



Early Childhood Mental Health Consultation (ECMHC) Project: Standards for the State of Maryland



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Division of Special Education/Early Intervention Services

June 2011

MARYLAND STATE DEPARTMENT OF EDUCATION
DIVISION OF EARLY CHILDHOOD DEVELOPMENT
DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES

**Early Childhood Mental Health Consultation Standards
for the State of Maryland**

June 2011

This publication was developed and produced by the Maryland State Department of Education (MSDE), Division of Early Childhood Development with funds from MSDE grant number SG901732. This document is copyright free. Readers are encouraged to share; however, please credit the MSDE Division of Early Childhood Development and the Division of Special Education/Early Intervention Services.

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Early Childhood Mental Health Consultation Standards for the State of Maryland

Overview

In recent years, there has been increasing evidence that young children (aged 0-6) are subject to social and emotional difficulties that can undermine their school readiness and lead to poor adult mental health. Many of these problems manifest as challenging behaviors exhibited when children are in early care and educational (ECE) settings. These problematic behaviors can place young children at-risk for removal or expulsion from these ECE settings. In a national study of state-funded Pre-kindergarten programs, Gilliam (2005) found that preschool-aged children were being expelled at a higher rate than comparable populations of school-aged children. If appropriate interventions are not provided, behavioral problems that arise early can escalate, leading to clinical trajectories in childhood and adolescence (Perry, Allen, Brennan, & Bradley, 2009).

There is growing evidence that early childhood mental health consultation is associated with positive outcomes for young children with problematic behavior. Early childhood programs with access to mental health consultation had lower rates of children expelled from their care (Gilliam & Shahar, 2006). In a recent review article examining staff and program level outcomes, Brennan, et al. (2008) found support for ECMHC building the capacity of ECE providers' confidence and competence in coping with challenging behaviors, as well as improved efficacy, and decreased adult stress and staff turnover. In a related review examining children's behavioral outcomes, Perry et al. (2009) found that mental health consultation is effective in reducing teacher-reported externalizing behaviors (inattention, hyperactivity, aggression, and anger), and in fostering pro-social skills.

Cohen and Kaufman (2005) describe mental health consultation in early childhood settings as a "problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise." Johnston and Brinamen (2006) suggest that collaboration underlies the approach of the mental health consultant (MHC) who is simultaneously an observer, interpreter, and participant. In practice, there are two general approaches to providing ECMHC: child- and family-focused consultation is initiated by concerns about the behavior of a specific child in an ECE setting; consultation can also be focused on the entire classroom, to benefit a group of children. The latter is often referred to as programmatic consultation and may be initiated at the request of an ECE teacher or director. In both cases, the primary goal of ECMHC is building capacity among ECE providers and family members to develop their skills to support social and emotional health in young children.

At the core of the consultation process are collaborative relationships between the MHC, ECE provider, and for child-focused consultation, family members. Each of these adults brings important experiences and unique expertise to the ongoing conversation about a child. For programmatic consultation, collaborative relationships between the ECE provider and the MHC reflect a mutual respect for the expertise of each participant. Consultants may also serve as coordinators and advocates in helping the family navigate complex systems of public and private service delivery for qualifying children. Additionally, in working with a population of families and ECE providers that is increasingly culturally and linguistically diverse, it is essential for ECMH consultants to act in culturally competent ways when considering a child's functioning across settings (Hepburn, et al., 2007).

The Evolution of ECMHC in Maryland

The State of Maryland has made a strong commitment to ensuring that young children enter school ready to learn (MSDE, 2009). The Maryland Model for School Readiness is a comprehensive initiative that includes a universal kindergarten assessment as well as high-quality professional development for personnel working with young children across settings. As part of this commitment, state funding was appropriated in 2006 to support ECMHC projects in 12 locations across the state.

The ECMHC project builds upon work conducted by the Maryland State Early Childhood Mental Health Steering Committee and promising results from an evaluation of two pilot projects (Perry, 2005). Concurrently, Maryland has invested in several related efforts that support school readiness and ECMHC. One such effort is statewide implementation of the Teaching Pyramid model developed by the Center for Social Emotional Foundations for Early Learning (CSEFEL; 2008). This framework articulates a continuum of research-based practices that address social-emotional promotion, prevention, and intervention with young children (Hemmeter, et al., 2006). In order to support the provision of high quality ECMHC services in the state of Maryland, MSDE contracted with Georgetown University Center for Child and Human Development to develop research-based standards.

These standards were established in collaboration with stakeholders from all of the state-funded ECMHC projects, as well as representatives from the Maryland State Department of Education.

Core ECMHC Principles, Objectives and Benchmarks

State-funded ECMHC projects in Maryland are guided by a set of core early childhood mental health principles:

- The key to healthy social-emotional development in young children is positive interactions and healthy relationships with caregivers (ECE providers and parents) in supportive environments
- All services must be culturally and linguistically responsive to family/provider context
- All services must take into account the infant/toddler or preschoolers' developmental stage
- ECMHC recognizes the primary importance of family¹ in a child's development, and acknowledges the necessity of fostering communication and collaboration between the home and early childcare setting in ways that support child development
- ECMHC is a primarily "indirect" service that seeks to build the capacity of the young child's ECE providers and family members through a collaborative approach

¹ The National Association for the Education of Young Children (NAEYC, 2005) defines family as adults outside of Early Care settings "involved with the responsibilities of educating, nurturing, and advocating for the child."

- ECMHC simultaneously builds upon the expertise, perspectives, and resiliencies of ECE providers and family members while nurturing inherent child strengths and emerging competencies
- ECMHC is a relationship-based, family-centered service that addresses the social and emotional well-being of infants, toddlers, and preschoolers and the ECE providers and families that care for them

State-funded ECMHC projects are implemented to achieve the following objectives:

1. Facilitate early childhood development through changes in the early learning environments to enable more children to enter school ready to learn.
2. Provide early care and education (ECE) providers and family members with intervention strategies to improve social and emotional development.
3. Address problematic social and emotional behaviors of young children in child care settings.
4. Refer families and children requiring more intensive intervention services to high quality assessment and clinical intervention services.

State-funded ECMHC projects have adopted the following benchmarks for success:

- Increased ECE providers' knowledge of importance of social-emotional development and capacity to manage challenging behaviors.
- Increased ECE providers' knowledge, attitudes, and behaviors that promote nurturing classroom environments for all children.
- Referred children are maintained in quality early childhood settings.
- Referred children have measurable decreases in problem behaviors and increases in social skills and resiliencies
- Increased referrals for children and families in need of more intensive interventions.
- Increased community awareness of social and emotional development of young children.

ECMHC Standards for the State of Maryland

In order to achieve these objectives and outcomes, all state-funded ECMHC projects must have: (1) high-quality consultation services, and (2) program and State-level infrastructure.

I. High Quality Consultation Services

A. Fostering Relationships through Consultation with Early Care and Education (ECE) Providers

1. ECMHC projects must describe the scope of their services and establish mutually agreed upon expectations with the early care and education site director and providers when services are initiated.

2. ECMHC services are informed by systematic observations of children conducted by the mental health consultants (MHCs) across relevant contexts in ECE classrooms and family day care settings.
3. Systematic assessments of the quality of ECE environment will measure structural, social-emotional and relational, and programmatic features. For example, MHCs should attend to: staff-child ratios, the emotional climate of ECE settings, and how transitions between activities are managed.
4. Early childhood MHCs should collaborate with ECE providers to formulate a plan that will guide the content of the consultation services. The plan should be a written document and specific strategies to meet this plan should be discussed with the ECE team.
5. Due to the dynamic nature of collaborative plans, early childhood MHCs should work with ECE providers over time to evaluate the efficacy of interventions and make modifications as needed.
6. Consultants will foster the ECE providers' use of norm- or criterion- referenced instruments to screen children's social-emotional development.
7. Consultants will model and/or train ECE staff on the systematic implementation of evidence-based strategies that target positive social-emotional development, address challenging behaviors, contribute to ECE staff wellness, promote team-building, and facilitate communication between ECE staff and families.
8. Any strategies that promote social-emotional and behavioral competence suggested by MHCs will be developmentally and culturally appropriate for the ECE context and, if relevant, the child identified for child-focused consultation.
9. Consultants will support ECE staff efforts to communicate with individual families about a child's development, challenging behavior, or any interventions that are planned to address these concerns, as needed.
10. Consultants will provide assistance to ECE providers for referrals to community-based services that address needs of the children in their care especially those with or at-risk for delays or disabling conditions.
11. In order to facilitate appropriate referrals, MHCs will cultivate a base of knowledge of statewide resources within and beyond the community, and foster relationships with local, direct service providers.
12. Consultants should adopt a consultative stance that foregoes the position of the "expert" by collaborating with the ECE provider in examining and interpreting the meaning of a child's behavior. Throughout the consultative process, the expertise and perspective of the ECE provider should be explicitly validated by the MHC.
13. Consultation should promote an increase in the skills, knowledge and expertise of the ECE provider as well as greater insights and reflectiveness about how their behavior influences children's behavior.

B. Fostering Relationships with Families through Consultation

1. Individualized consultation services may be offered to families for children identified with behavioral and social-emotional issues in ECE settings.
2. Information from the home environment should be gathered in a way that is respectful and be kept confidential; information should be sought that is relevant for the consultant in their work with the ECE provider and family.
3. Information about the home environment should be incorporated into the planning process including familial strengths as well as risk factors to the child's overall functioning.
4. For any child-focused consultation, intervention plans should be created with family input and must have the parental consent. A face-to-face meeting should be scheduled with the family, ECE provider, and ECMH consultant, whenever possible.
5. The consultant will provide information to family members on how to incorporate and sustain evidence-based approaches at home that address the social/emotional and behavioral needs of the child, improve parental wellness, and foster the relationship between the family and ECE staff.
6. Strategies implemented at home should coordinate with strategies implemented in ECE settings with the ultimate goal of reducing challenging behavior and helping the child succeed in home and school.
7. Drawing on a broad knowledge base of local and statewide resources, the consultant will provide assistance to families with referrals to community-based services that meet the mental health needs of family members and their children, as well as referrals for other developmental services needed by individual children.
8. Adopting a consultative stance that is characterized by availability, approachability, and mutual respect, the consultant will assist family members in becoming more empathetic and responsive to their child.

D. Well-prepared Consultants

1. At minimum, consultants must have a Bachelor's degree, preferably in a human-services related field (such as psychology, special education, social work, or counseling).² If a consultant's degree was not in a human-services related field, the consultant must have accumulated credits at the undergraduate, graduate, or professional development level in a human-services related discipline or field.
2. Consultants will have extensive knowledge and experience in core issues related to early childhood, such as typical and atypical child development, emotional and

² Across the country, the vast majority of early childhood mental health consultants have a minimum of a masters' degree in a mental health field.

behavioral health, family systems, cultural competence, and knowledge of evidence-based approaches to managing problematic behavior.

3. Consultants must have or develop specialized knowledge of how young children function in-group settings.
4. Consultant knowledge bases and qualifications must be aligned with core competencies in the state of Maryland for mental health and early childhood professionals.
5. ECMH consultants will attend trainings on key early childhood and consultation topics and practices, including CSEFEL.
6. Consultants will undergo background checks consistent with other professionals working one-on-one with young children.

D. Ongoing Support

1. Consultants will be provided with administrative supervision that relates to the compliance with federal, state and agency regulations, program policies, rules, and procedures.
2. Consultants will be provided with individual and/or group clinical and reflective supervision, preferably by a licensed mental health professional knowledgeable in issues related to early childhood. Reflective supervision addresses the emotional content of the consultant's work, and attends to relationships and the complex interactions between relationships (between the consultant and supervisor, consultant and caregiver, consultant and parent, parent and caregiver, and parent and child).
3. Consultants will have access to ongoing professional development and technical assistance that will be appropriate to their level of expertise and licensing requirements.
4. Consultants will have the opportunity to participate in peer support meetings.
5. Consultants are expected to maintain a caseload that balances program- and child-focused work and is consistent with the ECMHC model as locally defined.
6. The overall number of consultation visits is not fixed, but are responsive to the needs of the ECE provider and/or family.

II. Program and State-level Infrastructure

E. Local Infrastructure

1. ECMHC services should fit into a locally identified "continuum of supports" for children and families.

2. Each state-funded ECMHC project will have a well-articulated description of their consultation model as well as procedural guidelines, such as eligibility and intake procedures.

F. Data Collection, Evaluation, and Reporting Systems

1. State-funded ECHMC projects may develop a logic model that details the possible resources, activities, theories of change, and outcomes for mental health consultation in terms of the child, family, staff, and the larger system of care.
2. State-funded ECHMC projects will report on clear, measurable benchmarks on a periodic basis, as required by MSDE.
3. Each ECMHC project will assess the quality of their implementation and use these data to guide service planning, and to improve ECE provider and family engagement.
4. Standardized, strengths-based screening and assessment tools will be used to track outcomes for children referred for child-focused consultation services. Data will be collected for individual children once parent consent is secured. These data will be provided by the ECE provider and family when possible, at initiation of services and then again when consultation services are completed. Norm- or criterion- referenced instruments should be selected that reflect the cultural and ethnic backgrounds of the families served by the ECMHC projects.
5. Standardized tools will gather data on the social-emotional climate of the ECE environment receiving on-site ECMHC services. Data on changes over time in teacher and program-level outcomes will also be recorded for ECE programs receiving consultation services.
6. Consultants will keep track of the type and amount of consultative services provided as well as the number of referrals made to community resources.
7. Consultees will be given the opportunity to provide systematic feedback on the quality of ECMHC services provided to ECE providers and families.
8. State-funded ECMHC projects are expected to participate in administrative reporting to MSDE and statewide program evaluations.

G. Linkages with Community-Based Services

1. Representatives of ECMHC projects should be highly visible members of the communities they serve. Examples of community participation could include attending local meetings, or involvement with the boards of important local agencies.
2. ECMHC programs should undertake community outreach. Examples of outreach activities include contacting center-based and family child care providers by mail or phone, attending open house events at the same early child care facilities, and providing brochures and other materials that describe ECMHC services to the local pediatrics community.

3. Relationships with community-based services should be established so adequate referrals for direct services can be made in a timely fashion.
4. Formal mechanisms will be established to obtain feedback on children or families who are referred for additional services and support from outside agencies.
5. To facilitate coordinated individualized care plans (IFSPs and IEPs) for qualifying children and families, it is recommended that ECMHC programs maintain linkages with local Infants and Toddlers Programs, Preschool Special Education Services, the Judy Centers and Family Support Centers. Linkages with Early Head Start and Head Start programs as well as home-visiting programs are also critical.

H. State-level Infrastructure

1. The Maryland State Department of Education will establish a statewide system of ECMHC services delivered through locally operated ECMHC Projects (referred to as the ECMHC Program).
2. The State will provide adequate and stable funding for the ECMHC Program from consistent sources.
3. State funding will sufficiently cover expenses associated with appropriate clinical supervision for ECMH consultants by licensed mental health professionals with expertise in early childhood.
4. In order to support the development of local systems of care for referrals for young children's mental health promotion, prevention and intervention, state-level interagency agreements will establish linkages between child-serving programs. The Maryland State Early Childhood Mental Health Steering Committee or similarly comprised group will serve as a forum to foster these linkages.
5. The State will assist with activities to build awareness about the importance of early childhood social-emotional development. The Maryland State Early Childhood Mental Health Steering Committee or similarly comprised group will assist with these efforts.
6. Statewide technical assistance will provide support, training, and resources for the state-funded ECMHC Program, including activities that focus on social-emotional development, promotion, prevention, early identification, and intervention.
7. The Maryland State Department of Education is responsible for building connections between state-funded ECMHC projects through regular meetings and communication.
8. Ongoing professional development will be provided for state-funded ECMH consultants and ECE providers.
9. The Maryland State Department of Education is responsible for monitoring the quality of the implementation of the ECMHC Program.

References

- Brennan, E. M., Bradley, J. R., Allen, M. D., Perry, D. F. (2008). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. *Early Education and Development*, 19(6), 982-1022.
- Center on the Social and Emotional Foundations for Early Learning (CSEFEL) (2008). Pyramid model: Promoting social and emotional competence in infants and young children. Retrieved June 8, 2009, http://www.challengingbehavior.org/explore/camtasia/pyramid_overview/pyramid_overview_captions.html
- Cohen, E. & Kaufmann, R. (2005). Early childhood mental health consultation. Washington, DC: Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration and the Georgetown University Child Development Center.
- Duran, F. et al., (2009). Early childhood mental health consultation as an evidence-based practice. [Draft of report] Washington, DC: Georgetown University Center for Child & Human Development.
- Gilliam, W. S. (2005). Prekindergarteners left behind: Expulsion rates in state prekindergarten systems. New Haven, CT: Yale University Child Study Center.
- Gilliam, W. S., & Shahar, G. (2006). Preschool and child care expulsion and suspension: Rates and predictors in one state. *Infants & Young Children*, 19(3), 228-245.
- Hemmeter, M. L., Ostrosky, M., Santos, R. M., & Joseph, G. (2006). Promoting Children's Success: Building Relationships and Creating Supportive Environments. University of Illinois at Urbana-Champaign, Center on the Social and Emotional Foundations for Early Learning (CSEFEL)
- Hepburn, K. S., Kaufmann, R. K., Perry, D. F., & Allen, M. D. (2007). Early childhood mental health consultation: An evaluation tool kit. Washington, DC: Georgetown University, Technical Assistance Center for Children's Mental Health; Johns Hopkins University, Women's and Children's Health Policy Center; Portland State University, Research and Training Center on Family Support and Children's Mental Health.
- Johnston, K. & Brinamen, C. (2006). Mental health consultation in child care: Transforming relationships among directors, staff, and families. Washington, DC: Zero to Three Press.
- Maryland State Department of Education (MSDE). (2009). Fact Sheet on the Maryland Model for School Readiness. Retrieved August 3, 2009, <http://mdk12.org/instruction/ensure/MMSR/MMSRFA1.html>
- The Minnesota Association for Infant & Early Childhood Mental Health (MAIECMH) (2009). Best practice guidelines for reflective supervision/consultation. Retrieved June 8, 2009, www.rccmhc.org/resource_files/2009.03.25.BEST%20PRACTICE%20GUIDELINES%20FOR.pdf

- The National Association for the Education of Young Children (NAEYC) (2005). Code of ethical conduct and statement of commitment. Retrieved July 6, 2009, <http://208.118.177.216/about/positions/pdf/PSETH05.pdf>
- The Office of Head Start, US Department of Health and Human Services, Administration for Children and Families (2009). Competency goals and indicators for Head Start staff working with families. Retrieved July 6, 2009, http://eclkc.ohs.acf.hhs.gov/hslc/Family%20and%20Community%20Partnerships/Family%20Services/Professional%20Development/famcom_ime_00059a1_062005.html
- Perry, D.F. (2005). Evaluation Results for the Early Childhood Mental Health Consultation Pilot Sites. Washington, DC: Georgetown University Center for Child & Human Development.
- Perry, D. F., Allen, M. D., Brennan, E. M., & Bradley, J. R. (2009) The evidence base for mental health consultation in early childhood settings: Research synthesis addressing children's behavioral outcomes. [manuscript under review]
- Perry, D. F., Kaufmann, R. F., & Knitzer, J. (2007). Social & emotional health in early childhood: Building bridges between services and families. Baltimore, MD: Paul H. Brookes Publishing Co.

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January 2011

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Acknowledgements

Many individuals across the state of Maryland committed to supporting the social and emotional health needs of young children within early care and education settings contributed to the development of this guide. It is with sincere gratitude that we extend a special thank you to the following individuals for sharing their extensive experience, expert opinions and resources related to early childhood mental health consultation:

- Paul Armstrong, Consultant, Project Wise Identification Now (WIN) -Prince George's Child Resource Center
- Maci Elkins, Program Manager, Lower Shore Early Intervention Project, Lower Shore Child Care Resource Center,
- Barbara Howard, Project Coordinator, Child Care Choices
- Sharon Huffman, Director, PROJECT ACT/Abilities Network
- Beth Molesworth, Program Manager, Montgomery County Department of Human Services, ECMH,
- Susan Patterson, Coordinator, Project Right Steps,
- Nancy Pelton, Project Manager, Early Intervention Project - Baltimore City Child Care Resource Center
- Siobhan Ponder, Executive Director, Southern Maryland Child Care Resource Center,
- Aimee Schlereth, Consultant, PROJECT ACT/Abilities Network,
- Sue Ann Stottlemyer, Consultant, Early Intervention Project - Baltimore City Child Care Resource Center
- Debbie Yare, Program Manager, Howard County Office of Children's Services-CARE Center

We also want to thank the Maryland State Department of Education, Division of Early Childhood Development, for providing leadership and funding for this project. In particular, we want to acknowledge the contributions of Dr. Rolf Grafwallner, Linda Zang and Tresa Hanna. Thanks also to Peg Anawalt at the Chesapeake Child Care Resource Center for her contributions to the content as well as her management of the project details.

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Introduction

The State of Maryland has a long standing commitment to ensuring the state's youngest children enter school ready to learn. Much of this work has been embodied in the comprehensive effort—the Maryland Model of School Readiness (MMSR)—led by the Maryland State Department of Education (MSDE). This initiative began in 2000 and has led to annual data collected in seven developmental domains that serves as a basis for tracking outcomes for young children in the state. The MMSR data derive from a specialized form of the Work Sampling System (WSS)—a portfolio-based assessment completed for all kindergarten children in the state during the first 8 weeks of every school year. The MMSR provides a research-based, strategic framework for collaboration of multiple stakeholders involved with getting young children ready to learn.

Social-emotional health is one of the most critical factors in a child's healthy development and readiness for school and life success. The MMSR describes personal and social development as “[a] child gets along with others; follows rules; and starts, works on, and finishes an activity” (MSDE, 2010, p. 6). Approximately one quarter of kindergarten children across the state were not “fully ready” for school in the social and personal domain. Moreover, the percentage of kindergartners not fully ready varies from county to county, ranging from 10% to 37%. There is also variation in young children’s early experiences based upon prior care, and these manifest in differences in their levels of readiness. (MMSR, 2009-2010). These data underscore that targeted supports to child care providers may help close the gap in young children arriving at kindergarten ready to succeed.

In Maryland, there are more than 22,000 children in out of home care; most of these children receive care from family child care providers and licensed child care facilities. (Maryland Family Network, 2010). Young children whose social skills are not well-developed, as well as those with behavioral challenges, are at high risk for expulsion. In the most recent survey of child care providers in Maryland, nearly two-thirds of center providers and 70% of family providers reported they had, at some time, expelled a child from their care (Maryland Family Network, 2010). Nationally, rates of

expulsion for preschool children are substantially higher than rates of expulsion in school-aged children (Gilliam, 2005). State-funded child care programs with access to a psychologist or social worker reported preschool expulsion rates almost half the number of those programs that lacked access to consultation services (Gilliam & Shahar, 2006).

