relationship-based principles; reflective practice; and the ability to adapt to cultural, language, and organizational contexts. The *consultative role* is informed by both general consultation principles and discipline specific parameters. For example, the ability to identify and adhere to the indirect nature of consultation defines the role regardless of the consultant's professional background. However, ethical standards, legal limits, and professional

Attempts are just beginning to translate theory into training protocols and to cull the research data for characteristics of effective consultation in order to guide the field and establish common standards for quality.

boundaries differ depending on the consultant's scope of practice. Thus an early childhood educator providing consultation may have a keen sense about the impact on children of a provider's depression, but she cannot diagnose the difficulty. Although qualified to make that diagnosis, a mental health professional in the same position uses her expertise in keeping with the confines of the consultant role, addressing the influences on as well as effects of the mental health concern, careful not to cross the border into treatment.

An IMH Approach to Consultation

IMH emphasizes the importance of relationships on brain development, attachment, and the regulation of emotions and behavior. Consultation based on an IMH approach extends a transactional perspective of development to nonparental caregivers. Premised on the principle that relational experiences to a great degree determine the trajectory of a child's development in all domains, consultation concentrates on the quality of the child-provider relationship. From this perspective consultants pay attention to and address the myriad relationships affecting the child's development. These may include the web of adult relationships that surround the child, such as inter-staff and parent-staff relationships. If a consultant ascribes to a different perspective, she would give priority to other factors. For example, a consultant using a behavioral approach may prescribe a reinforcement plan. A behaviorally oriented consultant or coach would identify the problem behavior and direct efforts to reduce it. Conversely an occupational therapist consulting from a relational, IMH perspective would embed his ideas about the merits of specific strategies for a child with sensory sensitivities in an interpersonal context.

Reflective capacity is another hallmark of an IMH approach to consultation.

A consultant coming from this vantage point values inquiry as an avenue to awareness of herself and others. Using curiosity rather than giving advice, she seeks to cultivate internal aptitude in the consultee. Here again, discipline does not determine or preclude the possibility of incorporating a stance of wondering. An early childhood education coach can pose questions as readily as a consultant with a doctoral degree in psychology. A facility in integrating inquiry as a mode of intervention comes with practice and from an internalized idea about the benefits of reflective capacity. Therefore, while all practitioners can apply aspects of a relationship-focused, reflective approach, proficiency is possible only when premised on training. To what end the approach is used depends on the consultant's discipline.

Discipline-Specific Consultation Competencies

An IMH approach is incorporated by practitioners from diverse disciplines. The interdisciplinary field inherently obscures the conventional boundaries of discrete disciplines. While acquiring a relational, reflective IMH approach to apply to consultation requires a practitioner to learn new skills and adopt new sensibilities, it is important that the individual adhere to scope of practice parameters appropriate to their particular discipline.

A relational, IMH approach to consultation and associated instructional prerequisites should be clearly distinguished from the necessary academic precursors for practicing mental health consultation. Currently the mental health moniker is not reserved for those consultants whose background is in a mental health discipline—clinical social work, psychology, psychiatry, or counseling. Issues of availability as well as reasoned and reasonable disagreements about who is best suited to provide consultation contribute to an unwillingness to limit the professional pool.

Practitioners from diverse fields can and should be trained in a relationship-focused, reflective, and collaborative approach to the role of consultation or coaching. Clarity as to how these principles intersect with one's scope of practice is necessary. Infusing IMH concepts and processes into one's already established expertise does not diminish or usurp that specialization. Conversely, training in core concepts of IMH does not confer the same responsibilities and parameters of practice as a mental health degree. Accountability and realms of authority vary between mental health professionals from different disciplines. A practitioner's scope of practice informs the consultative role, whether within or outside of the mental health profession.

There is growing momentum around identifying early childhood mental health consultation as a subspecialization of infant mental health.

A mental health professional lends a particular expertise to the endeavor of providing consultation. Training in mental health typically includes coursework in clinical assessment, diagnosis and treatment, as well as psychopathology and many other topics. Because clinical interventions are oriented toward direct intervention and pathology, they must be adapted to consultative functions. Understanding of atypical development needs to be balanced by knowledge of typical development in its entire variations.

Most mental health professionals are trained to consider motivation, conflict, and the “defenses” that human beings use to protect themselves from overwhelming loss of self-esteem and anxiety. Mental health practitioners learn to examine and address the influences of these processes on the behavior of those who seek their help. As early childhood mental health consultants, mental health professionals apply this learning to adults as well as children, and they consider influences not only on the child’s but also the consultee’s behavior. Incorporating such skills in consultation is not to be confused with providing treatment to a consultee.

Next Steps for Creating ECMHC Competencies

CLEARLY DEFINING AND collectively agreeing to the knowledge base, skills, and stance associated with practicing ECMHC would go far toward clarifying currently murky role distinctions. The role of a consultant and a coach can be practiced from a similar approach where interventions are conceived as relational, reflective capacity is valued and cultivated, and inquiry is given standing over instruction. Similarly, the nonhierarchical contribution of expertise, characteristic of the consultation role, could be engaged in by myriad disciplines. All early childhood mental health consultants would benefit from training in collaboration and other consultation-specific skills. In tandem, the skills and perspectives associated with the consultative role as practiced from a relational and reflective approach would likely be useful regardless of educational background. The qualities asso-



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Consultants pay attention to and address the myriad relationships affecting the child’s development.

ciated with each are regularly highlighted in research on the efficacy of ECMHC (Green et al., 2006; Johnston & Brinamen, 2006). Establishing a set of core competencies for practitioners providing quality enhancement efforts in early childhood settings will likely increase the success of those efforts.

The association between the consultant’s professional affiliation and level of education and the effectiveness of the intervention requires further attention. Currently the majority of consultants are mental health professionals (Duran et al., 2009; Green, Everhart, Gettman, Gordon, & Friesen, 2004). Research on the efficacy of the endeavor therefore reflects the work as practiced by consultants from mental health disciplines. Identifying more precisely the discipline-specific attributes that correlate to positive outcomes will inform and direct the conversation about necessary competencies.