Background on Early Childhood Mental Health Consultation

Early childhood mental health consultation has been described by Cohen and Kaufmann (2000; 2005) as an ongoing, collaborative relationship between a consultant with expertise in young children's social-emotional and behavioral development and an early care and education (ECE) professional or parent. Through consultation, the skills and knowledge of the ECE provider and/or family member are increased to better able them to implement evidence-based strategies for children in their care. Early childhood mental health consultation serves as an important resource for early care and education providers to: 1) nurture the social and emotional development of all young children within their care; (2) increase young children's access to early identification and intervention services needed to address social and emotional wellness and 3) ultimately, to help ameliorate expulsions and reduce problem behaviors in those children at highest risk.

A decade ago, early childhood mental health consultation was being implemented in several areas of Maryland. Concurrently, a group of state and local stakeholders who were concerned about young children's social and emotional well-being formed a state-level steering committee. This interagency group was co-chaired by Maryland State Department of Education and the Department of Health and Mental Hygiene: Dr. Carol Ann Heath, Assistant Superintendent of the Division of Special Education/Early Intervention Services and Dr. Al Zachik, Director of Child and Adolescent Services, Department of Health and Mental Hygiene has led this group for the past 10 years. One of the early goals of the Early Childhood Mental Health Steering Committee was to expand the availability of mental health consultation to more regions of the state. Through funding made available by the State Child Care Administrator two pilot sites

were established in 2002 and an external evaluation of these projects was mandated by Maryland's legislature. Three years later, an evaluation report was presented to the Executive and Legislative branches—as required through HB 360.

The results from the pilot sites were encouraging: only two children who were provided child-specific consultation were expelled from their child care programs. Gains were made in social skills for children who had been referred for services—many of whom were quite delayed in this area. Reductions were seen in levels of problem behaviors in the majority of the children; aggression and oppositional behaviors were among the more common presenting concerns for children referred for services. Improvements in the quality of the child care programs were also evidenced, suggesting that the consultation had affected many more children than just those who received child-specific services (Perry, 2005). These results contributed to the decision to allocate nearly \$2 million in state general revenues to expand the early childhood mental health project across the state.

At the same time, the Maryland State Department of Education was selected as a state partner in the national Center for Social Emotional Foundations for Early Learning (CSEFEL) project. This effort was a collaboration of the U.S. Department of Health and Human Services Office of Head Start and Office of Child Care. The purpose of this initiative was to disseminate a research-based model for promoting social-emotional development and reducing behavior problems—the Teaching Pyramid—to early care and education settings such as public and private preschool and pre-kindergarten programs, child care programs, and Head Start programs. A state-level team, which was a sub-group of the ECMH Steering Committee, guided the selection of 4 demonstration sites across the state representing rural and urban populations. Intensive training of approximately 350 early care and education trainers was further supported by the development of local coaches to encourage high fidelity implementation. The demonstration sites received additional technical assistance and training from the state team and from representatives of the Center for Social and

Emotional Foundations for Early Learning, including leadership institutes and on-site monitoring visits to facilitate continued implementation and sustainability efforts.

The ECMH Steering Committee spearheads other efforts to support the development of a comprehensive approach to promoting young children's social and emotional development. Faculty at the University of Maryland's Innovations Institute developed an early childhood mental health certificate program to provide in depth training for mental health professionals. They trained over 121 individuals who had at least a master's degree, but lacked formal training in infant and early childhood mental health. Recently, UMD expanded their training to include bachelor and master-prepared individuals who are currently serving as consultants in the ECMH projects in Maryland. In addition, the ECMH Steering Committee members participate in Maryland's Blueprint for Children's Mental Health, Evidence-based Practices and Workforce Development Committees to build awareness and advocate across systems to incorporate the needs of young children and their families into policy and program planning and to increase access to effective early interventions.

Development of Research-based Standards for ECMHC

When the ECMH Project was expanded with state general revenues to the entire state, guidance to the newly funded sites was provided in the Request for Proposals (RFP). The applicants were given a detailed description of the key elements of the pilot sites and peer-to-peer technical assistance was provided by the programs that had already been in operation. Twelve ECMH projects were funded in 2006. Many of these projects were funded in the Child Care Resource and Referral agencies, following the models in both pilot sites. In several areas of the state, another lead agency was funded to implement the ECMH project; typically, these agencies had experience with consultation models prior to the RFP. A listing of the project sites and their location is available in Appendix C.

Over the first two-year cycle of funding, MSDE sought to build a state-level infrastructure to support the 12 regional ECMH projects. Recognizing the diversity in

levels of need, access to mental health resources and personnel, as well as the state's history of county-level autonomy, the decision was made to develop a set of program standards that could accommodate these factors. The Maryland State Department of Education (MSDE) contracted with Georgetown University Center for Child and Human Development to develop a set of research-based ECMHC standards. The standards were written in collaboration with stakeholders from the 12 state-funded ECMHC projects, as well as representatives from the Maryland State Department of Education. The content for the standards was drawn from a recently completed national study of effective ECMHC programs across the United States (Duran, et al. 2009). The standards were finalized and approved in October of 2009.

The standards set the stage for the development of a detailed implementation guide to ensure the highest quality ECMHC services were available throughout the state. This companion guide was developed to: 1) help ECMHC programs have a better understanding of the standards and 2) put into place services that are based on research and best practices. This companion guide can help the ECMHC programs ensure services are well organized, high-quality, stable and accessible for families and ECE providers. The growing body of research on ECMHC practice makes it clear that programs of high quality are imperative to assuring positive outcomes for children, their families and early care and education providers. This guide is intended to help ensure that ECMH projects are better able to implement the standards and provide a high level of excellence in their services.

How to Use This Guide

This guide has two main sections related to the standards: Part I: High Quality Consultation Services and Part II: Program-level Infrastructure. These two sections contain the standards which support them. Each individual standard is followed by: 1) research-based rationale supporting the need for the standard, 2) guidance that ECMHC program staff can use to help support quality practices related to the standard, and 3) self-assessment indicators that ECMHC programs can use to reflect on areas of strength and areas in which the program might benefit from enhancements.

Appendix A and B include supplemental forms and documents referenced throughout the guidance portions of Part I & II, that tie into the standards. ECMHC program staff may find these documents useful in supporting their work.

The glossary at the end of this guide provides guidance on some of the more particular terms used throughout this document.

The reference section includes the sources used to complete this guide. For those who would like a more in-depth look at research related to ECMHC it also provides an avenue for pursuing further investigation.

When the *Early Childhood Mental Health Consultation (ECMHC) Guide: Standards, Rationale, and Guidance* is implemented and used in its entirety; it is believed that ECMHC programs will further enhance their services, reaching an even higher level of quality, in turn helping children within ECE programs to reach their highest potential.

Part 1: High Quality Consultation Services

Section A. Fostering Relationships Through Consultation with Early Care and Education (ECE) Providers

1. ECMHC Projects Must Describe the Scope of Their Services and Establish Mutually Agreed upon Expectations with The Early Care and Education Site Director and Providers when Services Are Initiated.

Rationale: Carefully describing what it is a consultant will be able to do within an ECE program and reflecting with ECE staff on expectations for service is a critical first step in beginning quality consultation services. These initial discussions can be the foundation for developing strong relationships from which consultation can grow and thrive.

Consultation is different from traditional therapeutic services. The consultant takes on a partnership role, and the impact of consultation to both staff and families can build capacity to problem solve and change practices in the handling of challenges with young children. Developing a clear, flexible and mutually agreed upon understanding of early childhood mental health consultation (ECMHC) upfront allows for a higher level of investment and follow through later from all involved. This initial exchange sets the stage for how consultation will move forward. As Johnston and Brinamen (2006) state, "*The way in which we enter a child-care program will have lasting effects on a program's receptivity to and understanding of consultation*" (p. 38).

Guidance: The onset of ECMHC services is a critical time for consultants to begin to establish their role in the consultation process. A consultant entering a new ECE program is an unknown entity. Providers may feel apprehensive about the consultant's presence, based on lack of knowledge of the consultation process and the consultant's role. This common situation is one reason for the skillful application of relationship-based practice.

Consultants may choose to use multiple methods to describe to the ECE director and staff what ECMHC services are available to the ECE program and how these services are typically delivered. One method is to have an initial meeting with the director and staff to explain services with a written brochure. The consultant can begin

by meeting with the director and staff to discuss their concerns. As this sharing occurs and the consultant responds with supportive, encouraging statements, the relationship begins to take shape. The consultant then must clarify the roles of all involved in this process and establish the expectations of the consulting process.

As a written tool, a brochure is most helpful for a consultant. Often the services described in a typical ECMHC program would include:

- Child/family-centered consultation (to include family support within the home)
- Programmatic consultation
- Training topics available to ECE staff and families related to social and emotional health (e.g. attachment, temperament, behavioral concerns and strategies, etc.)
- And other services that may be unique to the program providing ECMHC services.

The consultant may make a phone call to the ECE director after the initial meeting for any follow up questions or concerns. Although an initial meeting is optimal, a consultant may schedule a phone call as an initial contact to review the scope of service with the director. This can be followed by a written statement and brochure for the director to share with staff. A third option would be a scheduled staff training, with the ECE director and consultant using the opportunity to discuss the ECHMC program services with ECE staff and families.

The next step in the consulting process is for the consultant to have additional meetings with the director and staff regarding the upcoming ECMHC services and their roles in the consultation process. The ECMHC consultant serves as a facilitator in building the capacity of the ECE staff to understand, recognize and nurture the social and emotional well-being of young children within their care setting. In Maryland, an ECMHC program on the Lower Shore developed a simple one page list describing what the consultant will do and what they don't do. This list is included in Appendix A (document #1). In addition, some programs may also want to set some parameters up front about the role of the ECE program and staff.

Some examples of responsibilities of ECE programs and staff may include:

1. Maintaining the confidentiality of the children and families receiving services.
2. Providing ECE space and /or rooms for observation by the consultant.
3. Being available for phone or personal consultations, including parent-provider meetings, if applicable.
4. Contacting the consultant if it is necessary to cancel observations or meetings.
5. Implementing those strategies agreed upon and written into a plan of action, if applicable.

Some ECMHC programs create a more formalized memorandum of understanding (MOU) at the onset of services that is signed by the ECE director. This memorandum, in most cases, clearly explains the scope of services provided and may additionally explain the roles of the consultant, the ECE provider and program staff. Two examples of agreement forms are located in Appendix A. One is a MOU from an ECMHC program on the Lower Shore (document #2) and the other is the *CCEP Child Care Agreement to Participate* (document #3) from a Michigan ECMHC program.

When the scope of services and roles are defined, the consultant may have additional meetings with the director and staff regarding their concerns and expectations for the upcoming ECMHC services. The consultant needs to understand the ECE program's philosophy, values and approach for a successful consulting relationship. This reflective dialogue can allow a consultant to better understand a program's readiness for change. The following are some indicators to assist in determining ECE program readiness:

- Does the program embrace a mental health perspective (e.g. does staff believe social-emotional skills are important?)
- Is there any stigma associated with participation in a mental health program?
- Is there openness to gaining new knowledge?
- What is the quality of the early childhood program?
- How does staff explain the situation that prompted consultation?

Carefully exploring initial expectations with ECE program staff is essential. If not clarified, the consultant and ECE program staff may walk away with differing views of how services will progress. Below is an example of a conversation regarding expectations between an ECMH consultant and an ECE program director:

Consultant: "Ms. Johnson, now that we have spent some time discussing the ECMHC services that can be offered to your program, I wanted to hear from you and the other staff about what you are hoping and expecting from these services. "

ECE Director: "Well, from my point of view, I am hoping that you can come regularly to help the teachers learn new ways to help children who are struggling with some behavior problems."

Consultant: "I see. As we discussed earlier, this is called a 'child-/family-centered consultation' and we will need the consent of families. We can talk more about this when I come back next week. Also, if you remember my role will be to help the teachers to use new strategies. I won't be working one-on-one with the children, but will provide support to the staff to implement new strategies."

ECE Director: "Also, some of the teachers seem to be feeling overwhelmed. I liked the idea of your providing time for them to meet with you during break times to discuss their feelings. This might also help morale."

Consultant: "Group consultation is part of what I can offer through ECMHC consultation. I often visit ECE programs once per week for approximately 2-3 hours per visit. I like to vary the days to get a good idea of how different teachers work and to ensure I meet all of the families. How does that sound to you?"

ECE Director: "That sounds fine but I would like to schedule your visits a few months in advance. We often have field trips or staff development days. How long did you say consultation might last?"

Consultant: "Typically, 3-6 months depending on the situation. We had discussed that we would put together a more formal plan for my services to your ECE program. Once those goals are met, if everyone is in agreement, consultation can begin to wind down

and we can begin our discussion of my transitioning out of the consultation. Remember, consultation is always optional.”

The following table can be used by a consultant to help guide the meeting in which the scope of services, roles and expectations are discussed.

Table 1. ECE Program Meeting Guide

Topic to Discuss	By Whom	Achieved Yes/No
1. Identify ECMHC services available	Consultant	
2. Define nature/philosophy of ECMHC	Consultant	
3. Reach consensus about consultant's roles and responsibilities	Program and Consultant	
4. Explore match between ECE program needs/beliefs and consultant needs/beliefs	Program and Consultant	
5. Define expectations for consultation	Program and Consultant	
6. Identify continuous feedback loop	Program and consultant	

Self assessment indicators for Standard A. 1

1. ECMHC program describes methods for defining ECMHC services, roles and expectations to ECE providers.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMHC programs have clear written program materials outlining services available.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

2. ECMHC Services are Informed by Systematic Observations of Children Conducted by Mental Health Consultants (MHCs) Across Relevant Contexts in ECE Classrooms and Family Day Care Settings.

Rationale: Early childhood mental health consultation is grounded in a mental health perspective that enables consultants to look at the behavior of children and the adults who care for them through the context of their relationships and the environment in which they function. As Johnston and Brinamen (2006) state, "*observation is an awareness of all component's of a program's functioning*" (pg 78). Observation is a method to help consultants collect unbiased and concrete information regarding behavior and is a critical part of the early childhood mental health consultant's role. This information can help to guide future ECMHC work within an ECE program as it brings clarity and direction to the assessment process.

Guidance: After ECMH consultation is initiated, one of the first stages of the consultation process involves observing children, adults and the environment in order to gather information for future planning. It is common for child care providers to want immediate answers from the consultant. The consultant must explain the observation process before any conclusions are made. At the same time, it is important that the consultant listens to and validates the feelings of concern, urgency, and frustration that the caregivers may be experiencing.

Consultants begin their observations by informally observing the environment as they enter an ECE setting. However, it is important for more formalized observations to also occur. Although the formal observation is ongoing throughout the consultation process, it is utilized most intensively at the outset to help guide the planning process. Observation involves a simple reporting of behavior or interactions without any particular meaning or interpretation attached.

Consultants take time to write notes on what they "see" and "hear" -leaving hypothesis or judgment statements out of the observation. Consultants typically use a variety of methods for completing observation. For example, they may carry a notebook to take running record observations, use a hand held voice recorder to record observations, or use standard observation forms. Most standard forms for observation include:

- The date
- The time
- The person observing
- The location
- A full summary of a span of time that includes a complete activity from beginning to end.

It must be noted that if a child has been referred for child/family centered consultation, the ECE program must have a "consent for services" document signed by the family before the observation even begins. Two sample consent or authorization for services forms are located in Appendix A (documents #4 & 5). The Maryland Family Network uses a standard form for observations in all of their ECE programs across the state. This form is located in Appendix A (document #6). Although methods for observing may differ, the process itself should be a mainstay of any quality ECMHC program.

Figure 1. Sample Child Observation

Date: 6/9/2008

Child: Marcelo, 36 months

Person observing: Ms. Kala

Time: 10:00 to 10:05 (Large Group time)

Others present: Ms. Jensen and Sara, Adam, Tanisha, James, Jose, Julie, Adam and Deb.

Marcelo dances and sings “Head, shoulders, knees and toes” with the other children and Ms. Kala. After the song finishes, Ms. Kala asks, “Who has another song?” Marcelo says, “Old McDonald!” The other children give other choices. Ms. Kala says, “Okay, let’s sing “Wheels on the bus.” Marcelo says, “No, No, No!” Ms. Kala starts to sing “Wheels on the bus.” Marcelo reaches to the child next to him and grasps onto her arm. Ms. Kala stops singing and says, “Marcelo, go sit by Ms. Jensen.” Marcelo walks over to Ms. Jensen and sits in her lap. Ms. Jensen puts her arms around him. Marcelo leans into her and smiles. After the song finishes, Ms. Kala says, “Marcelo, thanks for raising your hand.” Marcelo says, “Old McDonald.” Ms. Kala says, “Okay everyone let’s sing Old Mc Donald together.” Marcelo begins to sing.

When observing, some additional things that a consultant may consider are:

- **Providing visits to the site on a regularly scheduled basis to observe.**

Scheduling visits are based on need. Since every situation is different, there is usually no prescribed number of visits or length of time to complete the observation process. It is generally recommended that visits occur from one to several times weekly and should be varied from the morning to afternoon in order to develop a thorough picture of the program or classroom. However, it is the continuity of

regularly scheduled visits that builds a trusting relationship between parties and is the foundation for successfully working together.

- **Having conversations with providers and parents to gather information about the program's strengths, structure and current concerns.** The consultant interviews providers and parents to learn about the reasons for the requested consultation, strategies that have already been tried, previous consultation services, the program's strengths and needs, and what the director and staff are hoping to achieve.
- **Providing ECE providers with information to help families understand who the consultant is and what he/she is doing for the program.** Many times family members are curious as to why the consultant is on site, so some providers send home a letter explaining that the consultant is there to help build social and emotional quality. See a sample letter that ECMHC programs may use with families in Appendix A (document #7) titled: *Introducing CCEP Services to All Families in Your Care.*
- **Observation at the site by the consultant.** Ideally, the consultant works to blend into the environment, so that the observation is as objective as possible. However, often observation in a child care setting is not predictable. A consultant may need to lend a hand to a child who asks for a Kleenex or for a shoe to be tied, or to smile at a baby who is nearby. The consultant must be adaptable, and trust that the observations will not be unduly compromised as a result.

The mental health consultant will be able to use the information from the observations in combination with what has already been gathered through interviews and other means to informally assess how the child or children are doing with regard to social emotional development. Consultants should create a means of sharing observation information with ECE providers. Prior to the official planning meeting, the consultant may informally talk with the ECE provider to share some of the things observed.

Following the formal observations, a meeting should be scheduled with the appropriate attendees (e.g. family, ECE provider, director, consultant etc.) to evaluate

the possible meaning of behavior and interpretations. This systematic process of observation should, “tell a story from beginning to end.”

Self assessment indicators for Standard A. 2

1. The ECMHC program uses a scientifically valid method for observing children.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC program identifies a specific tool or form to record observations.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
3. The ECMHC program identifies how observations are linked to the development of individualized service plans.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

3. Systematic Assessments of the Quality of the ECE Environment Will Measure Structural, Social-Emotional and Relational, and Programmatic Features. For Example, MHCs Should Attend to Staff-Child Ratios, the Emotional Climate of ECE Settings, and How Transitions Between Activities are Managed.

Rationale: Research shows that effective ECE programs that address social-emotional health early in life can promote resilience and actually prevent social-emotional and behavioral problems later in life (Isakson, Higgins & Cooper, 2009). An important factor in supporting quality care environments for young children is being able to carefully assess all of the parameters of the environment that might impact a child's ability to express and regulate emotions, explore and learn and engage in behavior that leads to healthy attachment. Assessment allows the consultant an objective “snapshot” of environmental influences that support or impede the well-being of children in care and the adults who care for them (Mackrain and Marciniak, 2007).

Guidance: There are several tools that can support ECMH consultants to systematically assess the ECE program environment. Maryland has invested in the implementation of the Teaching Pyramid Model developed by the Center for Social and Emotional Foundations for Early Learning (CSEFEL, 2008). CSEFEL provides tools to systematically collect information on a program's practices. For infant and toddler settings that are implementing this model there is the Teaching Pyramid Infant Toddler Observation Scale (TPITOS) and for preschool settings there is the Teaching Pyramid Observation Tool (TPOT). Links to both of these tools can be found in Table 3, “Promotion Strategies and Tools” on page 37. These tools are most appropriate for child care programs that have been trained in SEFEL and where they are seeking to implement the Teaching Pyramid with a high degree of fidelity.

Other tools that may be relevant for assessing the quality of the early childhood program environment are: the Early Childhood Rating Scales, completed by raters reliable in the scales, including the ECERS-R,(Preschool) (Harms, T., Clifford, R.M., & Cryer, D. 2004), ITERS-R,(Infant and Toddlers) (Harms, T., Cryer, D. & Clifford, R.M., 2006), FCCERS-R, (Family Child Care),(Harms, T., Cryer, D. & Clifford, R.M., 2007),

SACERS, (School Age) (Harms, T., Jacobs, E.V., & White, D.R., 1995) and the CLASS (Pianta, 2007). The latter is being implemented in Head Start programs across the country. Finally, the Preschool Mental Health Climate Scale (PMHCS; Gilliam, undated) has been used in the Maryland ECMHC Evaluation protocol to assess classrooms receiving consultation.

Like observation, program assessment should be an ongoing process. Typically, when formal tools such as the TPOT are used, assessment will happen two to three times per year by the professional who is coaching those teachers in the Teaching Pyramid. It is recommended that the first ECMHC assessment happen within the first 30-60 days of the onset of consultation. If the ECMH consultant is also the Teaching Pyramid coach, then the TPOT or TPITOS may be the best tool to use. Otherwise, the consultant should use a tool that will help guide the development of an individualized plan for this teacher. Several observations of up to three hours are recommended for the use of the PMHCS, ECERS and the CLASS. This allows time for ample observation. There are many factors that a consultant will be observing related to the ECE program, including:

- How ECE program staff partner with families? For example, is there an open door policy?
- Activities and experiences - do children get an opportunity to run, relax, play and read?
- Routines and transitions- is there a flexible yet predictable daily schedule?
- The care-giving climate - is the provider nurturing and supportive? Are children making friends? What does it feel like to be a child in this care setting?
- The physical environment -are there enough adults to safely care for children? Is the room safe? Are there enough toys?

This information is collected over time during the consultation period. It is important for the consultant to keep the ECE staff apprised of all of the observation data to make sure that every step of the process enhances the partnership between the

consultant and the ECE staff. The consultant continues to model the behavior they would like to see the ECE staff use with the children and families: nurturing, respectful and consistent. When meeting with the ECE staff, the consultants need to fill in any gaps that the observations reveal. When a complete assessment is reached, it is important for the consultant to schedule a meeting with the ECE director and staff to give thorough feedback on the information collected. This meeting will identify both strengths and areas for growth, and put any plans into place, together with the ECE staff, that may be necessary to improve overall quality of the ECE program. This step is discussed in detail in Section A, Standard 4.

Self assessment indicators for Standard A. 3

1. The ECMHC program describes the tool(s) used to conduct ongoing ECE program assessment.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC program describes methods used by consultants to provide periodic feedback to the ECE staff on programmatic assessment.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

4. Early Childhood MHCs Should Collaborate With ECE Providers to Formulate a Plan That Will Guide the Content of the Consultative Services. The Plan Should Be Discussed With the ECE Team.

Rationale: Promoting and maintaining social and emotional wellbeing in young children requires a universal approach directed to all young children and their families. The development of a plan to guide the ECMHC services within the ECE program is a necessity. Ensuring that all young children are mentally healthy requires that the adults who provide early care and education understand what social emotional development is and what they can do to support it.

Guidance: The planning process is highly interactive when the development of the plan is completed during a meeting. No one person typically completes a draft of a plan. The composition should be done together with at least the ECMHC and the Director and anyone else involved. The role of the consultant is to serve as the facilitator, offering a framework of trust and support as the ECE team discusses the observation and assessment results and then generates action goals and strategies for the ECE program. Specifically, during the meeting some things the consultant may be responsible for include:

- a. Setting a positive, collaborative tone.
- b. Facilitating the discussion, allowing for all ideas to be heard.
- c. Providing a brief overview of the planning process and the planning form being used, explaining that:
 - 1) Although the consultant will help facilitate the development of the plan, the plan ultimately belongs to the director and staff. The ECE program has the final say about which goals, strategies and ECMHC services will be included.
 - 2) It may take more than one meeting to complete the plan.

(Two sample planning forms can be found in Appendix A, documents #8 & 9).

- d. Clearly describing findings derived from interviews, direct observations, reflective checklists, assessment tools, etc., highlighting both strengths and areas of potential growth.
- e. Ensuring that the team has ample time to ask questions about and comment on the findings.
- f. Reminding the team of the service array available to them through the ECMHC program. Baltimore City Child Care Resource Center and Montgomery County's Help Me Grow program have sample partnership agreements that can be found in Appendix A (documents #10 & 11).
- g. Assisting the team to brainstorm potential action goals and strategies.
- h. Suggesting potential goals and strategies (i.e. how frequently will the consultant visit), along with other team members.
- i. Assisting the team to prioritize goals and strategies.
- j. Negotiating agreements among team members when there are differences of opinion about goals and strategies; facilitates a problem-solving process when barriers to action are identified.
- k. Striving to be objective and refrains from taking sides.
- l. Keeping the focus on the task at hand; does not allow the conversation to stray too far off point.

(Adapted from CCEP, Chapter 6, Mackrain and Marciniak, 2007, pg 8)

Before ending the meeting, the consultant may consider reflecting with participants on the following points:

1. It will take time for the strategies identified in the plan to work. There are no "instant fixes."
2. The plan is a "flexible" document and may need to be revised more than once "until we get it right."
3. Sometimes challenging behavior may get worse before it gets better.
4. Continuity (providers and parents using the same strategies) and consistency (using the strategies at every opportunity) are key elements in implementing the plan.

After the meeting concludes the consultant may ask for feedback on the meeting and then use feedback to improve future meetings. Another important task will be to complete the plan and distribute copies to all team members and families when appropriate. It is very important for the plan to be dispersed among all involved in the ECE program so that there is a clear understanding for implementation.

Self assessment indicators for Standard A. 4

<p>1. ECMH consultant describes methods for ECE plan development (i.e. written protocol, sample forms, etc).</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. ECMH consultant describes methods used to share plans with ECE providers (teachers and directors) and families.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

5. Due to the Dynamic Nature of Collaborative Plans, Early Childhood MHCs Should Work With ECE Provider's Over Time to Evaluate the Efficacy of Interventions and Make Modifications as Needed.

Rationale: Evaluation is a critical tool in the process of early childhood mental health consultation. Using processes to investigate how interventions are working and modifying as needed, leads to better outcomes for children and families. When processes are put into place early on for evaluating agreed upon goals and strategies, all parties gain critical information that helps to drive future practices. It can also assess whether the current consultation model is working or not and how it can be improved to heighten the program's positive impact (Duran et al., 2009).

Guidance: Ongoing evaluation can help consultants to look at the strengths and barriers that may exist with implementation of the plan. Once the ECMHC plan is developed within an ECE program, the consultant usually provides consistent support for the parents and providers, assisting them to take action on the strategies that they agreed to implement. There needs to be a flexible approach to implementing the plan, and changes to the plan should be expected. Types of support typically provided by the consultant include the following:

1. Regular visits to the ECE program to:
 - a. Continue observations of the children and program.
 - b. Provide support for staff as they change their perspectives and learn to implement new strategies, always building on their strengths (e.g., engage staff in reflective discussions, role-play new skills with staff, provide feedback for staff as they practice new skills, provide emotional support for staff, etc.)
 - c. Provide materials or information on how to access resources.
 - d. Address any questions or concerns.
 - e. Assist with problem-solving as significant issues arise.

On average, in nationally recognized ECMHC programs, frequency and duration of visits vary depending on the situation as well as any already established partnership

agreement. On average consultants were found to visit programs from 3-6 months, and visit once per week (Duran, et. al, 2009).

As consultants work with ECE programs, there are many ways in which the efficacy of interventions can be evaluated. Typically, through regular conversations, the consultant and ECE staff will determine:

- The degree to which goals are being met
- The degree to which strategies are working
- The degree to which the plan is being implemented

Consultants collecting the information need to make these determinations using a variety of approaches and tools. Several key strategies are:

- **Observation**- Ongoing recording of what the consultant sees and hears to provide concrete data for how things are progressing.
- **Conversation and Feedback**- The consultant, during visits to the ECE program can engage in regular verbal exchanges with pertinent staff and families to ascertain how things are going, for example, *“Tell me how the visual schedule is working in your classroom?”* or *“How is the family communication board working?- do you feel you are better informed on your child’s day?”*
- **Use of Formalized Tools and Measures**- Plans for ECE programs can end up being quite complex, sometimes looking at individual child goals as well as program goals. Formal tools can be useful to measure ongoing changes over time. For children, this might be standardized, reliable and valid social-emotional assessment tools. For ECE programs, it might be the Teaching Pyramid Observation Tool (TPOT) or the Teaching Pyramid Infant and Toddler Observation Scale (TPITOS) to look at overall quality and fidelity to the Teaching Pyramid practices.

Consultants can set up regular "check in" meetings with the ECE director, staff and families when appropriate to share information gathered and to discuss whether or not interventions are effective or need to be revised. After further investigation, new issues arise and may need to be addressed. Perhaps, initial ideas are not being implemented and need to be amended, or the interventions are not working and need to be changed. In addition, unforeseen barriers may get in the way of progress as well, such as habits that are difficult to change and staff overload.

Sometimes adults are used to operating a certain way and find it difficult to change. For example, a provider may be used to having a free flowing daily schedule with little routine. Implementing a flexible, yet predictable schedule may be quite challenging without ample time and support for change. ECE staff often fill multiple roles and many times have families of their own with young children. These multiple roles and responsibilities can leave ECE providers feeling overwhelmed which can make follow through that much harder. Consultants should work with the ECE directors to ensure that the necessary support to staff is provided as they seek to implement new strategies in their classrooms.

Regular meetings can help to address these types of barriers before they interfere with the successful implementation of new strategies. Careful evaluation is the key to supporting ongoing, sustainable outcomes.

Self assessment indicators for Standard A. 5

1. ECMHC program describe processes, methods and tools used to measure intervention progress for children and ECE programs.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMHC program has procedures in place to provide feedback to teachers, directors and families as they implement new strategies.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

6. Consultants will Foster the ECE Providers' Use of Norm or Criterion Referenced Instruments to Screen Children's Social Emotional Development.

Rationale: Screening of social-emotional health is a key component of ECMHC promotion efforts. Screening instruments typically provide brief and general information designed to identify children that need more thorough and detailed assessment. If a young child is screened and determined to meet the criteria to enter services, the child would then be referred for an assessment, or possible immediate intervention if warranted. Research supports the notion that the earlier professionals and families intervene on behalf of young children the more positive the outcome may be. The use of high quality, developmentally appropriate screening and assessment tools for young children are necessary to enable providers to identify need and provide effective interventions for young children and families (Cohen et al., 2005).

Using instruments which focus on the social-emotional domain are imperative. Often times, general developmental screening and assessment instruments are not sensitive enough to measure the nuances of social-emotional and behavioral health of children birth to age five. Relying solely on general developmental instruments, children challenged with social and emotional health needs can often be overlooked. Screening all children for social and emotional well-being helps to build knowledge in the workforce and in families of behaviors associated with children's healthy social-emotional development. ECMH consultants can provide advocacy for 1) the importance of screening for social-emotional health within ECE programs and 2) for the use of tools with psychometric quality yielding meaningful results.

Guidance: When working with ECE programs and families to incorporate the use of high quality tools that screen for social and emotional well-being, it is important for ECMH consultants to:

- consider the differences between screening and assessment instruments
- consider the characteristics of the tools (e.g. psychometrics, cost, standardization, etc.) to support a good fit for the ECE program and families
- be prepared to share results with ECE providers and families using a strength based approach.

The screening process helps an individual reflect whether development is progressing typically or if there is cause for concern. Screening instruments are not designed to provide detailed description of developmental functioning or to design intervention strategies. An assessment is a more comprehensive process and one that ensures the inclusion of the family by evaluating the strengths of the young child and her family. The assessment usually takes place after screening and requires specialized mental health credentials and training. See Table 2 for more information on the differences between screening and assessment.

Table 2. Screening and Assessment Comparison

SCREENING	ASSESSMENT
Provides a quick glimpse of health status.	Is a continual process of tracking progress.
Determines whether further evaluation is needed.	Is part of the evaluation process.
Does not lead to diagnosis or developmental conclusions.	Results are a piece of the process that leads to conclusions and services.
Bottom line: Screening is a snapshot.	Bottom line: Assessment is thorough and ongoing and can lead to a diagnosis.

There are many considerations that need to be thought out before choosing any instrument for use within ECE programs. Some common considerations include:

- Psychometrics:** Consultants may look at the psychometric properties of the tool to ensure that the instrument is reliable, valid and norm or criterion referenced. When an instrument is deemed "reliable" it means that the tool yields consistent scores across people who rate the child or over time. An instrument is considered reliable when the same results occur regardless of when the tool is administered or who does the scoring. There should be compelling evidence to show that results are consistent across raters and

across scoring events. Validity of an instrument indicates how well it actually measures what it is supposed to measure. Norm-referenced instruments are used to compare the performance of an individual child to that of same age peers and determine if a child has achieved mastery in a particular domain. These types of instruments have a standardized approach to administration thus increasing the reliability of results.

- **Cultural and linguistic appropriateness:** To be culturally and linguistically appropriate, assessments should take into consideration the family's level of acculturation and assimilation; their cultural world views on health/wellness, illness, and treatment; and their values, traditions, beliefs, rituals, and practices (Bennett, et. al, 2001). In addition, whenever possible, assessments should be conducted in the family's preferred language (or with a translator). The family's literacy level must be considered, and assessments read to family members who may not be able to read the items for themselves. Finally, assessments should be conducted in a setting where the child and family feel comfortable.
- **Cost:** Many ECE programs are reluctant to adopt the use of instruments that are very expensive. Additional considerations related to cost are: who pays for the tools (e.g., the ECE program or the ECMH project?) Once the tool has been purchased, are the instruments allowed to be reproduced?

The Technical Assistance Center on Social Emotional Intervention (TACSEI) website (<http://tacsei.org>) includes a link to a document titled *Screening for Social Emotional Concerns: Considerations in the Selection of Instruments* (Henderson & Strain, 2009). This document has been converted into an interactive, searchable data base available on the web at www.echmc.org. This document discusses key considerations for choosing instruments such as, "Does the tool support family involvement in the process?" and "Is it useful for the population served?" This resource also lists details about several screening and assessment tools such as the Ages and Stages Questionnaire: Social-Emotional (ASQ: SE) and the Devereux Early Childhood Assessment (DECA).

Another helpful resource on screening and assessment tools comes from the National Early Childhood Technical Assistance Center (NECTAC). NECTAC created a list of developmental screening and assessment instruments with an emphasis on social and emotional development that can be found by going to the website <http://www.nectac.org/~pdfs/pubs/screening.pdf>

The ECMH consultant can conduct or facilitate the screening process. Once the screening is completed, the consultant might want to consider how the information is disseminated to both teachers and families. Often times, those involved in caring for the child being screened will be anticipating the results. Consultants can decide the most effective way to convey the information based on what they already know about the ECE provider and families. Most often, results are disseminated during a meeting with both teacher and parent present. A helpful strategy for sharing results is to use a strength based approach. Starting out by discussing all of the strengths garnered from the instrument and other means such as observation and interviews, sets the tone for a more positive meeting. Following a discussion of the child and family's strengths, the consultant may then raise any specific areas of concern or needs for further evaluation. Typically, ECE programs are advised to use screening methods on an ongoing basis- optimally 2-3 times annually with all children in their care.

It is important to note that in most ECMHC programs, the consultant does not use the information gathered from screening and assessments to label or diagnose the child. ECMHC programs typically focus on early childhood mental health promotion and prevention, not mental health treatment. If the consultant suspects that the child has a significant mental health problem, the child may be referred to a mental health program for evaluation, diagnosis, and treatment.

Self assessment indicators for Standard A. 6

<p>1. The screening tools recommended for use within the ECE program are norm or criterion referenced.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. The ECMH program documents their consideration about the match between the cultural, linguistic and economic diversity of the children and families when tools were selected.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

7. Consultants Model and/or Train ECE Staff on the Systematic Implementation of Evidence-Based Strategies That Target Positive Social/Emotional Development and Address Challenging Behaviors in Children, Contribute to Staff Wellness, Promote Team Building, and Facilitate Communication Between Staff and Families.

Rationale: Providing information through modeling and training to ECE providers on practices that support the social and emotional well-being of young children is fundamental to quality consultation. Children in early care and education programs are better prepared for school when their teachers have higher levels of education and specialized training. Providers with specialized training are more likely to be nurturing, to reinforce early literacy skills, and to challenge and enhance children's learning (NACCRA, 2009 Fact Sheet).

ECMH consultants support ECE providers to systematically implement evidence-based strategies that promote all children's social and emotional health, prevent longer-term impacts of mental health issues for at-risk children, and address the needs of children already exhibiting challenging behavior. It is important for strategies to be evidence-based—which includes interventions that have gone through rigorous research studies as well as those with proven results through clinical experience (Buysse & Wesley, 2006). Using evidence-based strategies greatly increases the likelihood of positive outcomes for children, their families, and ECE providers. The systematic implementation of such strategies will allow ECE providers to have the full array of supports and strategies they need to help all children and families within their care.

It is critical for ECMH programs to develop a framework for disseminating evidence-based strategies. This will ensure that modeling and training by ECMH consultants prepares the early childhood workforce to understand and address the social and emotional needs of young children (Cimino et al., 2007). ECMH consultants who are prepared to model and train ECE providers on evidence-based strategies using a sound framework can facilitate capacity building and sustainable and measurable change in the practices of ECE providers over time.

Guidance: There are a growing number of evidence-based interventions for young children and families. Many of these can be found on the SAMHSA website under the National Registry for Evidence-based Programs and Practices (<http://www.nrepp.samhsa.gov>). In Maryland, policymakers have invested considerable resources in promoting the Pyramid Model (see Figure 2), developed by the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) and the Technical Assistance Center on Social and Emotional Intervention for Young Children (TACSEI). This model provides a comprehensive structure for delivering practices that promote positive behaviors and prevent or intervene on behalf of challenging behaviors. The first and broadest tier of the Pyramid Model focuses on the *promotion* of universal practices that support all children, including the provision of nurturing and responsive relationships and high-quality environments. The second tier of the pyramid concentrates on *prevention* by offering targeted social/emotional strategies to prevent child-related problems. Finally, the third tier addresses *treatment* of challenging behaviors by utilizing individualized intensive interventions. Consideration for some evidence-based strategies to apply to each tier will be addressed in the next few sections.

Figure 2. The Pyramid Model: Promoting Social Competence and Addressing Challenging Behavior



Nurturing and Responsive Relationships and High-Quality Supportive Environments (Promotion)

The consultant plays a key role in supporting positive relationships within ECE programs. A significant investment of time is required for the consultant to build trusting relationships with providers. In turn, the providers may develop more trusting, nurturing relationships with the children and families in their care. This process cannot be rushed. Until the relationship between the provider or parent and the consultant is on solid ground, the provider or parent may hesitate to use the consultant's suggestions and may be uncomfortable making suggestions of his or her own. The relationship-based consultant facilitates optimal interactions by mirroring the attributes that need to be fostered. Consultants may consider the following abilities pertinent to their relationship-based ECMH work:

- The ability to form an alliance with the family and provider on behalf of the child.
- The ability to demonstrate concern and empathy.
- The ability to observe ecologically (e.g. home, child care, etc.).
- The ability to listen carefully without interrupting.
- The ability to identify and build on the strengths of others.
- The ability to promote reflection (*"I wonder what Jonathon might be telling us?"*).
- The ability to be aware of how the values and attitudes of the family or provider differ from his or her own.
- The ability to be aware of the impact of interactions with a family member or provider.
- The ability to respect role boundaries.

The tools listed in Table 3 can help consultants working with an ECE program learn more about the relationships among adults and children in the program and about the supportive quality of the environment. Consultants can then use the information collected to plan and implement overall program improvements.

Table 3. Promotion Strategies and Tools

Strategy/Tool	Description
CSEFEL Inventory for Promoting Children's Social and Emotional Competence http://www.vanderbilt.edu/csefel/modules/module1/handout4.pdf	This preschool inventory is used to identify training needs and a course of action to address those needs within ECE programs. The inventory aligns with the Pyramid Model and specifically covers four general areas: 1) building positive relationships, 2) creating supportive environments, 3) social/emotional teaching strategies, and 4) individualized intensive interventions.
CSEFEL Infant and Toddler Responsive Routines Inventory http://www.vanderbilt.edu/csefel/resources/trainings/2.4.pdf	This infant and toddler inventory provides a way for ECE providers to reflect upon routines of daily care for infants and toddlers and to look for ways to support the social/emotional development of each child.
Devereux CARE Checklists http://www.devereux.org/site/DocServer/DECA-IT-ReplicablePlanningForms.pdf?docID=7741	The Devereux CARE Checklists offer providers a research-based approach to assess the social/emotional quality of the infant/toddler ECE care setting in four areas: 1) connecting with families, 2) activities and routines, 3) responsive caregiving, and 4) environment.
Teaching Pyramid Observation Tool (TPOT) for Preschool Classrooms http://www.cde.state.co.us/early/downloads/PBS/TPOT_Revised_02-08.pdf	A tool to assess a preschool program's fidelity to the Teaching Pyramid Model of practices.
The Pyramid Infant Toddler Observation Scale (TPITOS) http://www.pyramidplus.org/resources/ParentConferenceMaterials/documents/Building%20Community%20Capacity%20August/Infant%20Toddler%20Sessions%20August/Session%20I%20-%20Intro%20and%20Reflective%20Inventory/TPITOS_tool_March_06_09.doc	This instrument focuses on the direct observation of adult behaviors and environmental arrangements specific to supporting the social/emotional development of infants and toddlers within ECE programs.

Appendix A (document # 12) provides a sample action plan completed for an infant/toddler room based on consultant observation and Devereux CARE Checklists completed by the caregiver.

Targeted Social/Emotional Strategies to Prevent Child-Related Problems (Prevention)

Consultants can be a rich source of information for ECE providers working with children at risk of developing challenging behavior. Often they can provide guidance on appropriate community resources. For example, a child experiencing speech difficulties may need to be referred for further evaluation, or a family grappling with a death in the family may be paired with family counseling services. (For a more in-depth discussion on offering referrals, see Section A, standard 10.) Another important role of the consultant is to help identify which social/emotional skills need to be targeted for particular children and then to create learning opportunities to develop those target areas in partnership with ECE providers and families. Table 4 lists prevention-based strategies that can be helpful. Each strategy can be found on the CSEFEL website at this link: <http://www.vanderbilt.edu/csefel/resources/strategies.html>

Table 4. Prevention Strategies

Strategy	Description
Positive Feedback and Encouragement	Processes of letting children know what they are doing well by describing what you see as a result of their actions. <i>“You have really learned to use your words to tell me what you want.” “Excellent way to share the paint brushes!”</i>
Social Stories	Scripted stories describe a social situation and provide simple guidance on what the child needs to do and how actions affect others.
Book Nooks	Guides for ECE providers and families that provide simple and fun ways to embed social/emotional skill building activities into everyday routines using children’s books.
Turtle Technique-CSEFEL	The Turtle Technique is a strategy for helping children with controlling anger. This strategy can be used in conjunction with the scripted social story <i>Tucker Turtle Takes Time to Tuck and Think</i> .
Visual Supports and Cues	Picture cues that help a child to know what is coming next, understand a sequence, learn about feelings, and reconnect with families or familiar caregivers.

It is important to note that the social and emotional health of adult caregivers may place young children at risk for social/emotional problems (Perry & Kaufmann, 2009). Experienced consultants can pick up on the cues, both verbal and non-verbal, that may suggest a provider is experiencing mental health concerns. Consultants may also

choose to offer reflection tools such as the Devereux Adult Resilience Survey. This tool is filled out confidentially by the provider and can be used to build personal self-control and initiative skills, relationships, and positive internal beliefs. This survey can be downloaded at:

<http://www.devereux.org/site/DocServer/AdultResiliencyChecklist.pdf?docID=7401>.

Individualized Intensive Interventions (Treatment)

As promotion and prevention efforts are being implemented to support children's social and emotional growth and prevent challenging behavior, there are times when some children will need additional intervention supports due to persistent problem behavior(s). Each child has differing reasons for exhibiting challenging behavior based on their needs, wants, development, temperament and other life circumstances. Therefore, even though some behaviors may look similar (e.g. biting, kicking, throwing toys, etc.) each situation will need careful collaboration and investigation to best meet the needs of the child. ECMH consultants can help ECE providers and families to carefully gather information, synthesize it, and make a plan to support the child and family. One helpful approach is Positive Behavior Support (PBS). PBS is an evidence-based, proactive, team-based framework for preventing problem behavior, developing pro-social skills, and using data-based problem solving to address existing behavior concerns (Dunlap et al., 2008).