There is widely held agreement that consultation is an indirect intervention addressing a broad continuum from mental health promotion to preventive intervention. At times direct treatment is an adjunct to consultation. Practitioners from the mental health disciplines are acknowledged as indispensable to the intervention end of the spectrum of services. When adults have concerns about children, when a child’s behavior is challenging, or when a family has experienced trauma, the expertise of a mental health professional is often necessary. Less well-articulated or agreed upon are the ways in which mental health training contributes positively to promotion and preventive consultative efforts. For example, mental health professionals are typically well-versed in

attending to subjective experience, parallel process, and an ecological systems perspective (Brack, Jones, Smith, White, & Brack, 1993). These professionals also specialize in understanding and addressing internal conflict and defensive structures that can interfere with how adults understand and care for children. Furthermore the ability of mental health professionals to assess and intervene on all levels of influence from the systemic to the cultural, to the interpersonal and intrapsychic is crucial to the practice of ECMHC.

The dearth of mental health professionals who possess other critical competencies such as training in consultation and typical early childhood development is well-documented (Green et al., 2006; National Research Council & Institute of Medicine, 2000; President’s New Freedom Commission on Mental Health, 2003). The shortage is cited as a reason to employ those from other professions as “mental health consultants.” Rather than relinquish the value of the discipline-specific contribution, there should be additional avenues for training more mental health professionals in the practice of ECMHC. While those from any academic background will require additional training, mental health professionals are well-positioned to add information and skills into an established experiential and knowledge base (Johnston & Brinamen, 2006). Alternatively, professionals from other disciplines may be equally or better prepared to provide consultation or coaching in the early childhood arena, but their title ought to reflect their specialization rather than referring to mental health.

It seems most sensible to establish training guidelines and competencies for ECMHC on IMH's already developed foundations of proficiencies. Where the oversight and credentialing of these skills might reside in order to provide maximal guidance for consultative practice is a question deserving serious discussion. For example, in states or communities that have adopted an infant and early childhood mental health endorsement, credentialing, or certification system, might consultation competencies be integrated into required preparatory efforts? In addition or alternatively, might the range of mental health and early childhood disciplines include the specific consultation aptitudes in their practice guidelines and scope of oversight, thus driving training and continued professional development? In any case, questions remain regarding how best to include ECMHC competencies into the expectations for the practice of those engaged in this professional activity.

Providing effective ECMHC calls for various and numerous distinct capabilities. Picking principles and practices from IMH, consultation, and mental health, a compilation of the needed knowledge base, skills, and experiences is beginning to coalesce. National will, research, and a concerted collective effort and support for intensive practice-based training programs are needed

to confer a mantle of legitimacy on the subspecialization of ECMHC and to ensure its competent practice within the field of IMH. 

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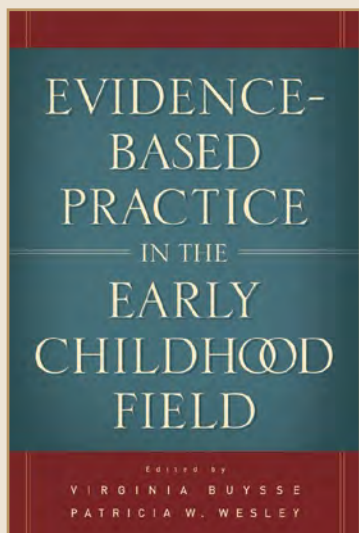
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The Way Forward

Paying for and Sustaining Early Childhood Mental Health Consultation in States and Communities

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Research on brain development in the last two decades has led to a consensus among researchers and child development professionals that early experiences greatly impact children's school readiness as well as their behavior later in life. Strategies that focus on enhancing children's early experiences can positively impact children's well-being and ultimately the trajectory of their lives.

Early childhood mental health consultation (ECMHC) is one strategy that focuses on enriching early care and education and other child and family serving settings by focusing on helping caregivers to understand children's mental health needs. ECMHC is a problem-solving and capacity-building intervention that aims to enhance the ability of staff, families, programs, and systems to promote the mental health of children from birth to 6 years old and their families. The goals of ECMHC are to assist those who care for young children in:

- understating the mental health perspective;
- fostering positive learning and development of each child through careful observation;
- implementing strategies that enhance learning experiences;
- promoting social, emotional, and behavioral development of each child;

- building relationships and communicating with parents; and
- seeking further consultation, when necessary. (Cohen & Kaufman, 2005)

In the last 10 years a number of studies have demonstrated the effectiveness of ECMHC in improving children's experience in early care and education settings. Specifically, studies have demonstrated ECMHC has: improved the classroom management skills of staff, increased their use of developmentally appropriate practices and expectations, and reduced staff stress and staff turnover (Brennan, Bradley, Allen & Perry, 2008). In some studies, staff who received consultation demonstrated better overall sensitivity to children. Other studies have found that consultation helped improve the overall quality of the programs (using measures such as the Early Childhood Environment Rating Scale (ECERS; Harms, Clifford, & Cryer, 2005). ECMHC services

have also been associated with reductions in teacher-reported externalizing behaviors in children (Perry & Kaufmann, 2009).

One of the most frequently cited barriers regarding ECMHC is a lack of funding, and hence, sustainability of this valuable intervention. In an effort to support states and

Abstract

One of the most frequently cited barriers to providing and sustaining early childhood mental health consultation (ECMHC) is a lack of funding. To support states and communities in their quest for sustainable ECMHC funding, this article highlights findings from a national scan on current funding strategies, as well as recommendations from mental health financing experts. The article offers a sustainability framework to help guide state and community efforts, a review of notable ECMHC funding strategies and critical challenges in funding ECMHC, a matrix of potential funding streams for states and communities to consider, and a checklist of essential sustainability tasks and recommendations for moving the field forward.

communities in financing and sustaining ECMHC, Georgetown University's Center for Child and Human Development (GUCCHD) conducted a national scan to understand how states are currently financing consultation, what the most pressing funding challenges are, and which policy changes might mitigate or eliminate some of these challenges. In addition, GUCCHD interviewed a number of finance experts to identify potential funding opportunities that, for the most part, have remained untapped.

This article will showcase these findings and provide states and communities new ideas and inspiration around sustainably funding consultation. Specifically, we highlight:

- a funding and sustainability framework to help guide state and community efforts;
- notable ECMHC funding strategies,
- critical challenges in funding ECMHC,
- potential funding streams for states and communities to consider,
- essential sustainability tasks, and
- recommendations for moving the field forward.