The Technical Assistance Center on Social Emotional Intervention for Young Children (TACSEI) offers a six-step plan for implementing PBS. These steps are followed in a designated order: 1) building a behavior support team, 2) person-centered planning, 3) functional behavioral assessment, 4) hypothesis development, 5) behavior support plan development, and 6) monitoring outcomes. A detailed and complete reference developed by TACSEI, which outlines the entire PBS process and a document outlining PBS that can be printed and taken on visits can be downloaded at: http://www.challengingbehavior.org/explore/pbs_docs/pbs_complete.doc

It is critical that the PBS framework or a similar process is used to clearly define, investigate and hypothesize the function of the behavior. The consultant, family and

ECE provider can brainstorm together strategies that best fit the child and the situation. When strategies are offered before the situation at hand is clearly understood, all those involved are at a greater risk of experiencing failure and frustration. Once the function or reason for the challenging behavior is identified, the team can brainstorm strategies to support the child from their own experiences and knowledge. Strategies used in the PBS behavior support plan are typically generated through ongoing discussion by the behavior support team and are culturally and developmentally appropriate for the child, family, and ECE provider. The strategies listed in Table 4 can also be instrumental individualized interventions for children to help with prevention of the challenging behavior and to teach new skills. Additionally, Georgetown University, Center for Child and Human Development, Center for Early Childhood Mental Health Consultation has adapted *Creating Teaching Tools* which includes practical strategies that come from research activities and experiences in Positive Behavior Support and that are known to be successful in helping young children with problem behavior. These resources can be found at: <http://www.ecmhc.org/TTYC/index.html> . Table 5 illustrates a sampling of strategies from the adapted *Creating Teaching Tools* Guide that consultants could model or facilitate teachers to use during daily routines if problem behavior occurs. The guide is much more comprehensive in nature and can be an instrumental tool for ECMH consultants within the child/family-centered consultation planning process.

Table 5. Sample of *Creating Teaching Tools* Intervention Strategies

Daily Routine	Reason for Problem Behavior	Prevention Tips	Possible Intervention Strategies
Circle Time	Child wants peer attention	<ul style="list-style-type: none"> • Allow child to take the lead in an activity • Let the child pick a friend to lead an activity • Model the behavior that you want to see 	Ignore inappropriate behavior Use simple verbal or visual reminders, <i>"First sit, then you choose."</i>
Art	Child does not like to get messy	Adapt materials for example, use glue sticks instead of paste, finger paint with spoons, allow children to wear gloves, etc.	Validate the child's feelings, for example, <i>"I see you are sad; you don't like getting messy; do you want help?"</i> Provide physical demonstration on how to use the materials
Outside Play	Child loves running and thinks outside means running away	Use a scripted story about staying safe outside. State when and where a child can run. State outside play expectations using visual cues if needed.	Remind child of outside boundaries, <i>"Remember we stay inside of the fenced area."</i> Prompt the child to play or stand near to the teacher.

Training and Modeling

ECMHC programs with consultants, well trained and experienced in applying evidence-based strategies, should consider how best to share that information in order to build provider capacity, through training and modeling. Training can be informal or formal and ECMH consultants often provide both types. Informal training generally occurs spontaneously, as situations arise in the course of working with a child/family or with an early childhood program. An experienced consultant might facilitate an impromptu discussion with staff about a child care topic recently in the media and then follow up with related articles for staff members to read. Informal training can be quite effective because it takes advantage of the “learning moment”—that exact instant when a learning opportunity naturally presents itself because the learner is so interested in and open to hearing the message.

Formal training involves a more systematic and carefully planned learning experience, which includes six phases:

1. Assess what knowledge and skills learners need to develop.
2. Design the training: Identify learning objectives, training methods for reaching the objectives, and means to evaluate whether the objectives have been reached.
3. Develop the training methods and materials.
4. Implement the training.
5. Evaluate whether objectives have been reached.
6. Evaluate learner satisfaction with the quality of the training methods.

To best meet the diverse needs of ECE providers, it is helpful to consider the following factors when planning formal training:

- The audience (Are the providers formal or informal?)
- Time the training is offered (What time is most convenient for the providers? Weekends? Evenings?)
- Location of training (Would more people participate if the training was held at a familiar community location such as a library?)

- Length of training (Would shorter evening sessions work best? Or perhaps lunch and learn sessions, etc.?)
- Incentives (Would participation increase if the trainer offered incentives such as food, books, child care, etc.?)
- Outreach (How will people know about the training?)

The Center on the Social and Emotional Foundations for Early Learning has developed training modules that can be used by ECMH consultants to train infant/toddler and preschool ECE providers. These modules can be found online at: http://www.vanderbilt.edu/csefel/resources/training_infant.html and http://www.vanderbilt.edu/csefel/resources/training_preschool.html.

Modeling is another effective approach consultants can use to transfer knowledge and application to ECE providers. Like training, modeling can be informal or formal in nature. If consultants engage in eye contact, have open body language, validate the other person's emotions, and reframe verbal feedback, they informally model active communication. If an ECE provider wants to use one of the prevention strategies learned in training, such as the Turtle Technique (CSEFEL), the consultant might formally model how to use the story and steps with a small group of children and then provide support to the ECE provider as she begins to use the strategy herself.

Self assessment indicators for Standard A. 7

1. ECMHC projects describe evidence-based strategies and materials that promote positive behaviors and prevent or intervene on behalf of challenging behaviors.	1=Not Met; 2=Partially Met; 3=Fully Met <u>1</u> <u>2</u> <u>3</u> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2. ECMHC projects describe the framework used to inform ECE providers about evidence-based strategies.	1=Not Met; 2=Partially Met; 3=Fully Met <u>1</u> <u>2</u> <u>3</u> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

8. Any Strategies ECMH Consultants Suggest Are Developmentally and Culturally Appropriate for the ECE Context and for the Child Identified for Child/Family-Centered Consultation.

Rationale: Over the past decade, the United States has seen an increase not only in the number of children served in ECE programs but also in the diversity of children, families, and staff. Variations in diversity span race, ethnicity, home language, and family structure. Today, 44% of all children are members of “minority groups.” By 2050, that figure will rise to 62% (NAEYC, 2009). Applying developmentally and culturally appropriate strategies ensures that learning experiences are meaningful, relevant, and respectful of children and their families.

Continuity between home and child care can be cultivated by adults who understand and respect families’ diverse cultural practices in the child care setting, and who have the skills to build upon them—even if they do not themselves share the families’ cultural or linguistic background (Chang, 1993). Children are rooted in their families. Gaining a clear understanding and respect for each family is critical to meeting each child’s needs and ultimately to making long-term, impactful, positive, change. As Copple and Bredekamp (2009) state, “When young children are in a group setting outside of the home, what makes sense to them, how they use language to

interact, and how they experience this new world depend on social and cultural contexts to which they are accustomed” (p. 10).

Guidance: Developmental appropriateness is based on research indicating that there are universal, predictable sequences of growth and change that occur in children. It is also based on awareness that each child is a unique person with an individual pattern and timing of growth impacted by individual personality, learning style, and family background (NAEYC, 2009). Cultural appropriateness recognizes the importance of understanding the social and cultural contexts in which children live—to include language, communications, beliefs, customs, practices, interactions, relationships, and behaviors (National Center for Cultural Competence, 2006). Knowing what strategies are developmentally and culturally appropriate for an ECE program and/or a child and family requires careful consideration of one’s own cultural beliefs and traditions, careful observation of children and adults across environments, and reflective dialogue with adults who care for children. Consultants who have an awareness of their own cultural views interact more effectively with children, families, and ECE providers because they have a better understanding of their attitudes, feelings, and behavior toward the diverse families and ECE providers supported through an ECMHC program. Having self-awareness of one’s own culture can help consultants better adapt to and respect diverse cultural practices.

Consultants may want to reflect on questions such as the following to learn more about their own beliefs and attitudes:

- What family traditions are important to me?
- How was I nurtured as a child?
- What was my family’s view on discipline?
- How did my family communicate?
- What developmental aspects are most important within my family (strong physical skill, language, cognitive skills, social skills, etc.)?
- How has my family culture changed over the years?
- What was my experience with the educational system?

- How do my religious and/or spiritual beliefs coincide with mental health practices?
- What do I believe my strengths are?
- What biases have I felt with regard to the cultural questions listed above?

One useful tool consultants can use to reflect on their practices within early childhood mental health is the Self-Assessment Checklist for Personnel Providing Behavioral Health Services to Children, Youth, and Their Families. This checklist was developed by Tawara D. Goode, with Georgetown University Center for Child & Human Development, and can be found at:

<http://nccc.georgetown.edu/documents/ChecklistBehavioralHealth.pdf>

Two additional self-assessment checklists for cultural and linguistic competence can be found on Georgetown University, Center for Child & Human Development, and Center for Early Childhood Mental Health Consultation's website at:

<http://www.ecmhc.org/assessment/admin.html> and

<http://www.ecmhc.org/assessment/staff.html>

Careful observation is important for gathering information about ECE programs, children, and families in order to create a clear understanding of their beliefs, skills, traditions, and family practices. This understanding helps ensure that the strategies consultants suggest are a good fit. Consultants should note what they see and hear while visiting a home or ECE setting to obtain pertinent, unbiased information. Consider the following example:

Miguel, Sara, and Tamika are sitting at a small group table. Ms. Susan puts some playdough, toy cars, and other toys on the table and says, "What are we going to make today?" She looks to Miguel and says, "Qué vamos a hacer hoy?" Miguel answers with, "Un camino!" Ms. Susan responds, "Si, un camino. Miguel is going to make a road. How about you, Sara?" Sara says, "I make a snake." Tamika gently pounds on the playdough and says, "pancake" while Sara takes the playdough in her hands and rolls it into a long snake. Sara rolls small pieces

and puts them on the “snake” and says, “I make eyes!” Sara rolls another “eye” and gives it to Tamika. Tamika says “eye” and smiles at Sara. Miguel says, “Quiero un ojo.” Ms. Susan says, “Sara, Miguel would like one too.”

In this short example several things can be noted about culture and development. The ECE provider is using multiple languages within the classroom and the children are displaying differences in language and fine motor skills. Consultants can use this information to begin formulating ideas about strategies that would fit into this group setting to meet the needs of all children.

In another example, a consultant is supporting a teacher who is struggling with one toddler during naptime. Before naptime the ECE provider reports that she always walks around the room and says to the children, “In three minutes we will clean up and go to naptime.” The children start to clean up and go to their cots. The ECE provider plays a lullaby CD and takes turns patting the children’s backs when they request it. Marcus, a 28-month-old, has a hard time transitioning and often throws tantrums when it is time for his nap. The provider communicates to the consultant that “all of the other children go right down for their naps.” The provider also mentions that the family is a bit distressed that Marcus is struggling because things go so well at home. The provider says it is hard for her to believe that things are easy at home. The consultant goes on a home visit and records the following observation:

Marcus is stacking blocks on the floor; he stops and rubs his eyes. His mother, also sitting on the floor says, “Marcus are you tired?” Marcus looks up and says, “No nap!” He begins to kick his feet and cry. His mother gently touches Marcus’s shoulder and looks at his face and says, “Marcus you are upset; you want to play with the blocks.” Marcus says, “blocks.” His mother says, “Okay, one more tower and then we will pick some stories out.” Marcus’s body is less tense. He says “tower.” Mom counts the blocks, “One, two, three, and four! Marcus you made a tall tower!” Marcus smiles. Mom gently sings “Clean up, clean up, everybody clean up.” Marcus sings along. His mother tells me she learned this song helping in her older child’s preschool class. The blocks are put into a container and his

mom asks, “Marcus what book would you like?” She holds out two books, and Marcus says “moon.” Mom says, “Oh, Goodnight Moon.” “Come here and snuggle with Mom and we will read your story.” Marcus picks up his blanket from the floor, backs into his mom’s lap, and holds his blanket close. Mom begins to read.

When developing strategies for the provider to use with Marcus to make transitioning to naptime easier, the consultant was able to share pertinent information from the home visit. The consultant shared the strategies that were successful within the home, such as getting down on Marcus’s level and using a light touch and eye contact to prompt transition, giving time for Marcus to finish up the task at hand, using a familiar transition song, and allowing Marcus to look at a familiar book such as *Goodnight Moon*.

Consultants may reflect upon the following questions when facilitating or infusing strategies into ECE programs:

- Is the strategy representative of the home cultures of the children?
- Is the strategy representative of the children’s diverse developmental levels?
- Will the strategy be “familiar” to the ECE provider and the children (easy to do, feel natural, etc.)?
- Is the strategy supportive of the linguistic diversity represented by families?

Some ECMH consultants find it useful to use a standardized interview questionnaire to gather information from families on the children’s culture and development during home visits, over the phone, or during a meeting outside of the home. Questionnaires can also be used to gather information from ECE providers about their beliefs on topics such as discipline, routine, activities, and other care-giving practices. A sample questionnaire, for families and providers, can be found in Appendix A (document #13).

Reflective dialogue is another useful strategy for collecting information on culture and development. Reflective dialogue between a consultant and ECE providers

encourages a clear description of specific situations, analysis of feelings, evaluation and analysis of the experience, consideration of other options, and reflection on how to address the situation if it arises again. The following dialogue offers an example of reflective conversation:

Consultant: "Tell me about the situation that happened today that bothered you."

Provider: "During free play, Josh took the toy from Jose. I told Jose, 'It's okay; let Josh have it. Let's go find something else.' Josh played with the toy and Jose cried. I picked him up and rocked him."

Consultant: "How were you feeling when this happened? What bothered you?"

Provider: "I was frustrated, mostly with myself. When Josh takes toys I don't know what to do. It's easier to just take over and let Josh have his way. That way no one gets physically hurt. I know conflict happens in real life and maybe I am not helping the kids by stepping in so fast and swooping a child away. I just don't know what else to do."

Consultant: "Tell me a little more about how your family dealt with conflict."

Provider: "I learned from an early age to avoid it at all costs. When my father got upset, my mother would take us kids outside or out for a drive. Maybe this is why my first instinct is to get away."

Consultant: "It sounds like dealing with conflict can be difficult."

Provider: "Yes, but I do want to learn new ways."

Consultant: "What are some things you think might work?"

Provider: "Well, talking with you helps me to see my part, so maybe one thing I can do is to continue sharing my feelings with you? I went to a training on conflict resolution, but I can't remember the steps. Can you help me re-learn the steps?"

Consultant: “I think meeting regularly is a good idea. Caring for children brings up a lot of emotion! I know it is hard to remember everything we learn, so yes, how about I bring in a visual of the steps and I can model how to use them. And if you like, when you start to go through the steps yourself, I can be close by to offer some encouragement.”

Provider: “That sounds good. Let’s try that.”

In this example, the consultant learned more about the ECE provider’s feelings and past experiences and how they affect her care-giving practices. It is difficult work and takes time, but consultants who use self-reflection, careful observation, and reflective, open dialogue will be more apt to support strategies and practices that are relevant to the child, the child’s family, and the ECE program and staff.

Self assessment indicators for Standard A. 8

1. ECMHC projects describe methods for supporting ECMH consultants in developing and furthering their own cultural competence and knowledge of child development.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMH projects describe methods used by consultants to ensure suggested strategies are culturally and developmentally appropriate for the ECE program and/or individual child/family.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

9. Consultants Support ECE Staff Efforts to Communicate With Individual Families About a Child's Development, Challenging Behavior, or Any Interventions That Are Planned to Address These Concerns.

Rationale: Families are more likely to actively participate in activities and achieve outcomes that they feel are important and reflect their values, culture and preferences. Regular ongoing communication with families not only builds their engagement but also helps ECE providers learn critical information about children and the world they live in outside of early care and education. The more ECE providers communicate about regular, day-to-day events, the easier it will be to share information that may be more challenging. When families and teachers exchange information regularly, they create bridges between children's homes and the ECE program (Koralek, 2005).

Guidance: There are several ways that consultants can support ECE providers in communicating with families. One idea is the concept of parallel process. Consultants can mirror the attributes and actions they would like to see the ECE providers take with families. Actions such as showing up on time, being dependable, sharing information in an easy, respectful way, calling the provider by name, listening and reflecting information back, and sharing strengths as well as concrete observations are all important for the consultant to keep in mind.

Just like children, adults absorb information in multiple ways, so it is important for providers to have multiple methods of communicating with families. Consultants can mentor ECE providers in using some of the following communication strategies to share information on a child's strengths, accomplishments, and development:

- Creating a communication board outside of the classroom to update families on what is happening each day.
- Sharing a daily communication sheet that lets families know about their child's day. An example of a daily communication sheet can be found in Appendix A (document # 14).

- Sending regular e-mail. Some ECE providers send a group e-mail to all of the families outlining activities for the day or the week, including positive highlights for each child.
- Creating newsletters.
- Making positive phone calls to each family every month. Print out a list of children's names to keep track of positive experiences their child experienced at the ECE program. This helps families feel more comfortable with phone calls from their child's teacher and lets the children know that you are communicating with their family on a regular basis.
- Facilitating parent-teacher meetings.
- Encouraging family visits. Invite family members to come in to read or to tell a story to children.
- Disseminating tip sheets or informational sheets on typical child development.
 - The Zero to Three website has free downloadable tip sheets for families on infant/toddler development at <https://www.zerotothree.org>.
 - The Center for Disease Control website has simple downloadable milestone pages for infants, toddlers, and preschoolers at <https://www.cdc.gov/ncbddd/actearly/milestones/index.html>
 - Johns Hopkins Center for Technology in Education host the MSDE Healthy Beginnings Tool at <https://www.marylandhealthybeginnings.org>

Talking with a family about a concerning behavior can be difficult for ECE providers, but having some guidelines for conversation can help. Table 6 has some simple guidelines that consultants can share with ECE providers about talking with families.

Table 6. Do's and Don'ts for Sharing Information with Families

Do...	Don't...
Start the conversation during a time that is convenient and in a place that is private.	Choose a busy, hectic time to share delicate information with a family. Once the conversation is started it is good to finish it rather than leave a parent wondering about what is going on.

	<i>"I need to talk with you about Haley's behavior, can I call you tomorrow?"</i>
<p>Use objective examples of what was seen and heard.</p> <p><i>"Sara went over to the block area, sat next to a child, and said 'I play.' The other child said no. Sara said, 'My block, me play.' The other child moved his arm with a block in it close to his chest. Sara reached for his arm and pulled it to her and bit down onto his arm. The other child cried out for my help. Sara looked up and started to cry."</i></p>	<p>Use blaming or feeling words to describe the behavior.</p> <p><i>"Sara did not have a good day today. She was grumpy and not getting along with peers. She was quite aggressive, too."</i></p>
Let the family know that you (ECE provider) need help so that you can best help the child.	Tell the family that they need to fix this problem.
Offer to set up a meeting time to discuss further at a place and time that is convenient for everyone.	Arrange meetings at a time that is difficult for the family. For example, if a parent works the day shift, scheduling a meeting at 9 am would be difficult for the family to arrange.
Be prepared. Have copies of any materials that might be helpful for the family to see, such as observations, information about typical development, etc.	Come unprepared and leave the room to retrieve materials.
Make arrangements for someone to translate if a family speaks a language other than English.	Arrange a translator until you have asked the family if they know someone that they would feel comfortable with first.

Give plenty of time for the family to talk and ask questions.	Schedule back-to-back meetings. This could cause overlap and disruption to the meeting at hand.
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Once the idea of challenging behavior has been approached and planning begins, consultants can think about their role as a facilitator to help bridge home and the ECE program. When parents are partners in creating strategies for their child, oftentimes it is helpful to keep the family in the loop. Consultants can help ECE providers understand the importance of keeping families informed. The family may be wondering things such as:

- Is my child doing okay?
- Are the strategies working?
- What I can I do to help?

By keeping in contact with families, these questions will not turn into constant stressors. Some simple ideas for sharing information with families about children's interventions and progress are:

- Keeping a home/school notebook.
- Sending regular e-mails home to the family.
- Setting meeting times that are convenient for everyone (e.g., monthly meetings).
- Making phone calls to check in regularly.

One consultant reported that, after the initial planning meeting with the family and child care provider, she began regularly visiting the child care site to support the teacher in facilitating the new ideas. One day she arrived when the mom was dropping off her son, and the mom didn't know the consultant was going to be there. The mother expressed concern that she was not being kept aware of what was happening with her "baby." All involved learned from this experience. Together they agreed that from now on the consultant would send the mother an e-mail letting her know in advance when she would be visiting the site and would call within the week to update her on her son's progress.

Self assessment indicators for Standard A. 9

1. ECMH projects describe materials consultants use to promote awareness of general child development.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMH projects describe methods consultants use to support ECE providers in talking with families about concerns.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

10. Consultants Provide Assistance to ECE Providers for Referrals to Community-Based Services That Address the Needs of the Children in Their Care, Especially Those With or At-Risk for Delays or Disabling Conditions.

Rationale: In a national cross-site study of effective early childhood mental health consultation programs, 69% of consultants reported making at least monthly referrals to other community resources for ECE providers and 72% reported making at least monthly referrals for families (Duran et al., 2009). In Michigan's statewide ECMH program in 2009, 27% of referrals were centered on developmental concerns that impacted the child's behaviors. Additionally, 7% of referrals were for children in need of more extensive mental health services. Some studies estimate that between 9-14% of children from birth to five years experience social and emotional problems that negatively affect their functioning and development (Brauner & Stephens, 2006). Far more children with special needs participate in typical early childhood settings than ever before (Sandall, Hemmeter, & Smith, 2005). Children with special needs can make significant gains through early intervention when they receive services while they are very young (Nelson, 2009).

Guidance: There are several strategies consultants may consider to help ECE providers with referrals for children and families to community-based services. These include: 1) developing guidance for ECE providers on how to prepare and talk with families about referrals, 2) helping providers use standardized referral forms and processes, and 3) sharing information on referral sources.

The initial conversations that ECE providers have with families about concerns with child development or behavior may be quite difficult. ECE providers often express fear that the family might disenroll the child from care if concerns are raised. These are valid fears as sometimes families do choose to take their child out of the setting. Sometimes families are not emotionally ready to address such concerns. Sharing information with families is the first step in the referral process, which can lead to critical services for children. Although it may be difficult, many times families are open to hearing what the ECE provider has to say—especially when there is an already established relationship built on trust and respectful communication. Consultants can help providers alleviate their fears, collect their thoughts, and be prepared. Some suggestions for helping ECE providers prepare to contact a family include:

- Have detailed observation data (focusing on what has been seen and heard).
- Have typical developmental Standards to use for comparison.
- Have a completed developmental checklist or screener (e.g., Ages and Stages Questionnaire).
- Meet with another person beforehand to reflect on approach and process.

It may be helpful for consultants to coach ECE providers on verbiage to use during meetings and on how to use specific examples and to avoid judgmental statements. Being clear and concise is helpful to families so they are not left feeling uncertain about a provider's concerns. For example:

“Last month, Adam used 2 words together to ask for things, such as, ‘Me drink,’ ‘Cup please,’ and ‘My ball.’ While observing this month, I noticed that Adam has been using some babbling instead of two word phrases. For example, I asked Adam if he wanted another cookie and he responded by saying, ‘Ooh’ and

reaching for the cookie. There is a wide range of ability of children Adam's age and how they use language. Typically older toddlers like Adam are using or trying to string together two-word phrases. That is why I wanted to talk with you- to see if perhaps you also noticed Adam using more babbling and gestures rather than words at home?"