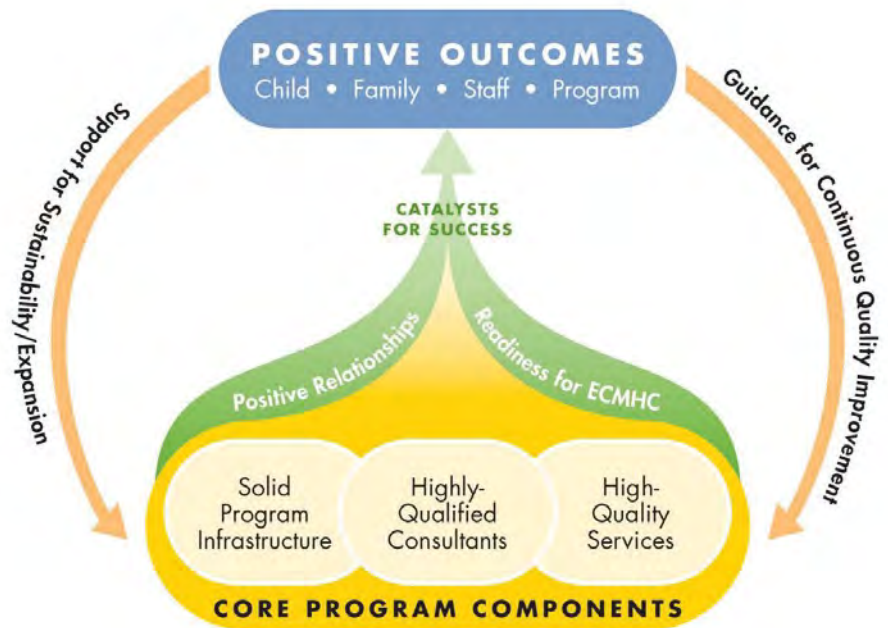
A Funding and Sustainability Framework

THE FIRST STEP in working toward sustainability of ECMHC—or any intervention—is determining what one is trying to finance and sustain. To this end, states and communities should clearly define their local consultation model, including which services will be provided and to whom, as well as the resources needed for this model to flourish. A growing body of literature on ECMHC provides a rich pool of examples for states to consider in developing their local models (Brennan et al., 2008; Perry, Allen, Brennan, & Bradley, 2010).

Although specific model designs may vary, high-quality consultation is generally associated with several key factors. As depicted in Figure 1 (Duran et al., 2009), effective ECMHC is rooted in three foundational components: (a) solid infrastructure, including a clear consultation model design, research and evaluation activities, and public awareness efforts, (b) highly qualified consultants, and (c) high-quality services. Coupled with (d) a consultee's readiness for consultation and (e) a positive consultant–consultee relationship, these five factors set the stage for positive outcomes and present a useful framework for identifying areas to be funded and sustained.

In addition to serving as an organizing tool, Figure 1 also helps to reinforce the importance of two activities that are essential for sustaining ECMHC efforts: research/

Figure 1. Components of Effective ECMHC



From *What Works? A Study of Effective Early Childhood Mental Health Consultation Programs*, by F. Duran, K. Hepburn, M. Irvine, R. Kaufmann, B. Anthony, N. Horen, & D. Perry, 2009, Washington, DC: Georgetown University Center for Child and Human Development. Copyright © 2009 by Georgetown University Center for Child and Human Development. Reprinted with permission.

evaluation and public awareness. Adequate funding in both of these areas should not be understated. Solid research demonstrating positive child, family, and caregiver outcomes stemming from ECMHC is an invaluable tool in forging new partnerships and garnering financial support. Likewise, research highlighting the need for early childhood mental health interventions (e.g., prevention of preschool expulsions; Gilliam, 2005), generates demand for ECMHC and, more important, addresses a real gap in the service system. Of course, research and evaluation data are of little help unless clearly and thoughtfully communicated to the public, particularly policymakers and current or potential funders. Thus, it is critical to regularly invest in both of these pieces when working toward long-term sustainability.

Although knowing what needs to be financed and for what purpose is a huge first step, it does not make the task of securing funds any easier. In addition to a strategic framework, it is important for states and communities to develop a detailed financial roadmap for starting up and maintaining consultation services. Financial mapping is a good place to start. This entails inventorying various federal, state, local, and private funding streams and determining (a) whether these dollars are, or could be, used for consultation-related efforts, (b) who administers these funds, and (c) what needs to be done to

use these funds for consultation in the future (e.g., policy or regulatory changes).

As states and communities gather this financial information, it is also wise to investigate which individuals have decision-making authority over allocation of the funds and to make sure a champion of ECMHC is among them. Having firsthand knowledge of the regulations governing approved uses of various funding streams is also critical; often, opportunities are missed because of misperceptions about how funds can and cannot be used. If consultation is not specified as an approved service, states and communities should investigate whether modifications can be made and what the process entails.

Notable ECMHC Funding Strategies

IN 2009, GUCCHD conducted a national scan that explored, among other issues, how states and territories are funding ECMHC. To gain an updated national picture on financing consultation as well as perceived funding barriers and potential solutions, GUCCHD issued another online questionnaire in December 2012.

Scan Methodology

The 2012 scan was sent via email to state (or territory) children's mental health directors and Early Childhood Advisory Council leaders, as they were identified as individuals

with knowledge of their state ECMHC efforts. If a state did not have an Advisory Council in place, the questionnaire was sent to the Head Start state collaboration director. Respondents were encouraged to collaborate and submit a joint response. Using Survey Monkey software, GUCCHD received responses from 27 states, with two states submitting multiple responses ($N = 29$). The short scan asked several questions, including:

- In what setting(s) does your state (or territory) provide ECMHC services?
- Which funding source(s) does your state currently use to finance ECMHC?
- What specific state or local policies have supported your efforts to fund ECMHC?
- What state or federal policy changes are still needed to permit financing of ECMHC?
- What recommendations do you have for achieving sustainable funding for ECMHC?

Findings from the scan are highlighted throughout this article to provide readers with field-tested financing strategies, ideas for policy or regulatory reform to support ECMHC, and recommendations for sustaining consultation in states and communities over the long-run.

Scan Findings: Funding Sources

Scan data revealed that funding is being channeled to support ECMHC in multiple settings, with Head Start/Early Head Start and center-based child care being the most prominent. Approximately half of respondents indicated that consultation is occurring in family child care settings or through home visiting (52.0% and 47.8%, respectively), while 43% are offering ECMHC in primary care settings and 25% are providing it in child welfare settings.

States are funding ECMHC services in multiple ways, although no one funding stream is consistently used across states (see Table 1). The most prevalent funding sources mentioned were state general funds (84.0%) and federal project grants, such as Project LAUNCH, Race to the Top, and Comprehensive Community Mental Health Services for Children and Their Families (80.0%). Many states are trying to use data from these short-term federal project grants to introduce or expand existing ECMHC services, as well as demonstrate the positive outcomes and cost effectiveness associated with ECMHC, in order to build public awareness and ongoing support. (See box Innovative Approaches to Funding.)

Overall, the majority of states are using some type of federal dollars to support ECMHC. Specific funding streams identified



PHOTO: KWI STREET STUDIOS

Scan data revealed that funding is being channeled to support early childhood mental health consultation in multiple settings, with Head Start/Early Head Start and center-based child care being the most prominent.

include federal block grants, such as the Community Mental Health Services Block Grant, Child Care and Development Block Grant, Child Care Development Fund, and the Maternal and Child Health Bureau's Early Childhood Comprehensive Systems Block Grant, as well as federal formula/categorical grants, such as Part B and Part C of the Individuals With Disabilities Education Act, Head Start and Early Head Start, Home Visiting, and Medicaid.

County or local government funds were mentioned by 72.0% of respondents, while slightly fewer states access philanthropic dollars or private insurance (68.0%, each). A couple of states are implementing ECMHC services at the community level through tax revenue (e.g., tobacco, hospital, property, or children's mental health tax initiatives).

While the scan provides valuable information on which funding sources states are using to finance consultation, it also sheds light on one of the greatest financing challenges: there are currently no dedicated funding streams for this work. As such, states must continue to piece together funds for consultation while simultaneously working to build demand and secure dedicated resources for this valuable intervention. The remainder of this article will explore the challenges inherent in this work and offer recommendations for achieving sustainable funding as well as potential funding streams for consideration.

Critical Challenges in Funding ECMHC

AS PREVIOUSLY MENTIONED, states and communities often struggle to fund consultation services because

there is not a dedicated funding stream to support the range of promotion, prevention, and intervention services offered through consultation. A comprehensive approach to ECMHC includes both child- and family-centered consultation and programmatic consultation. The former is characterized by mental health consultant activities that focus on a particular child with challenging behavior, or the family of that child, or both. Conversely, programmatic consultation activities focus on general program or classroom issues that impact the mental health of staff, children, or families (Cohen & Kaufmann, 2000).

Financing programmatic consultation is the most challenging given that the emphasis is on promotion and prevention for an entire group, rather than remediating the issue(s) associated with a particular individual.

Table 1. Funding Sources

| Funding Source | Percentage |
|-----------------------------------|------------|
| State general funds | 84% |
| Federal project grant | 80% |
| Federal formula/categorical grant | 80% |
| Federal block grant | 76% |
| Medicaid | 76% |
| County/local government | 72% |
| Philanthropic/Foundation | 68% |
| Private insurance | 68% |
| Other | 36% |

Note: Percentage of states that responded to the scan that receive funding for early childhood mental health consultation from a given source.

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States and communities often struggle to fund consultation services because there is not a dedicated funding stream to support the range of promotion, prevention, and intervention services offered through consultation.

Still, the overarching approach to both types of consultation is helping children indirectly, which is inherently difficult to fund, particularly through Medicaid or private insurance carriers. A mental health consultant's primary goal is to improve children's outcomes by enhancing the skills of the families and caregivers—not necessarily working one-on-one with the child. In some states and communities, the child-focused work extends beyond consultation to encompass direct clinical services to the child (e.g., play therapy). When this shift occurs and the services more closely mirror “traditional” mental health services, it is much easier to secure funding.

Another barrier to reimbursement for ECMHC through public or private insurance is the need to issue a diagnosis for the recipient of services. Given that ECMHC is focused on young children, some parents and clinicians are reluctant to issue a diagnosis at such a young age. Fortunately, a developmentally appropriate diagnostic tool for infants and toddlers is now widely available to ease some of these concerns. Many states have begun using the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised* (DC: 0-3R; ZERO TO THREE, 2005) as an alternative to other diagnostic tools designed for older populations. However, reimbursement using DC:0-3R codes is still not feasible, so several states have developed crosswalks between the DC:0-3R and the widely accepted *International Classification of Diseases, Ninth Revision, Clinical Modification* (National

Center for Health Statistics, 2012) in order to effectively bill Medicaid or other medical insurers. Again, this strategy can be helpful for child-centered consultation services, but less so for programmatic consultation.

Funding Streams to Consider

GIVEN THAT THERE is no shortage of challenges to funding ECMHC, this article strives to present a myriad of financing options for states and communities to consider. In addition to the opportunities highlighted in this publication, readers can also refer to an extensive inventory of potential funding sources compiled by researchers at GUCCHD (Perry, Kaufmann, & Knitzer, 2007). Their “Matrix of Early Childhood Mental Health Services and Supports” clearly outlines targeted funding streams within key child- and family-serving agencies including the federal Departments of Health and Human Services and Education, as well as other federal, state, local, and nongovernmental entities. A 2012 study by the Center for Law and Social Policy also provides a helpful summary of potential funding sources for early care and education services, including ECMHC, and offers short background narratives on key sources as well as information on allowable uses for these various funding streams (Johnson-Staub, 2012).

As states and communities investigate various funding streams, they should consider how cost-shifting might play a role in financing consultation. That is, if a particular funding stream is not a good fit for ECMHC, might another service be eligible for funding through that stream? If so, that could result in

INNOVATIVE APPROACHES TO FUNDING

Some of the innovative approaches to obtaining funding for early childhood mental health consultation (ECMHC) include the following:

Expanding settings: Massachusetts

Using Child Care Development Block Grant (CCDBG), Title IV-E, and general fund dollars, Massachusetts has implemented a statewide mental health consultation model that provides programmatic and child-centered consultation in child care. In addition, by combining grant dollars from several federal grants, they are implementing ECMHC and demonstrating the effectiveness of consultation within medical homes. This model will provide the state with new data as they define the benefit package for young children in The Patient Protection and Affordable Care Act (Public Law 111-148, 2010).

Using pilot studies to demonstrate success: Colorado

Colorado obtained funds from state philanthropic foundations to pilot mental health consultation in two counties and then used evaluation data to make the case for expanded consultation across the state. The legislature then approved the use of state general dollars to pay for early childhood specialists in all publically funded mental health centers. In addition, Colorado finances ECMHC by blending multiple funding streams together including Title V, Part C, CCDBG, Medicaid, and time-limited grants such as Project LAUNCH and Race to the Top.