After approaching families with concerns, a referral can be made. Here is an example of how a procedure for referral might flow:

1. ECE provider suspects a problem.
2. ECE provider completes or gathers comprehensive information (e.g., developmental screening, observations, interview information, photos, etc.).
3. ECE provider sets up a meeting with the family.
5. Meeting is held.
6. Further information is collected if necessary.
7. Referral is made.
8. ECE provider makes a follow-up call or meets with the family within one week of the referral to check in on progress and to provide any additional support.

Consultants may offer to be there for support when the family calls the community-based service provider. Consultants can let ECE providers know that sometimes families may decide not to go through with the referral, but families should still be supported and encouraged in a respectful manner.

In addition to having referral procedures to follow, supporting paperwork can also help ECE program staff be prepared for the referral process. Consultants can guide ECE providers by having knowledge of and access to standardized referral forms that might be proposed to the ECE program. Referral forms typically include the following key pieces of information:

- Date of referral
- Referral source
- Reason for referral
- Contact information for the referral source and the family, if not the same

A sample referral form is located in Appendix A (document # 15).

Brochures or other written information about the specific referral are also helpful to providers and families. Information on community-based services should be readily available to families, and consultants can help gather that information for ECE providers. It is important for consultants to be well informed of the array of community services available for young children. This includes knowing the eligibility criteria for the services, what services are provided, who the service contact is, costs involved, and steps for accessing services. Children can be susceptible to a wide range of behavioral and developmental risks, so it is important to have a diverse and expansive list of referral sources. This knowledge will expedite getting children and families to the appropriate source. Some possible resources to consider are:

Early Intervention and Special Education:

- Infants and Toddlers
http://www.marylandpublicschools.org/MSDE/divisions/earlyinterv/infant_toddlers/directories/local_program.htm
- Maryland's Early Childhood Intervention and Education System of Services for Children with Disabilities (Birth through 5)
<http://www.marylandpublicschools.org/MSDE/divisions/earlyinterv/>
- For further information on statewide services, consultants can access Maryland's statewide report on early childhood services at:
www.mdchildcare.org/mdcfc/pdfs/childcareandeducation.pdf
or go to the website of MSDE for up to date information on: 1) Resources for providers and families with young children with disabilities, birth through five:
<http://www.mdecgateway.org/home>
- Information related to child care at:
http://www.marylandpublicschools.org/MSDE/divisions/child_care/

Children's Mental Health Services:

Brief Overview of the Public Mental Health System at the State and local levels, including the State Mental Health Agency's authority:

The Mental Hygiene Administration (MHA) is the agency within the Department of Health and Mental Hygiene responsible for the oversight of public mental health services in Maryland. For children and families who are eligible for Medicaid and have a diagnosable mental health condition, these services can be an important resource. Primary mental health services means the clinical evaluation and assessment of mental health services needed by an individual and the provision of services or referrals for mental health services as deemed medically appropriate by a primary care provider. Under Maryland's 1115 Medicaid waiver, a redesigned public mental health system (PMHS) was conceptualized. Specialty mental health services - those mental health services that are beyond primary mental health services - are delivered through a "carve-out" arrangement that manages public mental health funds under a single payor system. The system serves Medicaid recipients and a subset of uninsured individuals who meet medical necessity criteria and financial and/or other specific criteria. The cost of mental health services is subsidized, in whole or in part with State general funds. Medically necessary mental health services are delivered to eligible individuals of all ages through the PMHS which is managed in collaboration with the Core Service Agencies (CSAs) and the Administrative Services Organization (ASO).

The CSAs are entities at the local level that have the authority and responsibility, in collaboration with MHA, to develop and manage a coordinated network of Maryland's public mental health services in a defined service area. There are twenty (20) CSAs covering all 24 jurisdictions. CSAs are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations. They vary in size, needs, budgets, and budget sources. CSAs are the administrative, program, and fiscal authority which are responsible for assessing local service needs and planning the implementation of a comprehensive mental health delivery system that

meets the needs of eligible individuals of all ages. CSAs are important points of contact for both consumers and providers in the PMHS. They are responsible for processing complaints, grievances, and appeals, as well as for monitoring the contract with the ASO and reporting findings to MHA. The Maryland Association of Core Service Agencies, (MACSA) Inc., was established to promote and support the effectiveness of each CSA in Maryland to plan, monitor and manage its local, publicly-funded mental health service system.

Effective, September 1, 2009, MHA began a five year contract with Value Options, Inc., the new ASO, for Maryland's PMHS. The major responsibilities of Value Options include: access to services, utilization management, data collection and management information services, claims processing and payment, evaluation services and stakeholder feedback. The goal of the system is to provide the benefits of the coordination of managed care, while preserving access to a comprehensive array of services, flexibility, and choice. ValueOptions® manages publicly funded and commercial contracts. They offer a wide range of managed behavioral health care services. ValueOptions® Maryland gives care to people served by the Maryland Department of Health and Mental Hygiene (DHMH), Mental Hygiene Administration (MHA). Either an individual or a family member seeing a DHMH/MHA provider can access relevant information. ValueOptions® Website <http://maryland.valueoptions.com> is available to the general public. It includes information for consumers, families, and providers about locating providers, applying for state programs and services, finding support groups, and more.

http://maryland.valueoptions.com/services/how_to_receive_svcs.htm

MHA: Special Needs Populations

The MHS office is responsible for the planning, development, monitoring and coordination of services for individuals with mental illness who have special needs. Services are offered to individuals who are homeless, individuals who are deaf or hard of hearing, individuals with mental illness and/or substance use disorders and trauma-related affects, individuals with one or more of these co-occurring disorders who are

also incarcerated, victims of natural or man made disasters, and veterans of the Afghanistan and Iraq conflicts who have behavioral health needs.

Trauma, Addictions, Mental Health, and Recovery (T.A.M.A.R.)

T.A.M.A.R has been offered for more than 10 years to individuals 18 and older who are detained in participating detention centers and have a history of physical and/or sexual abuse with a recent treatment history for a mental health condition plus an alcohol or drug disorder. Funded at over \$400,000, Maryland offers the program in eight detention centers and one state hospital reaching nearly 1,000 consumers. In addition to treatment in the detention center, four of the eight jurisdictions provide trauma treatment to inmates re-entering the community.

Chrysalis House Healthy Start Program:

Chrysalis House Healthy Start is a program developed for pregnant women who are incarcerated or at risk of incarceration in local detention centers and the Maryland Correctional Institute for Women (MCIW). The Chrysalis House Healthy Start Program is funded with State dollars and a small PATH grant. This holistic program aims to provide appropriate treatment and mother/child intervention to women with mental health, substance use, and trauma related disorders. The program provides services at a residential/transitional facility during the pregnancy and for several months post delivery. The Office of Special Needs Populations continues to provide oversight and technical assistance for this program.

For more information on these and other projects, contact: the Office of Special Needs Populations Director, Marian Bland at 410-724-3242.

Self assessment indicators for Standard A. 10

<p>1. ECMHC projects have an updated and comprehensive listing of community-based service providers and linkages for regional or state resources to supplement local resources.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. ECMH projects describe processes that consultants use to help ECE providers with referral processes, including feedback loops for results of assessments.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

11. To Facilitate Appropriate Referrals, Consultants Cultivate a Knowledge of Statewide Resources Within and Beyond the Community and Foster Relationships With Local, Direct Service Providers.

Rationale: Knowledge of community services and supports is a core competency of consultants that is essential to the provision of effective ECMH consultation (Duran, et. al., n.d.). In some instances consultants are the first stop for an ECE provider and a family with concerns about a child's development; if consultants are to be of any help, they need to be equipped with the knowledge of a vast array of community information. For example, many children in ECE settings are challenged by diverse needs beyond social/emotional health. Speech and language issues, regulatory concerns, sensory processing challenges, and cognitive delays are but a few of the global developmental challenges that a child may be facing. Consultants can use their knowledge of community resources to help link ECE providers and families with the necessary services right away.

Having a broader view of services beyond the local community can help consultants guide families to specialty services that might not be available in the local region. If consultation is being provided in a rural, somewhat isolated region and a child needs a neurological evaluation, the consultant may need to link the family with a clinic elsewhere in the state that has expertise in this area. Sometimes children receiving ECMH consultation are also receiving multiple services from other early childhood partners such as Infants and Toddlers or Judith Hoyer Centers. Consultants can serve as a team "manager" to help coordinate, optimize, and avoid duplication of services.

Strong relationships with local service providers can lead to consistent access to care for families. When local providers are communicating regularly, they get a clearer picture of what the others provide and time to process what approaches might work best for individual children and families. Some early childhood service providers partner to create common policies and forms for family services, making it much easier for families to access care.

Guidance: Consultants can familiarize themselves with state and local resources by joining early childhood committees, creating local ECMH advisory teams, attending state and local early childhood conferences, joining state and local organizations, setting up one-on-one meetings with key early childhood service providers, and providing presentations for local partners at Local Management Board meetings.

As a requirement of the ECMH grant from MSDE, ECMH projects must create an independent advisory council. The composition and requirements for the council are specified by MSDE and are intended to help initiate, guide, and support the delivery of high-quality services within a local system of care. The functions of the council may include the following:

1. Help plan the program.
 - Assess the needs of families and providers.
 - Gather information to document the early care and education system in the community.
 - Design interagency referral procedures and protocols.
2. Help implement and continually improve program quality.
 - Review project data and progress reports; suggest improvement strategies.
 - Help with problem solving as concerns or barriers arise.
 - Collaborate to provide training for ECE providers.
3. Help recruit, train, support, and retain staff.
 - Advertise staff position openings.
 - Provide training for staff.
 - Provide group-based case-conferencing for staff.
 -
4. Help promote the project among families, providers, community agencies, and the general public.
5. Make referrals to the project.

6. Take referrals from the project.

In addition to the recommended members of the advisory council, projects might also like to invite others to participate based upon local needs and resources, including:

- Early childhood mental health practitioners (e.g., infant mental health interventionists and others serving families with children birth through five years)
- Parents or guardians
- Maternal and child health staff
- Early childhood parent education and support program staff
- Advocates for young children
- Representatives of corporations or small businesses
- Representatives of community service organizations
- Community colleges and universities (e.g., departments of school psychology, early childhood development, social work, human ecology, etc.)
- Others who are interested in early childhood mental health consultation and improving the quality of child care.

Advisory council members often become great advocates for the ECMHC program and the families being served. Each member becomes intimately aware of other members' programming, and relationships formed within the group can lead to an increase in cross referral and timely access. State and local early childhood conferences and trainings such as those held by the Maryland Association for the Education of Young Children (MDAEYC) can serve as great opportunities to network and learn more about innovative services that could benefit families and ECE providers. For a calendar of MDAEYC and other early childhood events, go to <https://www.mdaeyc.org>.

As ECMHC is still somewhat new in many areas, consultants may find it beneficial to begin developing relationships by setting up one-on-one meetings with key early childhood service providers such as the Part C coordinator, local school district personnel, Head Start/Early Head Start coordinator(s), and others invested in ECE.

These one-on-one meetings can provide great opportunities for both parties to get to know each other better.

Consultants can ask questions about services the partner provides as well as questions about any other key meetings or events that the partner might recommend the consultant attend. Likewise, having a brochure, flier, or Power Point presentation prepared can help disseminate a clear message about the ECMHC program. More information about creating ECMHC program materials can be found in Section B, Standard 1.

Self assessment indicators for Standard A. 11

1. ECMH consultants describe their active involvement with local direct service providers.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <hr/> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMH consultants describe the ways in which they develop and maintain current knowledge of statewide and local infant and early childhood resources.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <hr/> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

12. Consultants Adopt a Consultative Stance by Collaborating With the ECE Provider in Examining and Interpreting the Meaning of a Child’s Behavior Rather Than Taking on the Position of “Expert.” Throughout the Consultative Process, the ECMH consultant Explicitly Validates the Expertise and Perspective of the ECE Provider.

Rationale: Relationships provide a powerful context for learning (Pflieger, 2002). Consultants who build a relationship-based partnership with an ECE provider rather than taking on the role of “expert” facilitate optimal adult-child interactions by mirroring

the relationship that should be fostered between the adult and child. The consultation relationship has the power to transform other relationships in the child care system (Johnston & Brinamen, 2006). Consultants are facilitators of change. By watching, wondering, and listening with ECE providers, attitudes and practices can change due to open, honest, and safe joint experiences.

Guidance: Important to consider is the tone that a consultant sets at the onset of services. A consultant entering a new child care setting is an unknown entity. Skillful application of relationship-based practice should quickly begin to put families and providers at ease. Consultants from a cross-site evaluation (Duran et al., 2009) shared tips for starting consultation off on the right foot:

- Be respectful and recognize that you are entering the ECE providers “space.”
- Convey an attitude of “I am here to help.”
- Take time to really listen to their needs; don’t be in a hurry.
- Establish that you are working toward the same goal, to help the child.

ECMHC differs from traditional direct service interventions delivered by a mental health professional who acts as the sole expert or primary source of intervention. ECMH consultants validate and welcome the ECE provider’s thoughts and participation in the consultation process. Rather than taking the role of the expert or the person who fixes the problem, the consultant takes a consultative stance and supports full cooperation and partnering with ECE providers and families.

Johnston and Brinamen (2006) describe a consultative stance as a “way of being” that highlights the mutual responsibilities and “shared endeavor” of the consultant and the staff or family members. The consultant must build trusting relationships with families and providers so that they, in turn, can develop more trusting, nurturing relationships with the children in their care, which requires a significant investment of time. Johnston and Brinamen describe 10 elements that are essential to the consultative stance. These are listed in Table 7. There is also a Best Practice Tutorial on the Consultative Stance at <https://www.ecmhc.org>.

Table 7. Elements of the Consultative Stance

Element	Description
Mutuality of Endeavor	The consultant and the ECE provider work together to contribute and to participate in the consulting process. The ECE provider's perspective and understanding of situations is imperative and valued by the consultant.
Avoiding Position of Expert	Consultant's work is collaborative in nature and information is gleaned from all participants. All perspectives are integrated into services.
Wondering Instead of Knowing	Consultant takes the stance of wondering with the ECE provider about situations versus "knowing" or solving. This demonstrates that understanding is a process and that the ECE provider is part of that process.
Understanding Another's Subjective Experience	Consultant accepts that the caregiver holds expertise about personal experiences as well as children's experiences.
Considering All Levels of Influence	Consultant takes into consideration the many influences on an ECE provider's point of view and ability to assist children. These influences can include internal feelings, external issues such as programmatic and bureaucratic pressures, program philosophies, and interpersonal issues such as relationships with co-workers.
Hearing and Representing All Voices, Especially the Child's	Consultant is committed to hearing about and listening to each individual. The consultant represents the voice of one participant to the other to garner cooperation and gives voice to the children while considering their experiences, skills, and needs. This voice is instrumental in including the child in the development of solutions and program experiences.
The Centrality of	All relationships surrounding the child are a central part of

Relationships	consultation. This includes relationships between parents, families and ECE providers, children and caregivers, and ECE providers and other staff within the care setting.
Parallel Process as an Organizing Principle	The consultant's way of being is respectful and understanding. The consultant behaves as she or he hopes others might and encourages this same behavior in others.
Patience	Consultant recognizes that change takes time. Through relationship-based practices consultants can move past the urgency to unearth, understand, and change perceptions and behavior.
Holding Hope	Consultant holds hope for possibilities and change for the ECE providers and families as they maneuver daily hassles and crises.

(Johnston & Brinamen, 2006)

Because of the unique characteristics of ECMHC, special consideration should be paid to the attributes and characteristics of people hired for this work. Consultants should come in the door with warmth, empathy, curiosity, flexibility, and the ability to self-reflect and reflect with others in an open, non-judgmental manner. Interviewers should engage in careful discussion around philosophy and “consultative stance” at the onset of the interview process to ensure best practices. The attributes of an effective consultant are difficult to teach and difficult to develop if they are not already in place. Sample job descriptions and interview questions are located in Appendix A (documents # 16 & 17).

Self assessment indicators for Standard A. 12

1. ECMH consultants clearly articulate their role in the consultation process.	1=Not Met; 2=Partially Met; 3=Fully Met <u>1</u> <u>2</u> <u>3</u> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2. ECMH consultants clearly articulate the ECE provider's role in the consultation process.	1=Not Met; 2=Partially Met; 3=Fully Met <u>1</u> <u>2</u> <u>3</u> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3. ECMH program has a job description and interview questions reflecting the core competencies of ECMH consultants hired.	1=Not Met; 2=Partially Met; 3=Fully Met <u>1</u> <u>2</u> <u>3</u> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

13. Consultation Should Promote an Increase in the Skills, Knowledge, and Expertise of the ECE Provider as Well as Greater Insights and Reflectiveness About How Their Behavior Influences Children's Behavior.

Rationale: As Cohen and Kaufmann (2005) state, "Early childhood mental health consultation aims to build the capacity of staff, families, programs and systems to prevent, identify, treat and reduce the impact of mental health problems among children and their families" (pg 4). Providing ECMHC services to support and increase ECE provider skill development pays off in "better problem solving skills, greater staff confidence in coping with difficult situations, a wider range of concrete strategies to help children and families, and the provision of a safety valve which enables staff to share their frustrations and to celebrate the victories of their work" (Yoshikawa & Knitzer, 1997). ECMH consultants that use reflective practices to support ECE providers can help adults to better understand the effect their behaviors may have on others such as children and families. This is called parallel process, as quoted infant mental health

expert Jeree Pawl explains as a process whereby you, "*Do unto others as you would have others do unto others.*"

Guidance: Much has already been written in relation to what types of strategies ECMHC should promote in Section A, Standard 7 and in the consultative stance that supports relationship based work and builds a reflective nature to the partnership between the consultant and the ECE provider in Section A, Standard 12. Guidance therefore will focus primarily on what skills, expertise and knowledge are paramount to supporting effective practices related to supporting social emotional health and some simple tips consultants might consider in supporting reflective practice with ECE providers.

In many ways the pertinent skills and knowledge that need to be supported in ECE providers are quite similar to those of the consultant and include:

Skills:

- The ability to form nurturing relationships with children and families
- Use of sound observation practice
- Ability to use simple screening tools and interpret the results
- Ability to use effective and individualized strategies to support children and families
- Linking families to necessary community resources
- Ability to look at strengths of themselves, children and families

Knowledge:

- Typical social emotional health indicators of young children
- Behavior in young children that may indicate social and emotional risk
- Services within the community (e.g. Infants and Toddlers programs, Head Start/Early Head Start, etc.)

- Best practices related to early childhood care and education, particularly related to social-emotional well-being.

Practices that consultants can consider which help support ECE providers to garner greater insight and reflection of their own behavioral influences include:

- **Parallel Process-** ECMH consultants that use reflective practices to support ECE providers can help adults to better understand the effect their behaviors may have on others such as children and families. This is called a “parallel process.” The basic concept is that if ECE providers are supported, they can better support families, who in turn can better support children. The consultant aligns with the ECE provider to share, observe and inquire together. By mirroring an engaging, open, and nonjudgmental relationship-based practice, the ECE provider feels both heard and understood. The provider, then, will not only be able to better hear and understand the children, but will also be more attentive in communication and behavior with others.
- **Reflective supervision-** Some ECMH consultants provide opportunities for either one-on-one or group reflective supervision opportunities for ECE staff. Reflective supervision entails the building of a positive relationship between staff and a reflective supervisor (for example, a consultant) who acts as a coach and teacher. Both supervisor and supervisee are active participants in listening and engaging in thoughtful questioning. Through reflective supervision, staff can become more attuned to child and parent functioning, address their own boundary issues, and think about how they can best promote positive child and family development. Staff can explore the impact families and children have on them and the impact they, in turn, may have on families and children. Reflective supervision usually happens a minimum of once per month for 2 hours. Groups usually consist of 8-12 members to assure ample time for each member to be heard.

Self assessment indicators for Standard A. 13

<p>1. ECMHC projects describe the key knowledge and skills they are helping ECE providers to build.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. ECMHC program describes methods used to support ECE providers to reflect on their own behavioral practices.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

Section B. Fostering Relationships With Families Through Consultation

1. Individualized Consultation Services Are Offered to Families Whose Children Are Identified With Behavioral and Social/Emotional Issues in ECE Settings.

Rationale: Young children are being expelled from child care at three times the rate children are expelled from K–12. (Gilliam, 2005). According to the *Early Childhood Longitudinal Study*, 10% of all kindergarten children have social and emotional problems that interfere with their functioning, and children from low-income families are three times more likely to have social and emotional issues (Raver & Knitzer, 2002). It is clear that an increasing number of young children are struggling with social/emotional and behavioral challenges that may jeopardize their early care and education placement and have a negative impact on later school success. However, there is hope for these struggling children. ECE programs with access to consultative support from a psychologist or social worker reported expulsion rates almost half that of those programs that lacked access to consultation services (Gilliam & Shahar, 2006).

Individualized consultation service, often referred to as child/family-centered consultation, is one of two well documented sub-types of ECMHC that helps to support children with challenging behavior (Duran et al., 2009). The primary goal of child/family-centered consultation is to help the family and ECE provider to successfully nurture the social/emotional development of a child who is exhibiting challenging behavior or whose social and emotional health may be compromised due to existing or imminent familial risk (e.g., divorce, death in the family, maternal depression, etc.). Typically, the consultant assists the family and ECE provider in identifying and addressing the reasons underlying the challenging behavior by taking into account factors within the child's personality, the child's family, the child care environment, and the child's community and then creating a comprehensive plan of support.

An important value inherent to ECMHC programs is that “families are considered to be full participants in all aspects of the design, implementation, and evaluation for programs and services for their young children” (Cohen & Kaufmann, 2005, p.2). Involving families increases the likelihood that family members will help implement

behavioral strategies at home and thus reinforces the impact of consultation (Center for Early Childhood Mental Health Consultation, n.d.).

Guidance: Child/family-centered consultation, although flexible and individualized, will usually follow these basic steps as it unfolds:

1. Referral and family consent
2. Gathering intake information for the ECE and home setting
3. Observation and assessment within the ECE and home setting
4. Meeting with the ECE provider and family to develop a positive child guidance plan
5. Providing support to the family and ECE provider to implement the positive child guidance plan
6. Making referrals to outside services as needed for the child and family
7. Conclusion of services
8. Follow-up services

Perhaps the most critical step in the child/family-centered consultation process is referral and family consent. This step can identify whether child/family-centered consultation will progress. It is natural for families to feel apprehensive about accepting ECMHC services for their child and to feel unsure about the consultant's role and their own role in the consultation process. Parental fears and questions may surface, such as: "Is my child the only one having concerns?" "Have I done something wrong?" "Am I going to lose this child care placement for my child?" When ECMHC processes and roles are clearly outlined at the time of referral, families may be more open to accepting services for their child (and for themselves) within the care setting.