Diversified funding: Rhode Island

Rhode Island is one of many states that have been able to blend several funding sources for their mental health consultation program rather than relying on a single source of funding. While the majority of funds (approximately 65%) are drawn from the CCDBG, more than 30% comes from a combination of Early Childhood Comprehensive Systems grant dollars and Title V dollars. These funds are used for programmatic consultation in child care. In addition, Rhode Island uses Project LAUNCH dollars to evaluate the effectiveness of child-centered consultation within medical homes.

a new pot of money available for consultation. For example, if states were able to implement a Medicaid waiver to pay for some services currently funded through a block grant, those very flexible block grant dollars would then be freed up for new service delivery. Likewise,

the recent health care reform legislation is designed to cover more populations than ever before. If states maximize the use of these funds, the savings could be applied toward new and expanded services, such as ECMHC.

To further support exploration of ECMHC financing, researchers at GUCCHD

conferred with several experts¹ on mental health financing to identify potential funding sources for consultation (see Table 2). While none of these funding streams are specifically earmarked for ECMHC, there are

¹ The authors thank Gary MacBeth, Sheila Pires, and Sherry Peters for their contribution to this article.

inherent opportunities to support consultation and consultation-related activities in each. Still, states and communities need to assess which opportunities are worth pursuing based on specific local funding needs and feasibility considerations, such as local politics and competing priorities. Although these

Table 2: Creative Funding Options

The following funding streams are largely untapped for early childhood mental health consultation (ECMHC). Although using these sources may require concerted effort, given competing priorities and other factors, one or more of these options could greatly enhance long-term financing of consultation.

| Funding Source/Strategy | Summary |
|---|--|
| Medicaid Funding | |
| Waivers | Waivers offer states opportunities to test innovative ways to deliver and fund health care services through Medicaid and the Children's Health Insurance Program (CHIP). Medicaid offers four types of waivers. Two that hold particular promise for consultation funding include the Section 1115 Waiver, which opens the door to "providing services not typically covered by Medicaid", and the Section 1915(b) Managed Care Waiver, which enables states to apply savings gleaned from using a managed care delivery system to pay for additional services. |
| State Plan Amendment | A state's Medicaid Plan outlines, among other things, what services are available and who is eligible for those services. To make changes to this Plan, states must submit a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services for approval. SPAs can be a valuable tool in financing consultation, if states are willing to expand their scope of services to include ECMHC and/or to specify that the parents or caregivers of children with challenging behavior are eligible beneficiaries of services designed to support those children. |
| Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program | EPSDT is Medicaid's child health component, and it is designed to address the physical, emotional, and developmental needs of low-income children. If, through screening, diagnostic testing, or both, an issue is identified, EPSDT-enrolled children are entitled to treatment, even if the needed service is not offered in the state's Medicaid Plan. EPSDT can be a useful vehicle for funding child-centered consultation, if a child is eligible and enrolled. |
| Money Follows the Person Rebalancing Demonstration Program | The goal of Money Follows the Person (MFP) is to help states shift Medicaid-eligible people from institutional settings to the community. Although not geared toward the early childhood population, savings generated from this rebalancing effort are available for states to use for any effort that builds the capacity of community-based care. |
| Administrative Funds | Although not an option for funding ECMHC services, Medicaid administrative funds could be used to finance trainings to support infrastructure-building efforts around consultation. |
| Patient Protection and Affordable Care Act Funding | |
| Medical Homes | The Affordable Care Act places a strong emphasis on implementing medical homes as a means to enhance both care quality and cost-efficiency. A medical home is centered around the patient's, and often the family's, needs and seeks to optimize care through better patient-provider communication and enhanced care coordination, with service referrals emanating from a centralized place (i.e., the medical home). As states implement medical homes—and enhanced reimbursement rates to providers offering the medical home model—ECMHC advocates should explore ways to build in consultation as part of the package of available services. |
| Maternal, Infant, and Early Childhood Home Visiting Program | This Home Visiting Initiative, which was authorized through the Affordable Care Act, seeks to improve the health and developmental outcomes of at-risk children through evidence-based home visiting models. All states receive Home Visiting Program funds that are usually managed by their Maternal and Child Health division. Although ECMHC is not a home visiting model, per se, consultation could be woven into home visiting efforts through coaching of home visitors or by having trained mental health consultants conduct the home visits with young children and their families. |
| Prevention and Public Health Fund | The Affordable Care Act created this fund to support a variety of prevention activities through grants to states. Designated federal agencies have jurisdiction over specific Fund activities or programs. Two opportunities of note for consultation work include Health Resources and Services Administration's Mental Health Training grants and Substance Abuse and Mental Health Services Administration's Primary Behavioral Health Care Integration grants. |
| Health Resources and Services Administration Funding | |
| Health Center Program Grant/Federally Qualified Health Center | Public and private nonprofit health care organizations are eligible to apply for Section 330 funding. If awarded, Section 330 funding is relatively flexible and offers a number of options for delivering mental health services, including ECMHC. If an existing Health Center does not offer ECMHC, it can apply to expand services to include consultation through a Service Expansion Grant. |
| Health and Human Services Funding | |
| Title IV-E Child Welfare Waiver Demonstration Projects | The federal Department of Health and Human Services can award up to 10 Title IV-E waivers in the upcoming fiscal year (FY2014), which are in addition to waivers already granted to several states. The waivers give states greater flexibility to pilot new service delivery and financing methods, but do not provide additional funding. Higher priority is given to state applicants seeking to address the trauma experienced by children in the child welfare system as a means to improve child outcomes. ECMHC is an effective strategy for dealing with trauma, making it a compelling intervention to consider for the child welfare population. |

funding streams are largely untapped for consultation and may require concerted effort to use them for ECMHC, they are worth strong consideration.

Sustainability: The Ultimate and Ongoing Objective

ONCE STATES AND communities have mapped out their financing needs and identified potential funding sources, the next step is to pursue opportunities in a strategic way so as to move toward the ultimate goal of sustainability. Consultation funding must stretch beyond service delivery to encompass workforce development, research, and social marketing, underscoring the need for a winning, long-term financing strategy and strong leadership.