Many times the ECE provider is the first one to talk with families about the need for child/family-centered consultation. ECMH consultants can play a vital role in making sure this initial conversation is supportive and strengths-based. Guidelines for talking with families about challenging behavior are addressed in Section A, Standard 9.

Consultants can share tips with ECE providers to prepare them for talking with families about ECMHC services, for example;

Do Say:

- ECMHC is a consultation service that can help us better understand your child.
- Young children communicate through their behavior; ECMHC can help us figure out what your child is trying to tell us with his behavior.
- ECMHC can help us figure out what we need to do to make sure that your child has a better experience in preschool or child care.
- ECMHC can help us do a better job of caring for your child.
- ECMHC can help us look at your child's social/emotional development (in other words, her ability to get along well with others and experience and handle feelings in healthy ways).
- ECMHC can help us make a plan to promote better behavior by meeting your child's particular social/emotional needs.
- ECMHC may involve a home visit (if that's all right with you).
- ECMH consultants don't label or diagnose children.
- Other parents and child care providers who have used ECMHC services say that they're glad they tried ECMHC because it really helped their children.

Don't Say:

- If you don't refer your child to ECMHC, we will expel her. (This usually sets the parents up to resent working with the ECMHC program.)
- We think your child is delayed.
- Your child is bad or uncontrollable.

Consultants might also consider having simple, appealing, easy-to-read ECMHC program brochures or informational fliers on hand for the ECE provider to share with the family. Some helpful hints when creating ECMHC program materials include:

- Content should be at a 6th grade reading level or below for reader ease.

- Photos of children, families, and ECE providers should be representative of the populations served.
- Content should clearly answer pertinent questions about cost, services provided, eligibility criteria, and contact information.
- Content should not be laden with acronyms or mental health jargon. The words “mental health” in general can evoke feelings of doubt.

An example of an ECMHC program flyer is located in Appendix A (document # 18).

Additionally, it can be helpful for consultants to ensure the ECE program has a clear understanding of what the ECMHC program offers before they begin to discuss details with families. Some programs have developed a memorandum of understanding (MOU) for the ECE program to read and discuss so that everyone is on the same page. Sample MOU forms can be found in Appendix A (documents # 2 & 3).

If an ECE provider is apprehensive about approaching a family for referral, the consultant may take time to sit down with the provider to role-play, coach, and/or rehearse what to say to the family. Ms. James, a toddler provider, describes how she approached a parent about a referral:

“I set up a time to talk with Joshua’s mother, Ms. Lopez. She already knew that we were having some problems with Joshua biting during free play and large group time. We had agreed that maybe it would help for him to have his blanket to hold during group time and for me to be closer in proximity to him during free play. These things helped somewhat, but Joshua was still biting and other parents were starting to complain.

During the meeting with Joshua’s mother I let her know what was going well with Joshua and also shared some examples of when the biting was occurring. She said that she was also still seeing some biting at home. I let Joshua’s mom know that I needed more help to do my best by Joshua and that there was a

great program that could provide a consultant to come in and help us to problem solve together how we might best help Joshua. Ms. Lopez asked if there would be a cost. I said that there was no cost for this particular program and assured her it would be confidential and that she could choose to discontinue the support at any time. I asked Ms. Lopez if the consultant, Mr. Johnson, could give her a call to explain further, and she agreed. I told her to call me if she had any other thoughts or questions. Before she left I gave her the Bright Beginnings (ECMHC program) brochure.

I felt good about how the meeting went. It helped that Mr. Johnson met with me previously to discuss how I might best approach this referral. I felt better prepared.”

Once a referral is received and the ECE provider indicates the family is open to the process, the consultant may directly reach out to the family to further explain the ECMHC program. How consultants enter a relationship with a family can have lasting effects on the family’s level of participation and understanding of ECMHC. To support a positive beginning to this new relationship, the consultant may consider the following tips:

1. Immediately invite the parents into a partnership, conveying respect for the parents as the “ultimate expert” on the child and continually seeking their perspective on the child and the situation.
2. Clarify the purpose of consultation and describe the consultation process as many times as necessary, verbally and in writing, during the initial meeting with the family. The handout *How Will ECMH Services Work for My Child and Family?* is useful in this regard and can be found in Appendix A (document # 19). It describes six common steps of the ECMHC process, provides quotes from parents who have used ECMHC services, and answers questions frequently asked by parents.
3. Carefully explain to families that all information gathered is confidential and that families have the right to dissolve ECMHC services per their request at any time.

4. Actively listen to family members' point of view on what they are feeling, thinking, and observing at this time.
5. Repeatedly convey support of the parents, as well as a willingness to help them work with their child's care provider to improve the situation for their child.

Consultants and ECE providers might be anxious to get started with ECMH support, but best practice is to not begin ECMHC until the consultant is able to get consent for services signed by the parent. (An example of consent for services form is included in Appendix A (document #20). Sometimes parents need to reflect and ask further questions before they are ready to consent to service. Once the parental consent is received the consultant can move on to the intake process. If parental consent is not provided, it will be important for the consultant to help the ECE provider remain supportive of the child and family. To accomplish this, the consultant may suggest program-wide strategies that benefit not only the child referred but all children in the group setting—for example, having duplicates of favorite toys for toddlers to eliminate conflicts over sharing. The consultant must be careful not to discuss any particular child or family by name without the family's consent. Also important to note is that programmatic strategies, as discussed in Section A, Standard 7, that help build quality in the ECE setting for all children are often incorporated into a child/family-centered plan. For example, if a particular child referred is having trouble with transitions, the team may decide to post a visual schedule in the classroom. This schedule could potentially have a positive impact on transitions for all the children.

Child/family-centered consultation is imperative to ECMHC programming. Consultants and providers should carefully examine and work through the barriers that inhibit families from accepting and participating in these types of services to best meet the social/emotional needs of young children and their caregivers.

Self assessment indicators for Standard B. 1

1. ECMH projects have simple, easy to understand program materials that can be disseminated to ECE providers and families.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMH projects describe the process for procuring child/family-centered referrals and consent for services.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

2. Consultants Gather Information from the Home Environment in a Way That Is Respectful and Confidential, Seeking Only Information That Is Relevant in Their Work With the ECE Provider and Family.

Rationale: Relationships built on trust and respect are central to effective ECMHC. A part of building trust with families is ensuring shared information is kept private. ECMHC programs need to have guidelines, protocols, and expectations regarding confidentiality so as not to breach trust and damage relationships (Center for the Study of Social Policy, 2004). Information collected from families should be pertinent to the guidance of services and to consultation efforts.

The National Association for the Education of Young Children's (NAEYC's) 2005 position statement *Code of Ethical Conduct and Statement of Commitment* places an emphasis on relationships, pledging commitments to "recognize that children and adults achieve their full potential in the context of relationships that are based on trust and

respect” and to “recognize that children are best understood and supported within the context of family, culture, community, and society” (p. 1).

Guidance: When gathering information from families, consultants may ask, “What do I need to know to best help the adults support and nurture this child’s social/emotional well-being?” More specifically, a consultant might ask:

- Do I know enough about this child? - What kind of temperament does she have? What is her developmental history? What are her strengths, preferences, and biological rhythms?
- Do I know enough about the family? - What do I know about their culture? What are their beliefs and traditions? How do they discipline? What are the family strengths and stressors?
- Do I know enough about the ECE setting? - What are the policies and procedures? How is staff supported? How many children are enrolled? What is the program’s philosophy on caring for young children?
- Do I know enough about the staff making the referral? - What do I know about their culture? What are their beliefs and traditions? What is their personal feeling of efficacy? What are their strengths?
- How am I being welcomed into the setting? - Am I greeted by the staff? Does everyone know why I am there? Have families been informed of my presence?
- Is there information that I need to collect for ECMHC evaluation or contract obligations?

Consultants typically collect this information from families using a few methods: conducting home visits, meetings outside of the home, phone calls, and—if the child is receiving support from other agencies or programs—meetings with other service providers (with the parents’ consent). Typically consultants offer to schedule an initial home visit so that they can gather data in a setting that is most comfortable to the child and family. However, some families may not feel comfortable having the consultant in their home until they have established a strong, mutual relationship. One state found that, of the total combined visits consultants provided to ECE programs and families in that state, approximately 75% of consultation occurred within the ECE program and

25% occurred within the child's home (Van Egeren et al., 2009). Some things that consultants can do to help families feel more comfortable with accepting a home visit include:

- Sharing concrete reasons for coming to their home (e.g., to learn more about their child and the family's strengths)
- Clearly stating your professional role (e.g., acting as a facilitator, not as a representative of child protective services or someone who does diagnostic testing)
- Having other parents available to talk with "new" families about their experiences with ECMH consultation
- Setting up the home visit for a time and day that is most convenient for the family
- Encouraging the family to invite other friends or family members to the home visit if that would make them more comfortable.

When home visits are not possible, consultants can offer families a neutral place to meet that is convenient, appropriate, and offers a confidential place to talk. Some consultants have met with parents at the ECE setting, a local library, another relative's home, or other community locations.

If a meeting isn't possible, a consultant might work with the family to set up a time to talk over the phone. Again, the consultant should consider days and times that are convenient for the family. Enough time should be set aside so that the conversation is not rushed.

In some cases the child and family may already be receiving early childhood services through Infants and Toddlers programs, Early Head Start, or other agencies. If the family signs a release of information form, then consultants may talk to and/or receive information from other professionals involved in the child's life. A sample release of information form is included in Appendix A (document # 21).

Common tools and practices that consultants may use to collect information from families to guide consultation include:

- **Standardized intake forms.** ECMHC intake forms typically capture basic information on the ECE program, the child, and the family, including contact

information, demographics, and reason for the referral, previous expulsions from child care, and other services that the child is receiving. Sample intake forms from two Maryland ECMHC projects can be found in Appendix A (documents # 22 & 23).

- **Interviews.** Some programs have created informal interview questionnaires that help guide conversation and ensure that the information collected is pertinent to consultation. Typically interview questions will center on:
 - The family (family makeup, strengths, stressors, culture, etc.)
 - The child (strengths, preferences, temperament, developmental history, etc.)
 - Care-giving practices (discipline, routines, communication, etc.)

Best practice would be for consultants to walk through some or all of the questions with a family either during one or more meetings or conversations on the phone rather than leaving the questions with a family to answer on their own. A sample family interview questionnaire is located in Appendix A (document #13).

- **Observation.** Each period of observation should serve to build relationships and gather information about the child's strengths and behaviors of concern. Because every child and situation is different, there is no prescribed number of visits or length of time for the observation process.

For observation to be effective, consultants must remain impartial. However, this is not always possible. At times, the consultant may have to step out of the role of impartial observer and respond to a toddler who asks for his shoe to be tied or to smile at a baby who is crawling toward her. At other times, the consultant may intentionally interact directly with the child to learn more about him. In this instance, the consultant is mindful to observe the child in order to consult with the primary caregivers in the child's life, not to enter into a therapeutic relationship with the child.

Consultants typically use the “running-record” observation method. Running-record observation has three important qualities:

1. **Accuracy.** Children are observed in different situations and settings at varying times of day and on varying days of the week. This variety ensures that the consultant has captured an accurate picture of the child’s behavior, strengths, and needs.
2. **Objectivity.** Consultants record only what they actually see or hear. They avoid labeling the child’s behaviors (either positively or negatively) and avoid making judgments about the child’s motives. Anyone should be able to read the observation and feel as if he were in the room. This objectivity allows for an unbiased picture of the child.
3. **Completeness.** Observations include a beginning, middle, and an end, whenever possible. Consultants typically observe long enough to have an opportunity to see the triggers leading up to a behavior (the antecedents), the behavior itself, and then the consequences of the behavior.

Although consultants can simply keep their notes in a notebook or on a pad of paper, they may choose to use a more structured, standardized observation form. A sample observation form can be found in Appendix A (document # 6). For more information regarding observation see Section A, Standard 2.

Self assessment indicators for Standard B. 2

1. ECMH projects have written confidentiality processes and procedures.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p style="text-align: center;"><u>1</u> <u>2</u> <u>3</u></p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMH projects describe the processes and tools used to collect information from families.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p style="text-align: center;"><u>1</u> <u>2</u> <u>3</u></p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

3. Consultants Should Incorporate Information from the Home Environment Into the Planning Process, Including Both Familial Strengths and Risk Factors.

Rationale: As Duran et al. (n.d.) explain, ECMHC’s approach acknowledges that to understand and address a child’s behavior, one must look holistically at the environments in which a child functions (i.e., ECE setting and the home). Jointly, consultants, ECE staff, and families assess the challenges and determine a plan of action across all settings.

Guidance: The consultant can synthesize information gathered from the family through intake forms, interviews, observation, and assessment, as discussed in Section B, Standard 2, to prepare for the planning process. It’s important to generate a good list of the family’s and child’s strengths, as this list can be used to develop strategies for promoting growth. For example, if a child is biting due to frustration when another child takes her toy and the consultant has learned that visual learning is the child’s strength, the adults may use a pictorial cue card to remind the child to say, “No, mine” or “Teacher, help!” At the onset of the planning process, the consultant can start the conversation with parents and ECE providers by sharing findings about the child’s strengths. For example:

“I am so glad everyone could make today’s meeting to talk about how we are going to work together to support Maria in making friends at her preschool. I wanted to start by sharing some of the information I have collected from both you, Mr. Javez, at the home visit and from Ms. Katie, Maria’s teacher. I would like to start by sharing the many strengths that Maria has shown us and that you both have reported. What I learned from you, Mr. Javez, is that Maria is a very affectionate and loving child. She likes to hug and easily accepts comfort from you. She also likes to laugh and is pretty happy most of the time. She is also a very observant child; she likes to watch everything around her before she jumps in. Does that sound right?”

“Yes, that’s right. Maria also likes me to read her stories and while we work together out in the garden she likes when I have the music playing.”

“Mr. Javez, you also mentioned that your family lives in a neighborhood with a lot of children and that you attend a community church on the weekend. Also, you get quite a bit of one-on-one time with Maria after work and on the weekends. At school it seems that Maria has a strong relationship with Ms. Katie. She goes to Ms. Katie for help quite often and also likes her to read stories during free play. During large group activities Maria likes to sit close to Ms. Katie. Maria takes initiative in the classroom quite often; she gets out activities for herself during the day, cleans up after play and snack, and is able to ask for what she needs. She often asks Ms. Katie for her favorite music to be played during rest time. Would you agree with this information Ms. Katie?”

“Yes, Maria is quite easy-going and observant; she seems to be quite creative and visual. She loves to do activities on her own like puzzles and painting most of the time.”

As can be seen in the example above, Maria’s father and the ECE provider reported Maria’s many strengths. This feedback can be incorporated into the planning meeting. Starting with strengths not only sets a positive tone for the meeting but also sets everyone up to remember that the strengths of the child and the family are critical to creating a holistic, sustainable plan and that the family and the child all bring skills that can be used as a foundation for change.

Once strengths have been discussed, the consultant may then summarize the risks that the family and ECE provider have shared regarding the child’s behavior.

“Ms. Katie, you had mentioned that you would like to see Maria increase her play skills with other children. You also mentioned she watches other children playing together and sometimes moves closer to those other children but doesn’t always seem to know how to join in. What are your thoughts, Mr. Javez?”

“I agree. When Ms. Katie approached me about her concern with Maria’s play skills I started to watch her more often around the neighborhood kids and I also noticed she kind of held back. She certainly giggled at what other children did and seemed interested but stayed close to me.”

“If you both remember, I had given you a one-page assessment to complete. The assessment helps to gather more information about Maria’s ability to get along with others, take initiative, and express her emotions. You both reported that Maria takes initiative and expresses many emotions just like other children her age. There were a couple of items where you both reported that Maria was not yet doing the particular behavior. You both said she was not yet asking other children to play or participating in make-believe play with other children. These items both center around peer play.

“It seems from the information gathered that there is agreement that the main goal for us all to think about is finding ways that you both can help Maria to increase her play skills with friends at home and at school. Does that sound right to both of you? Are there other things that we haven’t talked about yet that you would like to discuss?”

At this point the consultant, family, and ECE provider are ready to use the child’s and family’s strengths to start goal planning for the child in the home and ECE setting. Consultants may wish to use planning forms such as Devereux Early Childhood Initiative’s *Positive Child Guidance Plan*. This form can be downloaded at:

https://www.devereux.org/site/DocServer/Reproducible_Planning_Forms.pdf?docID=11241.

Self assessment indicator for Standard B. 3

1. ECMH projects describe how information about the child and family’s strengths and risks are incorporated into child/family-centered plans.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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4. For Any Child- Focused Consultation, Intervention Plans Should be Created With Family Input and Must Have the Parental Consent. A Face-to-Face Meeting Should be Scheduled With the Family, ECE Provider, and the ECMH Consultant Whenever Possible.

Rationale: As Johnston and Brinamen (2006) state, the consultant “honors the parent-child relationship as the place where knowledge is held and change will occur” (p. 285). Active family involvement in the planning process 1) acknowledges the family’s role as primary and 2) supports families and staff in supporting a child by implementing complementary strategies consistently across settings to reinforce new behaviors. Programs that demonstrate and support family-centered approaches tend to have families that feel more confident and comfortable in supporting their children’s development (Wilcox & Weber, 2001).

Guidance: Once information has been gathered from the ECE setting and the child’s family, the ECMH consultant typically facilitates a team meeting to develop an intervention plan for the child. Planning meetings include immediate family members, ECE providers, and others who are close to the situation at the request of the family (e.g., grandparent, neighbor, aunt). Meetings typically occur at a time and location that is familiar, comfortable, and convenient for all those involved, such as the child’s home, the child care setting, or another community location that allows for comfort and privacy.

Planning meetings are a time for the team to reflect together on all of the information gathered thus far and, once strengths and goals are discussed (see Section B, Standard 3), to formulate sound strategies that will support the child at the ECE setting and at home. It is important that consultants allow enough time in the meeting for reviewing and discussing the information to determine the function of the child’s behavior or, in other words, figure out “what is the child trying to tell us.” The consultant typically takes on the role of facilitator, offering a framework of trust and support as the team discusses behaviors and next steps.

Convening a team meeting to develop the intervention plan is best practice. If not all parties are able to participate either in person or by phone because of scheduling conflicts or unforeseen situations, the consultant can work to ensure that all parties

have an opportunity to provide input prior to the meeting and that all receive a copy of the intervention plan after the meeting takes place.

Some things a consultant typically will do prior to the intervention meeting include:

- Speak with the parents to prepare for the meeting. Elicit their suggestions for the agenda, location, date, and time, and address any questions they may have about what will happen at the meeting. Make sure they understand that this meeting is open to anyone they would like to have present, including other family members and other service providers (e.g., Part C Family Service Coordinator).
- Prepare all necessary materials. Integrate data collected through interviews, observations, and assessment tools in a way that can be easily digested by parents and providers.
- Obtain copies of child/family service plans developed by other providers (e.g., Individualized Family Service Plan, special education individualized education plan (IEP), wraparound plan, etc.)
- Learn about the culture and values of the family and of the provider, and reflect on how they may differ from your own culture and values. This is important for remaining open minded and non-judgmental throughout the meeting.

Some guidelines for consultants to consider as part of their role during the meeting include:

- Set a positive, collaborative tone that supports the partnership between parent and provider.
- Communicate clearly and simply, without jargon or acronyms.
- Limit distractions.
- Clarify the roles of planning team members. Emphasize that your role as the consultant is to facilitate the meeting and serve as the voice of the child.
- Provide a brief overview of the planning process and intervention planning forms. Be sure to explain that the consultant will facilitate the development of the intervention plan, and the parent, provider, and consultant will jointly identify strengths, goals, and strategies. However, the plan ultimately belongs to the

family. This means that what the family says will be taken very seriously. It also means that once all of the options that are acceptable to the whole team are on the table, the family has the final say about which goals and strategies will be included in the plan. It may take more than one meeting to complete the intervention plan.

- Clearly describe findings derived from interviews, direct observations, assessment tools, etc., highlighting both child strengths and areas of potential growth.
- Ensure that the team has ample time to ask questions and comment on the findings.
- Brainstorm and suggest potential goals and strategies, along with other team members. Then help the team prioritize those goals and strategies.
- Negotiate agreements among team members when there are differences of opinion, and facilitate a problem-solving process when barriers to action are identified.
- Strive to be objective and refrain from taking sides. Keep the focus on the task at hand; do not allow the conversation to stray too far off point or become adversarial.
- Ask for feedback on how the meeting went (and then use it to improve future meetings).
- Complete the intervention plan in writing and distribute copies to all team members.

An example of an intervention plan is provided in Appendix A (document #24). It should be noted that in the example, every box in the grid has been completed for purposes of illustration. However, most real-life plans will not be this comprehensive and every box need not be completed.

Family involvement is critical to providing holistic support to a child across the environments in which they live and play. Families offer a keen insight into a child's strengths, development, personality, and what strategies might work best.

Self assessment indicators for Standard B. 4

1. ECMH projects have written policies and forms to support the requirement of signed consent from families prior to intervention planning.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <hr/> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMH projects describe the processes and tools used to involve families in intervention planning.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <hr/> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

5. The Consultant Will Provide Information to Family Members on How to Incorporate and Sustain Evidenced-Based Approaches at Home That Address the Social Emotional and Behavioral Needs of the Child, Improve Parental Wellness, and Foster the Relationship Between the Family and ECE Staff.

Rationale: Responsive relationships between children and primary caregivers support healthy social-emotional development. These relationships form the foundation of mental health for infants, toddlers and preschoolers (Zero to Three, n.d.). Families hold the primary and most impactful relationship with their child. ECMHC programs that actively involve and support families to prevent, identify and treat social emotional health problems within young children can reduce the long term, negative impacts these challenges present.

Guidance: There are several considerations for consultants when sharing information with families on how to incorporate ideas within the home to support child development, adult wellness and relationship building. These considerations include: 1) what might the consultant do to reduce barriers for implementation of strategies? 2) What strategies should be shared? 3) What approaches might work best to share information with families? (e.g. training, home visit, etc.).

In both child/family-centered consultation and programmatic consultation it is best practice to actively partner with families to create and decide upon strategies that will support children's social and emotional well-being. Families are active partners in the information gathering, assessment and planning phases of consultation thus far as discussed in Section B, Standards 2-4.