The overarching question that state and community leaders should ask themselves in pursuing funding is “How will this lead to sustainability?” This is not to say that potential funding opportunities should be overlooked if they do not offer long-term financing, only that there should be a clear vision of how to put each dollar to use strategically. For example, short-term grant dollars might be used to develop a cadre of local trainers in a particular evidence-based practice using a “train-the-trainer” model. Likewise, a one-time infusion of dollars might fund an outcomes evaluation with the potential to generate compelling data to support future advocacy and fundraising efforts. Finally, one might bid on a short-term subcontract to provide ECMHC services to a strategically positioned organization or local agency, with the hopes that it might lead to a long-term partnership after relationships are well-established. See box Strategic Uses for Funding Beyond Direct Service Delivery for additional suggestions for states and communities to consider when evaluating uses for funding.

Moreover, diversifying funding is also critical to long-term financing. Scan respondents and researchers agree: avoid sole source funding if at all possible (Stroul & Manteuffel, 2007). The likelihood of sustainability is greater if funding is braided or blended across a number of secure funding streams (e.g., entitlement programs such as Medicaid), as it provides a buffer if one of the sources is significantly cut.

The Head Start/Early Head Start program, for example, has a long-standing history of working to sustain ECMHC. From its inception in the mid-1960s the federal Head Start program has demonstrated a commitment to integrate mental health as part of its comprehensive services to children and families. ECMHC is included in the Head Start Program Performance Standards—the required standards of service for each Early Head Start and Head Start program. Typically

STRATEGIC USES FOR FUNDING BEYOND DIRECT SERVICE DELIVERY

In addition to funding consultation services, states should invest in other critical elements that will help bolster early childhood mental health consultation (ECMHC) quality and sustainability, such as these listed below.

- Increase the pool of well-trained mental health consultants.
- Draw attention to the need for high-quality ECMHC.
- Strengthen the case that ECMHC generates positive outcomes for young children, their families, and other caregivers through new research.
- Foster partnerships among other organizations or initiatives with shared goals, thereby preventing duplication of effort and using fewer dollars to achieve similar outcomes.
- Better prepare participants in the consultation process (e.g., families, caregivers, administrators), so as to maximize the positive impact of this intervention.

individual programs pay for ECMHC using their federal funds. The programs also use creative funding approaches to extend their capacity to provide ECMHC by: providing clinical supervision in order to serve as internship sites for colleges and universities, partnering with child care programs to blend funds, obtaining donated/in-kind or reduced cost services from individual consultants or local mental health agencies, and partnering with local education agencies and child care programs to jointly apply for grants.

Sustainability Tasks

When seeking funding, states and communities need to make a compelling case tailored specifically for each potential funding partner. While all partners need clarity on what ECMHC is, how it is locally implemented (i.e., the local consultation model), and why it is a sound investment, they also need to have a firm understanding of how a funding partnership is mutually beneficial. What is the overlap in vision? How can ECMHC help them address mandates from their funders? How does consultation address a local issue of importance to this funder? This is where the need for a strong evaluation and social marketing component is most evident. In the beginning, states and communities may not have data on local consultation outcomes, but fortunately, there is a growing

body of research pointing to ECMHC’s positive impact (Brennan et al., 2008; Perry et al., 2010). Other data ECMHC advocates might access in building their case include local prevalence data on mental health diagnoses in young children, preschool expulsion rates, and school readiness at kindergarten entry.

While securing funding is essential, to truly achieve sustainability, ECMHC advocates must attend to a variety of tasks that support, yet extend beyond, financing efforts. Long-lasting ECMHC is associated with a number of best practices. These sustainability tasks, which are also presented as a state/community checklist in Table 3, include:

1. Clearly articulate the model. A

well-defined, stakeholder-sanctioned consultation model is the cornerstone of a sustainable ECMHC program. It not only specifies what services will be provided, by whom, and for whom, but it is an essential communications tool when soliciting funds and recruiting partners. Model clarity also helps to maintain service quality and support model fidelity. All involved in the model (consultants, consumers, governance board, and administrative staff) should be able to describe the core model components and the intended impact.

Table 3. Sustainability Task Checklist for Early Childhood Mental Health Consultation

States and communities can use the checklist below to assess which sustainability elements are in place and which tasks remain as they work toward sustainable early childhood mental health consultation (ECMHC).

| Sustainability Task | Completed or Underway? <input checked="" type="checkbox"/> |
|---|---|
| 1. Clearly articulate the local ECMHC model. | |
| 2. Build strategic partnerships. | |
| 3. Put strong leadership into place. | |
| 4. Create demand for ECMHC. | |
| 5. Use evaluation and research data effectively. | |
| 6. Pursue policy and regulatory reforms that support ECMHC. | |
| 7. Support a well-trained consultant workforce. | |
| 8. Cultivate champions of ECMHC. | |
| 9. Secure multiple sources of reliable funding for ECMHC. | |

2. **Build strategic partnerships.** Successful, long-term ECMHC requires a coordinated, multipronged approach and, consequently, the need for strong partnerships is critical.

For example, states looking to ensure timely identification of social-emotional problems in young children and referral to ECMHC services might seek to build linkages with local primary care practices. Others might enlist the help of an ally at Centers for Medicare & Medicaid Services to provide guidance on how best to change a state Medicaid plan or to include ECMHC in a waiver program. While some partners may provide funding, many may provide valuable nonmonetary contributions.

3. **Put strong leadership into place.**

Implementing and sustaining high-quality consultation is challenging and requires leaders with vision, commitment, and the ability to foster strategic relationships and to “think outside of the box.”

4. **Create demand for ECMHC.** To implement, expand, and, ultimately, sustain consultation, key audiences need to understand why ECMHC is important and how it can help in a variety of settings, including early care and education, primary care, and child welfare. General public awareness campaigns, as well as targeted outreach activities, help audiences recognize the promise that ECMHC holds in addressing preschool expulsions, trauma-related symptoms, and other social-emotional issues facing young children and families.

5. **Use evaluation and research data effectively.** States and communities would be wise to invest in process and outcome evaluations that show how their local models positively impact the lives of children, families, and other caregivers. These data are invaluable in making the case to funders and in supporting continuous quality improvement efforts. In addition, states and communities should avail themselves of the research base on ECMHC’s effectiveness, particularly in addressing “hot topic” issues such as preschool expulsions, aggressive behavior, teacher stress and turnover, and quality of classroom environments (Brennan et al., 2008; Perry et al., 2010).

6. **Pursue policy and regulatory reforms.**

Ongoing pursuit of policy and regulatory changes are important to long-term sustainability of consultation. Scan respondents underscored the need for Medicaid reforms that better support ECMHC, particularly programmatic consultation and other promotion and prevention efforts. ECMHC advocates

need to stay abreast of opportunities in current and future legislation and to continue to work at the federal, state, and local levels to craft or modify existing policies to expand access to consultation.

7. **Support a well-trained consultant workforce.** Sustainable consultation relies heavily upon the infrastructure on which it rests. States and communities must focus energy on workforce development to ensure that the quality and number of mental health consultants continues to increase. Localities should consider partnering with higher education to ensure adequate preparation of future consultants (pre-service) and providing ongoing professional development and reflective supervision of consultants to hone their skills and promote model fidelity (in-service). Further, a number of states are moving toward defining core competencies for consultants to provide consistency and reflect best practice in the field.

8. **Cultivate champions.** Last, but certainly not least among the sustainability tasks to pursue, is the cultivation of champions. Advocates, legislators, satisfied families, philanthropists, agency administrators, and business leaders can all be compelling ambassadors for ECMHC. To support their efforts, make sure they have up-to-date information, print materials, and testimonials they can use when they have the opportunity.

Long-Term Sustainability

Sustaining consultation is not a “moment in time” event, but rather a continuous process to ensure the availability and quality of services as long as they are needed. Many activities feed into this process, including ongoing workforce development, research, local needs assessments, and advocacy. This underscores the need for shared local ownership of and commitment to ECMHC; sustainability is a marathon, not a sprint.

States and communities will continually need to make a compelling case for consultation to the general public and for strategically identified audiences, such as policymakers, service delivery partners, and funders. As new data becomes available and staff or political turnover results in new leadership, ECMHC advocates need to maintain a strong presence.

ECMHC advocates must also continue to seek expansion of ECMHC beyond child care and Head Start into home visiting, primary care, child welfare, adult service settings, and other frontiers. This not only ensures that a greater number of children and families will benefit from consultation, but allows for an ongoing infusion of new dollars.



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Early childhood mental health consultation services might seek to build linkages with local primary care practices.

Learn More

A GUIDE TO FINANCING COMPREHENSIVE SERVICES IN CHILD CARE AND EARLY EDUCATION

www.clasp.org/admin/site/publications/files/A-Guide-to-Financing-Comprehensive-Services-in-Child-Care-and-Early-Education.pdf

CENTER FOR EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

www.ecmhc.org

SOCIAL AND EMOTIONAL HEALTH IN EARLY CHILDHOOD: BUILDING BRIDGES BETWEEN SERVICES AND SYSTEMS (SYSTEMS OF CARE FOR CHILDREN’S MENTAL HEALTH)

J. Knitzer, D. Perry, & R. Kaufmann (2007)
Baltimore, MD., Brookes

MEDICAID FUNDING

www.medicaid.gov

PATIENT PROTECTION AND AFFORDABLE CARE ACT FUNDING (I.E., HEALTH CARE REFORM)

www.healthcare.gov/law/index.html

HEALTH RESOURCES AND SERVICES ADMINISTRATION FUNDING

<http://bphc.hrsa.gov/about/index.html>

HEALTH AND HUMAN SERVICES FUNDING

www.acf.hhs.gov/programs/cb/news/title-iv-e-waiver-demonstration-projects

PHOTO: © ISTOCKPHOTO.COM/ROSEMARIE GRABHART



Results from a growing number of research and evaluation studies provide data that validate anecdotal observations and testimonials—early childhood mental health consultation helps children, families, and other caregivers.


Recommendations for Moving the Field Forward

FOR MORE THAN a decade states, communities, and programs have struggled to answer the question, “How do we pay for ECMHC?” It is due to diligence, creativity, and belief in the efficacy of ECMHC that the model has flourished. Indeed, results from a growing number of research and evaluation studies provide data that validate anecdotal observations and testimonials—ECMHC helps children, families, and other caregivers. So why is it still so difficult to pay for these services?

As results from the scan attest, at this time there is no single funding mechanism that can fully fund all aspects of ECMHC. Follow-up interviews with a handful of scan respondents revealed that several states tried to pay for consultation with only one funding source, and found that when state priorities shifted or the fiscal climate changed, the program experienced drastic cuts. Scan findings further illustrated that most state and community ECMHC programs are combining funds, aligning initiatives, diversifying the settings in which consultation is occurring, and using evaluation data to market results.

In working toward sustainable ECMHC, states and communities must be well-informed and have a thorough understanding of a myriad of funding options: public, private, short-term, entitlements, fee-for-service, federal, state, and local dollars in order to maximize financing. They must be flexible and unafraid to push the envelope and explore new funding possibilities. They must also consider how each dollar can help

move toward firmly entrenching ECMHC into the service delivery system.

Financing and sustainability are intertwined. In the What Works study (Duran et al., 2009), the salient features of an effective program require a solid program infrastructure, highly qualified mental health consultants, and high quality services. Funding leadership and administrative tasks, building a strong work force, and investing in and evaluating evidence-based interventions and strategies are not one-time costs. Diversifying, blending, and braiding funds are needed in order to build and sustain early childhood mental health consultation. 

FRANCES DURAN, MPP, is a policy associate at the Georgetown University Center for Child and Human Development. As part of the National Technical Assistance Center for Children’s Mental Health, Ms. Duran assists states and communities as they work to develop strong, sustainable service delivery systems that support the social and emotional needs of infants and young children. She focuses much of her research on early childhood mental health consultation, exploring essential features of effective consultation and investigating ways to expand the availability of this intervention. Prior to her work at Georgetown, she was the lead evaluator for a federally funded, community-based early childhood mental health systems change initiative.

ROXANE K. KAUFMANN, MA, is the director of early childhood policy for Georgetown University Center for Child and Human Development. During the past 30 years on faculty

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MARISA IRVINE, MPP, is a policy associate at the National Technical Assistance Center for Children’s Mental Health of the Georgetown University Center for Child and Human Development (TA Center). Since 1995, she’s been with the TA Center working on key policy issues to improve the early childhood health and mental health at the national, state, and community levels. Ms. Irvine has completed numerous research, evaluation, policy analysis, technical assistance, and training projects to tackle the complex challenges involved in developing systems of care for children and adolescents with or at risk for emotional disorders and their families. She works with states, territories, tribes, communities, family organizations, and youth leaders to plan and implement culturally competent, family-friendly policies and services in multiple child-serving systems. She earned a masters of public policy from the Georgetown Public Policy Institute and a bachelor’s degree from the Johns Hopkins University.