If consultants feel some family reticence to incorporating ideas or engaging in follow up support the consultant may want to step back and reflect on possible barriers that may need to be addressed such as:

- **Stigma.** Sometimes just hearing the words "mental health" can be a bit fearful for families. Consultants should keep in mind the importance of the "consultative stance" as discussed in Section A, Standard 12 and Section B, Standard 8.
- **Mismatched expectations.** At times, families may not fully understand the consultation structure and in turn the consultant's expectations might not be matched to the family's expectations. The consultant may need to step back and continue discussing ECMHC processes and also revisit the planning process to ensure it is indeed completed through a partnership with the family at the core.
- **Time constraints.** Families may have many responsibilities limiting their time such as working multiple jobs, caring for multiple children, and dealing with other family issues and daily hassles that may compromise their ability to fully take part in the consultation process. Consultants should reflect with families on whether or not the strategies suggested are feasible and how they might work together in a way that does not over burden the family (e.g. meeting with families at convenient times, using evening phone calls, etc.)

There are many methods that consultants can use to provide information on how to use and sustain social-emotional strategies within the home. Some suggestions are training, home visits, sharing written materials and resources, support groups, and videos.

Some consultants provide regular social and emotional training opportunities for families. This provides a way for consultants to share tips with families that coincide with activities that are being implemented within the ECE program setting. The Center for Social and Emotional Foundations for Early Learning provides free, downloadable training modules that consultants can use with families. There are six one hour modules that can be found at: <http://www.vanderbilt.edu/csefel/index.html>, and include the following topics:

1. Making Connections!
2. Making it Happen!
3. Why do Children Do What They Do?
4. Teach Me What To Do!
5. Facing the Challenge (Part 1)
6. Facing the Challenge (Part 2)

The benefit of providing a series of training opportunities versus a single training opportunity is that information can build over time and families can provide feedback on what is and what is not working within their home setting. A training series can also foster family relationships and provides an avenue for peer to peer learning.

Home visits provide a unique opportunity to help families infuse strategies into a home setting. Families may be apprehensive to allow consultants into their home setting if a relationship has not fully been established or reasons behind the visit are not clarified. A consultant may need to allow time to build trust with the family within the ECE setting before providing home visit. For example, the consultant may:

- Be at the ECE program regularly and greet the family by name at drop off
- Share strengths of the child with the parent(s) that were seen during observation

- Listen and reflect with the family

It is important for consultants to anticipate questions that a family might have about home visits and answer them upfront. Parents may wonder things as:

- Is everyone getting a home visit?
- Will the consultant judge my parenting skills?
- How long will they stay?
- Will I have to do anything I am not comfortable with?
- Model safe, nurturing practices while at the ECE program

Having family friendly resource materials to share during trainings and home visits can offer concrete reminders for families on how to implement strategies. There are many resources available for families on the CSEFEL website

<http://www.vanderbilt.edu/csefel/index.html> that can be downloaded such as:

- 1-2 page handouts for families regarding social emotional topics like, dealing with conflict, biting, communication and feelings.
- Simple scripted stories to help children practice social skills.
- Lists of popular children's books that support social emotional health with accompanying activities that can be done in the home setting.
- Games that focus on developing social emotional literacy.

Strategies that are incorporated and supported within the home setting should be culturally and linguistically appropriate, based on research or evidence if possible, be easy to implement and should be based on the child and families strengths.

Self assessment indicators for Standard B. 5

1. The early childhood mental health consultant will assure family has information and strategies to address the social/emotional and behavioral needs of the child.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC program will work together with the family on addressing the specific needs of their child in the home environment.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

6. Strategies Implemented at Home Should Coordinate With Strategies implemented in ECE Settings With the Ultimate Goal of Reducing Challenging Behavior and Helping the Child Succeed in Home and School.

Rationale: Included in the Search Institutes 40 developmental assets for early childhood (2007), is an emphasis on home and program connections. When a strong home-program connection is built it helps a child to experience security and consistency which support the building of internal assets. Achieving a strong family-program partnership requires a culture that supports and honors reciprocal relationships, commitment from program leadership, a vision shared by staff and families, opportunities to develop the skills needed to engage in reciprocal relationships, and practices and policies that support meaningful family engagement (Stark and Moodie, 2009). When partnerships are strong, the likelihood of strategies being consistent between home and school are greatly improved. All children, especially those who display challenging behavior, need this consistency from reliable and loving adults who provide support and guidance, especially during difficult times.

Guidance: Consultants have the unique position of being the link to connecting ECE program staff and families and to ensuring strategies being implemented are

coordinated across environments. By this juncture, the consultant, ECE staff and the family will have worked carefully together to develop a plan of action with identified strategies to be implemented across the home and early care and education program environments as discussed in Section B, Standard 4. To strengthen consistency and coordination of these strategies the consultant may suggest some of the following activities;

- **Team meetings.** Regular team meetings at the ECE program between the family, consultant and ECE staff can provide an ongoing opportunity for all involved to discuss progress and barriers with implementation of strategies. The consultant can fill the role of facilitator asking open ended questions (e.g. "Tell me more about how the visual schedules is working at home, and at school") and coach.
- **Parent visits to the ECE program.** Consultants can work with ECE program staff to encourage an open door policy with families so they feel welcome to come in and observe how their child is functioning in the school setting and to see how the ECE teacher is implementing the strategies agreed upon within the child/family-centered plan.
- **Home visits.** The consultant can use home visits to share information with families about progress at the ECE program and reflect on home consistency. If possible (would need proper consent from all families) the consultant may consider videotaping parts of the child's day within the ECE program to share during a home visit. Not all families are able to stop in to their child's place of learning due to work and life constraints.
- **Written check in.** When meetings are not possible, consultants might consider asking ECE providers to use e-mail check-ins with families or a notebook that travels between home and school with daily updates on the child's progress as well as the teacher's success in following through with techniques agreed upon in the team planning meeting.

Self assessment indicators for Standard B. 6

1. The early childhood mental health consultant will work to ensure consistency in strategies between the ECE setting and the home.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <hr/> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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7. Drawing on a Broad Knowledge Base of Local and Statewide Resources, the Consultant will Provide Assistance to Families with Referrals to Community-Based Services That Meet Mental Health Needs of Family Members and Their Children, as Well as Referrals for Other Developmental Services Needed by Individual Children.

Rationale: Early childhood mental health consultants can help create a coordinated system of care that is compatible to the needs of children and families. Referrals to other services are an important part of the ECMH consultation process. The Campaign for Children's Health Care (2007) reported that one in five households with children in the United States includes at least one child with special health care needs, nationwide, that includes more than 13.5 million children. Special health care needs can include illnesses such as, mental illness, developmental problems, health problems, such as severe asthma, autism, ADHD, sensory impairments, and more. Consultants must have an extensive foundation of knowledge and links to community resources to help families navigate their way through a referral process to gain access to needed services.

Guidance: Sometimes families ask for outside help as they have recognized a need for supplemental help. Other times, as a consultant works with families, it may become evident that the child or family members may need additional help that has not yet been addressed. This takes sensitive practice on behalf of the consultant as they broach the referral with the family. Some helpful considerations a consultant can reflect upon before talking with a family can include:

- What must it be like to be this family? What are their strengths and challenges in life?

- How can I make this information palpable? (e.g. share information about typical development and what observation might show)

Consultants should make a time to meet with families about concerns and referrals, in a confidential location. During the conversation consultants might consider the following process steps in their discussion:

A. Define the Need or Concern.

Consultant: "During my observations of Jonathon, I noticed that he often covers his ears throughout the day when the room gets a little loud." I wonder if it might be a good idea to have this checked into to see if there might be things we can do to help him be more comfortable?"

B. Decide Together- What Can We Do?

Consultant: "What do you think Mom and Dad?"

Mother: "He does do this at home and we just think it might be something he saw another child do or maybe he really is sensitive to noises?"

Consultant: "What are your thoughts on what we might do?"

Father: "We could talk to his doctor. The practice has quite a few specialists."

Consultant: "That is a good idea. I also have links to our local early intervention program that does some preliminary evaluation as well."

Father: "Okay, we'll try his Dr. first and then let you know how that goes."

C. Consider together- What is Your Desired Outcome?

Consultant: "I want Jonathon to thrive in school and don't want to overlook something that might affect this."

Mother: I agree, we should get it checked out to be on the safe side."

D. Determine Tasks to Do and Persons Responsible.

Consultant: "Okay, so you will make the appointment with your Doctor in a week or so. In the mean time I can put together some information for the Doctor with my observations if you like. Why don't we set a date to follow up in a few weeks?"

Detailed information on how to talk with families about challenges can be found in Section A, Standard 9.

Once a possible risk is identified, consultants need to have an array of referral sources in their back pocket, remembering special health care needs cover a broad range (e.g. mental illness, developmental problems, health problems, such as severe asthma, autism, ADHD, sensory impairments, etc.) of challenges. In Maryland, The Maryland State Department of Education makes resources accessible on their website at, <http://www.marylandpublicschools.org/msde>. Another referral example is The Therapeutic Nursery in Baltimore City. This is a specialized ECE setting which offers supportive comprehensive services to young children and families who are homeless. This program which is a collaboration of Kennedy Krieger and Early Head Start offers a therapeutic environment to vulnerable young children and their families who are in need of intensive supports. More detailed information on what resources consultants should be aware of and how to create working alliances with these referral sources are explained in Section A, Standards 10-11.

Below, is a snapshot of one consultant's experience with making referrals to other services:

"After getting called to a child care site for a particular child's frequent tantrumming and crying, we realized quickly that other resources could be helpful to enhance consultation and positive outcomes for this child and family. After observations and meetings with all those involved, it was found that the child was

missing a lot of care due to the mom's inability to pay for child care. The mother indicated that the father had recently left the family, and the child was having nightmares and fear related to his father's absence. We were able to link the mother with the local human services office to apply for a child care subsidy. Once the subsidy was approved so that mom could work and afford quality care, the child's schedule became predictable. The mother indicated that she was feeling sad, angry and tired on a regular basis, and felt it was affecting her relationships both at home and outside of home. She was willing to seek outside help, which led to a referral to a local therapist who worked on a sliding fee scale. We also linked the parent and child with a local divorce support group that included a playgroup. In addition, we linked the providers with a local child care provider group that was facilitated by the local school district. This provided them with an extra avenue for reflecting and experiencing what other child care providers were going through. In many child and family situations, linking to resources that families want builds capacity and empowerment and supports the consultant's role in facilitating quality care and strong, nurturing relationships."

Families may not always be willing or able to follow through with a referral. A parent may fear that the referral could result in an undesirable diagnosis or label for the child. Or, if the parent is suffering from depression or a substance use disorder herself, she may worry that if she seeks treatment, she could lose custody of her child. The consultant must gauge how ready the parent is to receive a referral recommendation, and pace the timing of the recommendation accordingly. Readiness depends, to some extent, on the level of trust that the consultant has developed with the parent.

Despite the consultant's best efforts to develop trust, appropriately time the referral, and frame the need for the referral as sensitively as possible, some parents simply are not ready or able to accept the recommendation, even after multiple attempts. This can be extremely distressing and frustrating for the consultant, especially when he or she believes the child is in desperate need of other services.

However, unless a protective services referral is indicated, the parent is the one who is responsible for deciding to accept or reject the referral.

If the parent is willing to accept the referral, the consultant must gauge if the parent is willing and able to contact the service provider herself or if the consultant needs to help facilitate the referral. In either event, the consultant follows up with the parent after a suitable amount of time to determine whether or not the parent actually accessed the service, and if not, to offer additional assistance to facilitate the referral.

Self-assessment indicator number 1 for Section A, Standard # 10 is applicable to this standard as well as indicators 1-2 for Section A, Standard #11.

An additional Self Assessment indicator for Section B, Standard 7 includes:

<p>1. ECMHC projects describe processes that consultants use to help ECE providers with referral processes for families.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p style="text-align: center;"><u>1</u> <u>2</u> <u>3</u></p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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8. Adapting a Consultative Stance That is Characterized by Availability, Approachability, and Mutual Respect, the Consultant Will Also Assist Family Members in Becoming More Empathetic and Responsive to Their Child.

Rationale: The consultative stance is a position that the ECMH consultant establishes in the ECE program to create warm, trusting working relationships. In their book, *Mental Health Consultation in Child Care*, Johnston and Brinamen (2006) describe the consultative stance as a “way of being” that highlights the mutual responsibilities and “shared endeavor” of the consultant and the staff, caregivers, or family members. An effective consultant understands fully that the child’s parent is and always will be their primary teacher and that the best way to meet the child’s needs is through a collaborative relationship. When consultants use a reflective, nurturing and responsive

stance with families they are mirroring behavior that families can use with their own children.

Guidance: The consultative stance supports healthy relationships. Some simple ways at the onset of consultation to help initiate relationship with families can include:

- Encouraging the ECE program to offer opportunities to “meet and greet” the consultant.
- Being accessible to families. Consultants can offer a schedule of their time onsite and simple information on how to arrange a meeting when needed.

The Center for Early Childhood Consultation website shares tips on mastering the consultative stance and some Do's and Don'ts for consultants to keep in mind at: http://www.ecmhc.org/tutorials/consultative_stance/mod2_3.html. Additionally, Section A, Standard 12, provides further detailed information on the consultative stance.

Self Assessment Indicator, for Standard B 8

<p>1. The ECMH consultant describes the methods they use to support a consultative stance.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p style="text-align: center;"><u>1</u> <u>2</u> <u>3</u></p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Section C. Well-Prepared Consultants

1. At a Minimum, Consultants Have a Bachelor's Degree, Preferably in a Human Services-Related Field (Such as Psychology, Special Education, Social Work, or Counseling). If a Consultant's Degree Is Not in a Human Services-Related Field, the Consultant Has Accumulated Credits at the Undergraduate, Graduate, or Professional Development Level in a Human Services-Related Discipline or Field.

Rationale: To provide high-quality programmatic and child/family-centered consultation, ECMH consultants need to have qualifications that enable them to address the complex issues faced by the service population. Consultants surveyed in the What Works? report (Duran et al., 2009) indicated that the quality of consultants is one of the most essential elements of a program's success.

A 2009 snapshot of the educational qualifications of mental health consultants across six study sites representative of quality ECMHC programs found that 75% of consultants had a master's degree and 25% had a bachelor's degree. Ninety-two percent reported that their degree was in a field related to mental health: psychology, marriage and family therapy, social work, or counseling (Duran et al., 2009). A similar finding in a research synthesis regarding early childhood mental health consultation states, "the consultant pool is largely comprised of mental health professionals licensed or certified within their state to practice a variety of human service disciplines" (Duran et al., n.d., 7). Although ECMH consultants come from diverse educational backgrounds, Allen, Brennan, Green, Hepburn, and Kaufmann (2008) observe that "the early childhood mental health workforce is in transition from one of broad diversity in terms of training, experience, roles, responsibilities, and work expectations to one that has specific expertise in early childhood mental health and the specific skills required to take on the role of consultant" (21).

Cohen and Kaufmann (2000) reported that a roundtable discussion supported by the Center for Mental Health Services recommended that mental health consultants be licensed as mental health professionals. Expertise in infant and early childhood mental health is essential to ECMHC work. Many states are recognizing the importance of ensuring that consultants have a sound clinical foundation and a relationship-based

approach to meet the complex demands of ECMHC work. Furthermore, these states are requiring that consultants hired to do ECMHC come in the door with a minimum of a master's degree or higher in social work, psychology, or a related field. Examples of nationally recognized ECMHC programs with this requirement are;

- Child Care Enhancement Program in Michigan
- Kid Connects in Boulder, Colorado
- Early Childhood Consultation Partnership in Connecticut
- Early Intervention Program in San Francisco, California
- Together for Kids in central Massachusetts

Guidance: In the absence of national licensing or accreditation for ECMH consultants, ECMHC programs can support high-quality services by setting an educational requirement for their consultants. National research is guiding the field of ECMHC to hire, at a minimum, professionals with a bachelor's degree in a mental health-related field and moving toward hiring licensed or licensed eligible professionals with a master's degree in a mental health-related field. These guidelines should be part of ECMHC programs' hiring procedures and included in their job postings, job descriptions, and preferably in the contractual agreements between state and local agencies and between local agencies and contractual consultants and/or employees. For example, in Michigan's Child Care Enhancement Program, the interagency agreement between the administrating agency and the contract agency stipulates that consultants:

Will have a master's degree and endorsement through the Michigan Association for Infant Mental Health (MI-AIMH), specifically:

- 1) ALL consultants hired to do ECMHC services must have a master's degree in social work, psychology, or a related field. License or license-eligible preferred.

- 2) All current consultants providing services need to maintain Level II MI-AIMH endorsement.
- 3) All consultants hired in the new fiscal year must attain Level II MI-AIMH endorsement within one year from the date of hire.
- 4) Consultants will be responsible for tracking and reporting on progress made toward meeting staffing qualifications, including MI-AIMH endorsement and educational degree (when applicable).

A sample job description from Michigan's Child Care Enhancement Program can be found in Appendix A (document # 16).

Self Assessment Indicator for standard C 1

1. ECMH projects have written and enforced policies on the educational level of consultants hired.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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2. Consultants Have Extensive Knowledge and Experience in Core Issues Related to Early Childhood, Such as Typical and Atypical Child Development, Emotional and Behavioral Health, Family Systems, Cultural Competence, and Knowledge of Evidence-Based Approaches to Managing Problematic Behavior.

Rationale: A core feature that helps define early childhood mental health consultation is the consultant's qualifications (Hepburn et al., 2007). ECMHC work is complex and multi-faceted. In one long-standing statewide ECMHC program, consultants surveyed (N=29) reported having an average range of 2½ to 30 years of experience providing early childhood mental health services. Three quarters of consultants had worked in the field for at least 10 years (Vanegren et al., 2008). Administrators need to have an unwavering commitment to setting standards for consultant competencies, hiring, and training and to continually improving a highly

qualified staff via multiple methods of technical assistance, supervision, and interpersonal support.

Guidance: According to Duran et al. (2009), it is critical for program administrators selecting ECMH consultants to consider the individual's existing skill set and the extent to which training and/or experience might fill any gaps. There are several ways program administrators can be thorough in the hiring process and thoughtful about maintaining support to grow and sustain consultants' expertise. From the onset, administrators need to be clear about what type of mental health services the consultant will provide. Most ECMHC programs provide both child/family-centered consultation and programmatic consultation, each of which typically includes program-focused planning to build quality. Child/family-centered consultation typically includes child assessment and intervention (but not therapy). The focus of the ECMHC services will help drive the type of degree, skills, and experience the consultant will need.

Administrators should develop a clear and concise job description to use during the initial hiring process. When the job requirements are clear, it may lead to a pool of applicants who are better suited for the position. Typically the job description includes:

- A summary of the position. For example:

This is a professional position providing early childhood mental health consultation (ECMH) prevention services to help adults nurture the social and emotional development of children birth through five years in licensed, registered, and enrolled child care and to improve the quality of care across settings. The ECMH consultant will consult with families and child care providers caring for children with social/emotional behavioral challenges that put them at risk for expulsion from child care settings or impact their success within care. The ECMH consultant also will consult with providers on ways to strengthen their overall program or home caregiving practices to promote the social/emotional development of all of the children in their care. The ECMH consultant will serve licensed child care centers and registered family child care homes in _____ County.

Credentials required. For example:

1. Bachelor's degree in a human service field.
2. Master's degree in social work, psychology, or a related field preferred.
3. License or license-eligible preferred.

- Experience required. For example:

Experience should include two years working as a mental health clinician specializing in relationship-based work with young children and their families. A general knowledge of early childhood development and assessment, as well as knowledge of the workings of early care and learning systems, is imperative. Experience providing training, consultation, and observation is needed. Lastly, this person must be a warm, flexible individual with strong communication skills.

- Responsibilities of the consultant, such as:
 1. Provide child/family-centered consultation when providers or parents have concerns regarding the social/emotional development of a particular infant, toddler, or preschooler.
 2. Observe and assess young children with social/emotional behavioral risks or challenges.
 3. Work with parents and providers to develop an action plan that identifies appropriate strategies/interventions for a child who needs individual support.
 4. Provide coaching and mentoring for the adults to help them implement the plan.
 5. Make referrals for children and their families to appropriate outside services when necessary.
 6. Provide discussion and training opportunities for providers and families to help them develop new skills that will enable them to understand and more effectively support the social/emotional development of all children,

including those with behavioral issues (may include observation, role-modeling, etc.)

7. Provide programmatic consultation as part of a child referral on certain elements of a child care program to address specific issues that affect more than one child, staff member, and/or family member.
8. Closely collaborate with other early childhood providers to integrate the ECMH consultation program within child care settings in the community.
9. Heighten community awareness of the mental health needs of young children in early care and learning settings.
10. Promote and market the program regionally.
11. Assist in program implementation and reporting, as required by funding source.

It is also important during the hiring process to consider the consultant's attributes. As Duran et al. (2009) state, "at least equally important as skills and knowledge is the consultant's approach to delivering consultation" (67). Program administrators may choose to list the key characteristics essential to high-quality, relationship-based service in a job description. Attributes may include:

- Warm, empathic personality
- Excellent communications skills (listening, oral, written, and public speaking)
- Ability to facilitate communication between persons with differing views
- Open-minded
- Flexible
- Respectful of other people's opinions
- Culturally competent (Ideally, the candidate will be representative of the ethnic population to be served.)
- Strong skills in developing collaborative relationships with diverse groups of people
- Ability to work independently and as part of a team
- Dependable with data collection and reporting requirements
- History of reliability and follow through

- Open to receiving continuing education in the field
- Strengths-based
- Patient
- Good listener

Appropriately disseminating the job announcement can also help improve the overall compatibility of a pool of applicants. ECMHC candidates can be pulled from a myriad of differing human services fields. Administrators might consider posting the ECMHC job announcement in the following places:

- University training programs in social work, psychology, and human service departments
- State and national organizations such as infant mental health associations, the National Association of Social Workers, etc.
- State Head Start Associations
- State mental health boards

Once the interview process begins, administrators may prepare a set of carefully constructed questions for the candidate. See Table 8 for a list of sample questions.

Table 8. Sample ECMHC Interview Questions

Philosophical Approach

1. Tell us about how you involve families in your work.
2. Describe what you think a consultant's role is in a child care setting and with a family.
3. How might this role differ from your prior clinical work (if applicable)?
4. How do you feel you might approach this change in approach?
5. Tell us about mental health principles that are important to your work (i.e., relationship-based, strengths-based, family-centered, etc.).
6. Tell us your thoughts on using a culturally sensitive approach in your work.
7. How do you think families you have worked with in the past might describe your work together?

Mental Health and Early Childhood Developmental Experience

1. Describe your mental health work with infants, toddlers, preschoolers, and families.
2. Describe your experience with reflective supervision. (How has it been helpful?)
3. What kinds of early childhood mental health screening and assessment tools are you proficient in using (i.e., child-focused, environment-focused, other)?
4. Describe the specialized mental health training you have had regarding infants, toddlers, and young children.
5. Describe the developmental knowledge/expertise you have regarding young children.
6. Tell us about some of the strategies you have used to support adults working/caring for young children. (Any evidence base?)
7. Tell us about your experience with observation and facilitating the planning process for young children with families and caregivers.