AMY HUNTER, MSW, LICSW, is an assistant professor at Georgetown University’s Center for Child and Human Development. Amy plays a leadership role in overseeing the mental health section of the Head Start National Center on Health. Prior to coming to Georgetown, Amy served as the director of program operations for the Early Head Start National Resource Center (EHS/NRC) at ZERO TO THREE, in Washington, DC. In addition to her work with the EHS/NRC Amy directed the infant–toddler portion of the CSEFEL project. For 20 years Amy has been involved in early childhood mental health including providing training and technical assistance to individuals and groups around the country.

NEAL M. HOREN, PhD, is deputy director, early childhood policy at Georgetown University Center for Child and Human Development. He is a licensed child psychologist and a technical assistance specialist for the Head Start National Center on Health and for Project LAUNCH. His work focuses on early childhood mental health and he has worked extensively with states, tribal nations, territories, and communities on development of their early childhood system of care.

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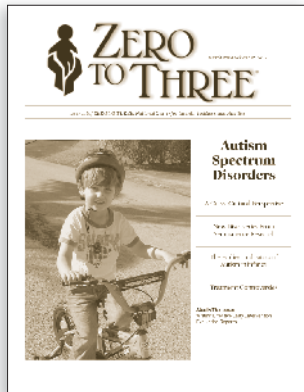
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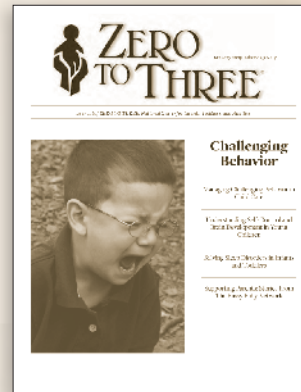
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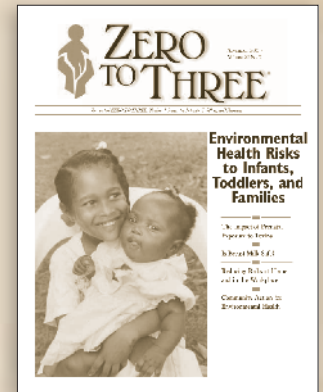
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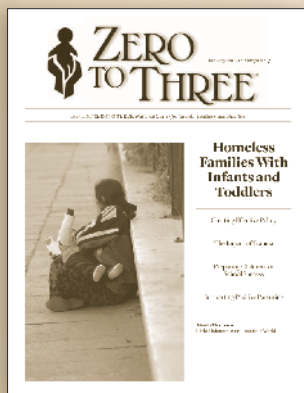
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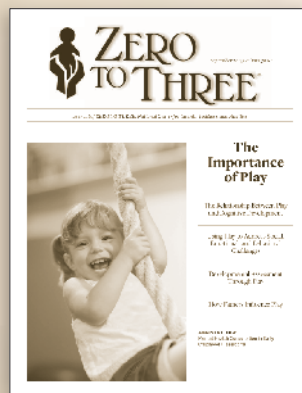
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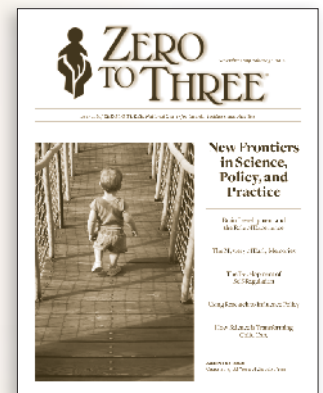
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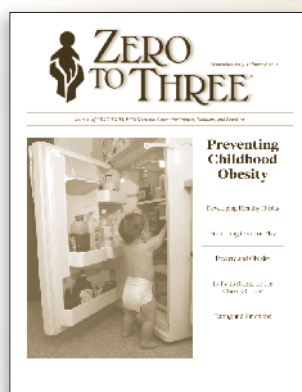
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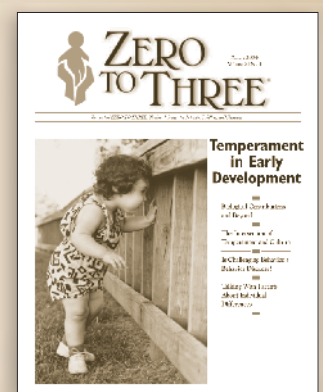
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Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *Zero to Three*, we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

| Phrase | What it means |
|---|--|
| Center on the Social and Emotional Foundations for Early Learning (CSEFEL) Pyramid Model | The Pyramid Model provides a conceptual framework for organizing practices needed to promote young children's social-emotional development, prevent the development of challenging behavior, and deliver individualized interventions to children with persistent behavioral concerns. [Find it in Boothe & Nagle, page 45] |
| Consultative Stance | Johnston and Brinamen (2006) offered 10 elements, coined the Consultative Stance, to guide the consultation process. (1) Mutuality of endeavor, (2) Avoiding the position of the expert, (3) Wondering instead of knowing, (4) Understanding another's subjective experience, (5) Considering all levels of influence, (6) Hearing and representing all voices—especially the child's, (7) The centrality of relationships, (8) Parallel process as an organizing principle, (9) Patience, and (10) Holding hope. [Find it in Johnston, Steier, & Heller, page 52] |
| Early Childhood Mental Health Consultation (ECMHC) | Early childhood mental health consultation is a capacity-building and problem-solving intervention implemented in early childhood settings and home. A professional consultant with infant-early childhood mental health expertise develops a collaborative and reflective relationship with one or more consultees (e.g., an early care and education provider, service provider, or family member). ECMHC focuses on enhancing the quality of young children's social and emotional affective environments, as well as the needs of individual children. [Find it in Kaufmann, Perry, Hepburn, & Hunter, page 4] |
| Project PLAY (Positive Learning for Arkansas's Youngest) | Project PLAY was established to facilitate collaboration between community mental health centers and early child care programs. Project PLAY matches early childhood mental health consultants with early care and education providers throughout the state of Arkansas. [Find it in Conners-Burrow, Patrick, Steier, & Lloyd, page 38] |
| Southwest Human Development Smart Support Program | Smart Support is a program that partners early childhood mental health consultants with child care providers to promote the social and emotional development of all children in care and to help providers respond to children with behavioral challenges throughout the state of Arizona. [Find it in Conners-Burrow et al., page 38] |

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