Training Experience

- Describe the training that you have delivered (topics, audience type, and size of audience).
- Describe the trainings that you have developed.
- Are you comfortable/experienced using technology within training?
- How comfortable are you with training?

Professional Skills

- What written documents have you produced? (Ask for a work sample.)
- Describe your experience with coordinating projects/meetings.
- Describe how you like to organize a new project.
- What is your familiarity with other early childhood programs (i.e., Head start, Part C, etc.)?
- Describe how your work experience has involved mentoring and coaching others.
- Have you ever had to market a new program? How do you feel about doing outreach to generate referrals?
- Describe your ability to meet deadlines and work under pressure.
- Describe your ability to take initiative.
- Describe your ability to complete paperwork and keep records.
- What level of supervisory support do you feel that you need or would like?

Personal Attributes

- Describe your personal strengths.
- How do you tend to deal with challenging work situations?

Once hired, consultants, along with administrators, may work to figure out where the consultant might need additional training and/or experience. These areas may be evident from the hiring process, but another helpful tool that ECMH consultants may consider using to reflect on needed skills is the *Mental Health Consultation in Early Care and Education Settings Core Knowledge and Competencies* self-evaluation checklist, which covers program consultation and child-focused consultation. The checklist, developed by researchers in Colorado, can be downloaded on the JFK Partners website (www.jfkpartners.org) as part of the publication *Mental Health Consultation in Early Care and Education: A Resource and Sustainability Toolkit for Providers*.

Some ECMHC programs offer comprehensive ECMHC orientation training to consultants. The orientation most likely will include comprehensive information on the program's process, policy, and practices, but it may also include standardized modules on child development, infant and early childhood social/emotional health, cultural competence, family-centered practice, evidence-based strategies, and other topics. Some state ECMHC programs team with training entities that specialize in infant and early childhood mental health, such as infant mental health associations, for training purposes.

Obtaining specialized infant and early childhood mental health credentialing or endorsement (such as Michigan's Association for Infant Mental Health [MI-AIMH] Endorsement) is another way for consultants to build their knowledge and skills. The intent of the MI-AIMH Endorsement is to recognize and document the development of infant and family professionals within an organized system of culturally sensitive, relationship-based, infant mental health learning and work experiences. Endorsement by the MI-AIMH "will verify that an applicant has attained a level of education as specified, participated in specialized in-service trainings, worked with guidance from mentors or supervisors, and acquired knowledge to promote the delivery of high-quality, culturally sensitive, relationship-focused services to infants, toddlers, parents, other caregivers, and families" (MI-AIMH, n.d.). Additionally, the endorsement can be useful in developing individual professional development plans. More information on Michigan's endorsement system can be found at www.mi-aimh.org/index.php.

New consultants who enter ECMHC programs with well established and “seasoned” consultants may take time to shadow and team with these co-workers to experience firsthand culturally competent practices and modeling of evidence-based strategies. This peer-to-peer learning can be quite instrumental in bringing training and book learning to life for a consultant. Typically this shadowing may occur over the first several months of a consultant’s job and may taper off as the new consultant takes on more work and begins to feel more comfortable in practice.

Consultants may also participate in state and national infant and early childhood conferences to increase their knowledge base on critical ECMH topics. In some states, ongoing ECMHC state-level technical assistance affords regular specialized training. For example, in Michigan, the state-level technical assistance staff coordinated quarterly, in-person meetings that all staff were required to attend; these included specialized 2–3 hour early childhood mental health training with attached social work CEUs. This allowed their consultants to network and learn from each other while receiving up to 8–12 hours of annual training relevant to their work and licensure.

Finally, consultants can gain knowledge and skills through clinical and reflective supervision. As the Michigan Association for Infant Mental Health’s *Best Practice Guidelines for Reflective Supervision/Consultation* (2009) explains, although clinical supervision is case-focused, it “does not necessarily consider what the practitioner brings to the intervention nor does it necessarily encourage the exploration of emotion as it relates to work with an infant/toddler and family” (1). The *Guidelines* document goes on to observe that supervision that is primarily clinical in nature will most likely include the following objectives:

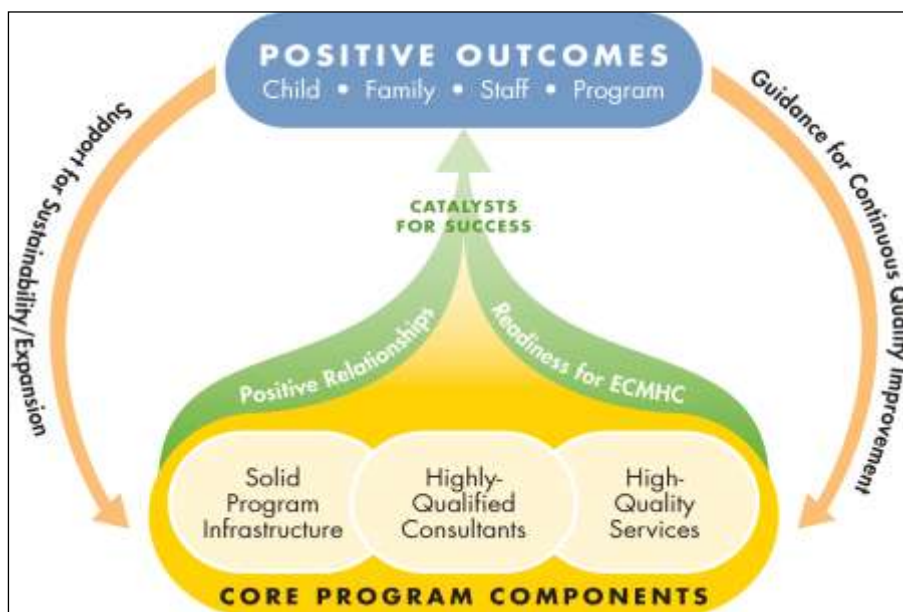
- Review casework
- Discuss the diagnostic impressions and diagnosis
- Discuss intervention strategies related to the intervention
- Review the intervention or treatment plan
- Review and evaluate clinical progress

- Give guidance/advice
- Teach

Reflective supervision gives consultants the opportunity to communicate with their supervisor individually and target specific issues that occurred during consultation services. Ideally, both the consultant and the supervisor actively listen to one another, engage in thoughtful questioning; topics of reflection and feedback should remain confidential. Reflective supervision is a hallmark of the Infant Mental Health (IMH) model (Gilkerson, 2004). The trusting relationship that develops between a supervisor and consultant is effective in reducing feelings of isolation, promoting personal and professional reflectivity in working under challenging circumstances, and increasing reflectivity about ECMHC practices (Heffron, 2005).

A model of ECMHC emerging from a national study of quality ECMHC programs completed by Georgetown University (Duran et al., 2009) places highly qualified consultants at the core of quality, alongside a solid program infrastructure and quality services (see Figure 3). Without highly qualified consultants, ECMHC programs have a decreased chance of reaching positive outcomes for children, families, ECE staff, and programs.

Figure 3. Emerging Model of Early Childhood Mental Health Consultation



Self Assessment Indicators for Standard C 2

1. ECMH projects have written and enforced policies on the knowledge and skills of consultants hired.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMH projects have built-in support and training mechanisms for supporting consultant growth and learning (e.g., ongoing TA, ongoing training opportunities, peer-to-peer events, etc.)	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

3. Consultants Have or Develop Specialized Knowledge of How Young Children Function in Group Settings.

Rationale: Both child/family-centered consultation and programmatic consultation require consultants to understand how children develop and function in group settings. Promoting the social and emotional well-being of all children in group settings requires an understanding of the qualities of high-quality supportive environments. A qualitative Head Start study stated that consultants who work in early childhood environments should have experience in early childhood education and an understanding of the challenges of teaching young children (Allen, 2008).

Guidance: Many consultants come into their role with prior work experience in early care and education settings. This knowledge of group care settings is essential within ECMHC programs. For consultants coming from areas such as home-based therapy or clinical work, the ECE program experience can be overwhelming at first. Going from individual child or family therapeutic practices to diverse group work that includes child, family, and ECE program and staff dynamics can be particularly

challenging. Mental health expertise provides a good foundation for growing knowledge and experience with group environments. Consultants can use this expertise (relationship-based practice, empathy, cultural sensitivity, etc.) to develop relationships with ECE providers and other consultants to learn more about group settings where children learn and grow.

Consultants need to have a fundamental understanding of what constitutes quality in ECE settings. Consultants should know the licensing requirements for ECE settings as set by their state licensing department. Maryland's licensing regulations for ECE programs can be obtained through the Maryland Department of Education. Consultants should also be familiar with state early care and education program standards. Maryland's State Department of Education's is revising their *Guidelines for Healthy Child Development and Care for Young Children*. The updated version can be downloaded from www.marylandhealthybeginnings.org

To gather background information on ECE program quality, consultants may spend some time familiarizing themselves with the TACSEI and CSEFEL Teaching Pyramid Model observation tools as listed in Section A, Standard 7. These tools list the many quality activities and ECE staff behaviors that ECMH consultants should be observing in group settings. Another helpful resource on best practice is the National Association for the Education of Young Children's position statement, *Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth through Age 8*. This position statement can be downloaded from NAEYC's website at: <http://www.naeyc.org/positionstatements/dap>.

Another avenue consultants can take to familiarize themselves with group settings is to obtain and view video clips developed by reputable sources such as West Ed (i.e., *The Next Step: Including the Infant in the Curriculum*) or NAEYC (which offers many videos on developmentally appropriate practices). If consultants are coming into their role with little or no experience in ECE settings, in addition to familiarizing

themselves with multimedia materials and research, consultants can greatly benefit from gaining hands-on experience in ECE settings. This experience may come into play through shadowing another consultant who has already established relationships with ECE programs. If shadowing is not an option, a consultant may reach out to ECE providers in the community to request a chance for observation. Consultants may consider visiting sites in Maryland that have proven to have reached a higher level of quality within the Maryland Child Care Tiered Reimbursement program. This program recognizes child care programs that go beyond the requirements of state licensing and registration regulations. To find out more go to:

https://www.marylandpublicschools.org/MSDE/divisions/child_care/credentials/tiered.

Consultants may also familiarize themselves with the dynamics of group settings through ongoing clinical and reflective supervision, as discussed in the previous Standard.

Self Assessment Indicators, Section C 3

1. ECMH projects have tools to help support the quality of group settings.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMH projects have practices in place to support consultants' knowledge and experience in group care settings.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

4. Consultant Knowledge Base and Qualifications Must be Aligned With Core Competencies in the State of Maryland for Mental Health and Early Childhood Professionals.

Rationale: Recent trends indicate that younger children and their families require a level of support and intervention that necessitates a special skill set in promoting and addressing social emotional wellness. Early childhood mental health consultants are professionals who are able to offer specialized techniques in building capacity and providing strategies to target young children with challenging behaviors within early care and education settings. It is necessary for the professionals servicing young children and families in a mental health capacity to have the proper credentials. Credentials can help to support a level of ECMHC program quality.

Guidance: At a minimum, consultants should have a degree in psychology, social work, or the human services which focus on the area of mental health. A recent national study found that in all but one of six exemplary ECMHC programs, the mental health professionals had a minimum of a master's degree and most were licensed (Duran et al., 2009). As a result of the lack of experts in this area, the consultant might have a Bachelor's degree in a field that teaches mental health topics such as psychology or social work. Those individuals with Masters level education and licensure in social work or counseling are highly desired. Some ECMH programs are able to bring on individuals with a Doctoral degree specializing in infant mental health.

The credentials of an individual are imperative, but just as relevant is the individuals professional experiences. ECMH programs may want to consider any previous experience working within early childcare setting and/or early childhood mental health. To assist, it is helpful for ECMH programs to have available a list of the skills required and duties to be performed for the ECMH consultant and become familiar with them. Some of the skills recommended are listed:

- Ability to provide strategies to the classroom staff to target specific child behaviors.
- Conduct observations (program and/or child specific) and give feedback

- Ability to develop and provide quality training and mentoring
- Excellent communication skills (written and verbal)
- Ability to be a team player

There are also core knowledge, skills, and attributes which include the following:

Knowledge of Child Development

Underlying concepts of social-emotional development
 Developmental knowledge to include pregnancy, infancy and early childhood
 Attachment and Relationships
 Trauma, separation and loss
 Screening, assessment, and clinical indicators
 Evidence-based strategies for mental health promotion, prevention and intervention
 Community resources
 Family systems

Knowledge of Early Care and Education System

State child care licensing rules
 early care and education program assessment
 Creating safe environments

Skills Observation

Listening and interviewing
 Working with families and staff within collaborative relationships
 Reflection
 Modeling
 Cultural competence

Attributes

Warmth
 Empathy
 Respect
 Reflection

Adapted from Early Childhood Mental Health Consultation: An Evaluation Tool Kit (Hepburn et al., 2007).

Self assessment indicator for Standard C. 4

1. The consultant's knowledge base and qualifications align with the core competencies for the state of Maryland.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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5. ECMH consultants Will Attend Trainings on Key Early Childhood and Consultation Topics and Practices; Including CSEFEL.

Rationale: With the growing needs of young children and their families in ECE settings, it is essential for training efforts to be devoted to early childhood mental health consultation. It is important to have support to build and maintain a workforce to support ECMH initiatives. The ECMHC projects need buy in from the local and state level policymakers to ensure that there are adequate training opportunities. For an early childhood mental health consultant to better attend to the rising needs of young children and families within ECE settings it is important to stay current on trends and the latest evidence based practices.

Guidance: As mentioned in the Introduction to this guide, the ECMH Steering Committee has led Maryland's efforts to adopt the Teaching Pyramid model—referred to locally as SEFEL. From 2006 through 2010, there have been three statewide Teaching Pyramid Train the trainer sessions conducted to ensure an adequate pool of SEFEL trainers (such as the ECMH Consultants and the state's MMSR trainers) are available to train early care practitioners to fully implement the training modules. Approximately 350 SEFEL trainers are available in Maryland that are capable of conducting the CSEFEL training modules for providers, as well as 50 coaches

supporting implementation to fidelity via the coaching model. In 2007, the ECMH Steering Committee helped support the development of an Early Childhood Mental Health Certificate program. This certificate program is for post master's level professionals to gain expertise in early childhood mental health. The Dean at the School of Social Work at University of Maryland, Baltimore, recognized the need to further develop the early childhood mental health workforce and invited experts from the University of Maryland, Baltimore Center for Infant Study; Secure Starts program focusing on early childhood mental health to teach a course as an elective for graduate students in social work. With the availability of such initiatives, ECMH consultants can continuously increase their knowledge base and skill set through various training.

There are several efforts to build the workforce to meet the increased demand for professionals needed to assist with young children presenting with challenging behaviors. Partnering organizations, such as Maryland Coalition of Families, MARFY, Maryland Family Network and Innovation Institute, have worked with the state to develop training modules, including SEFEL training, for childcare providers and families, as well as, technology assisted trainings, such as webinars and an online core competencies course for educators. These efforts grew out of the increased awareness and collaborative efforts to address the unmet mental health needs of young children and their families. The Maryland Model for School Readiness grant funding is available to local school systems to provide training and materials on SEFEL to address the social emotional domain of the MMSR and improve social emotional literacy for all children in school based early childhood settings. Additionally, funding is available from the Division of Special Education/Early Intervention Services to local school systems through the "Building Bridges" grant to improve child outcomes for children ages 3 through 5 with disabilities. As of 2010, 15 local school systems have accessed funding from one or both sources and are training ECE staff and implementing SEFEL in local jurisdictions in both school based and community partner programs. The committee and community stakeholders continue to advocate for increasing and sustaining the workforce's capacity to identify and intervene early to support the future success and well-being of young children.

Self assessment indicator for Standard C. 5

1. ECMH Consultants have attended training relevant to early childhood and consultation.	<p style="text-align: center;">1=Not Met; 2=Partially Met; 3=Fully Met</p> <table style="width: 100%; text-align: center;"> <tr> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	1	2	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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6. Consultants Will Undergo Background Checks Consistent With Other Professionals Working One on One With Young Children.

Rationale: Experts and the literature both identified conducting background checks as one of several critical licensing activities that help states ensure safety and health of children in healthcare settings. To ensure the utmost safety of young children the ECMH program is responsible for making sure the individual serving as the ECMH consultant has had a background check. This background check looks at history of child abuse, criminal, court, and other records of individual. The ECMH programs want to be able to have the consultants work one on one with the children and also be certain that they have made all necessary attempts that the children will be safe.

Guidance: The ECMH program implement procedures required for screening consultants that will be entering settings to work with children. Obtaining the background check is an important part of the initial process of bringing on the ECMH consultant. The ECMH program can either require that a consultant obtain a background check with the proper state agency or get consent to receive documentation of the results if the consultant has already had one completed recently.

Self assessment indicators for Standard C. 6

1. ECMH Consultant has undergone a background check.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMHC programs have results of the consultant background check.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

Section D. Ongoing Support

1. Consultants Will be Provided With Administrative Supervision That Relates to the Compliance With Federal, State, and Agency Regulations, Program Policies, Rules and Procedures.

Rationale: There is a level of accountability to the regulations, policies, and procedures for practicing consultation within ECE programs. An administrative supervisor can be the overseeing individual to aid in ensuring adherence to these rules and procedures through the work being performed by the ECMHC. This supervisor can encourage the promotion of good standards of work which align with the policies of the ECE program.

Guidance: The administrative supervisor along with the ECMH consultant will be provided the program policies, rules and procedures by the Director of the ECE program during the initial meeting discussed in Section A. Often the administrative supervisor is a part of the program management team or staff. This enables the consultant to have a main contact within the program who may be available more often than the Director or ECE provider. It is still important however, to keep the ECE program Director informed of what is happening with the consultation. The administrative supervisor can serve as the linkage.

Self assessment indicator for Standard D. 1

<p>1. ECMHC programs provide administrative supervision to the consultant that relates to the compliance with federal, state and agency regulations, program policies, and rules and procedures.</p>	<p style="text-align: center;">1=Not Met; 2=Partially Met; 3=Fully Met</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;"><u>1</u></td> <td style="text-align: center;"><u>2</u></td> <td style="text-align: center;"><u>3</u></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	<u>1</u>	<u>2</u>	<u>3</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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2. Consultants Will be Provided With Individual and/or Group Clinical and Reflective Supervision, Preferably by a Licensed Mental Health Professional Knowledgeable in Issues Related to Early Childhood. Reflective Supervision Addresses the Emotional Content of the Consultant's Work, and Attends to Relationships and the Complex Interactions Between Relationships (Between the Consultant and Supervisor, Consultant and Caregiver, Consultant and Parent, Parent and Caregiver, and Parent and Child).

Rationale: Early childhood mental health consultation requires careful guidance in its effort to be executed appropriately. What makes ECMHC a unique field of work is its merging of child care and mental health. This requires a special balance from a skilled individual with knowledge and expertise in each area. Reflective supervision from a licensed professional is highly recommended for ECMHC. The consultants should have access to reflective supervision—that is a licensed mental health professional with whom they can discuss relationship-based aspects of their work with young children, teachers, and families (Gilkerson, 2004). Those individuals who are operating in the positions of consultants encounter complex and stressful situations in which emotion needs to be teased out to function in the job more effectively. It is imperative to have an ongoing support system in which cases are able to be reviewed and learned from and assistance with problem solving occurs.

Guidance: ECMHC projects should offer direct supervision and/or oversight to its consultants by a licensed mental health professional. It is recommended that the supervision take place at regularly scheduled team meetings or on an as needed basis. A good example of an appropriate model of reflective supervision is the Johns Hopkins Bayview Medical Center, Child and Adolescent Psychiatry Department. It has offered ECMH consultation to Baltimore City Head Start for several years and has always provided a clinical supervisor who is skilled in the area of infant mental health to oversee its consultants. This program has been successful due to their development of a system for hiring and training their staff and the nature of the supportive relationship between the supervisor and the ECMH consultants. Contact the University of Maryland,

Center for Infant Studies to receive a list of graduates from their ECMH certificate program who might be able/willing to serve in this role.

Reflective supervision can also encourage a systematic way of supporting teachers through gaining an understanding of their behaviors and attitudes and its impacts on relating to children, fellow staff, and families (Gilkerson, 2004). The ECMH consultant is instrumental in helping the teachers to examine their interactions. It is also important for the ECMH consultant to have access to guidance in the event of being unclear about a situation and to receive assistance in providing quality services on an ongoing basis from another licensed clinician. The supervisor can provide other supports such as:

- Helping to better understand the ECE staff, children, and families.
- Assisting the consultant in becoming more aware of their own reactions and responses (transference/counter transference)
- Examine cases and develop new ways of intervening.

Self assessment indicator for Standard D. 2

<p>1. ECMH Consultants have documented that they have received clinical and reflective supervision by a licensed professional on a regular basis.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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3. Consultants Will Have Access to Ongoing Professional Development and Technical Assistance That Will be Appropriate to Their Level of Expertise and Licensing Requirements.

Rationale: The knowledge and skills that are required to be an effective ECMH consultant spans early childhood development, early education, mental health, social work, and family systems. Early Childhood Mental Health consultants will need to have access to opportunities to further their knowledge and skills. This training and technical assistance must take into account the great variation in backgrounds, years of experience, and formal training in mental health that the current workforce of consultants possesses in Maryland.

Guidance: Given the increased need for professionals with expertise in early childhood mental health, there are opportunities made available to individuals with varying levels of education and experience. As discussed in Section C, there are many initiatives available to master's prepared professionals. In addition, several state agencies servicing young children and families do a great job of providing training and educational workshops for consultants or anyone else at varying levels. Many of the Child Care Resource Centers offer ongoing training as well as technical assistance to consultants. Also Head Start, Core Service agencies, and the Department of Mental Health and Hygiene may offer annual training and ongoing technical assistance.

Self assessment indicators for Standard D. 3

<p>1. ECMH Consultants have access to ongoing professional development and technical assistance.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p style="text-align: center;"><u>1</u> <u>2</u> <u>3</u></p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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4. Consultants Have the Opportunity to Participate in Peer Support Meetings.

Rationale: Peer support groups reinforce a true commitment to a relationship-based approach to ECMHC. It is clear that relationships are a key ingredient for the success of ECMHC. While a consultant's primary focus is on relationships with ECE providers, families, and children, so too should ECMHC programs promote professional relationships among consultants. Peer support groups are ideal for building these relationships.

The concept of collaborative learning has been widely researched and advocated throughout the professional literature. "Collaborative learning" refers to an instruction method in which participants at various performance levels work together in small groups toward achieving a common goal. The participants are responsible for one another's learning as well as for their own. Thus, the success of one person helps others to be successful (Gokhale, 1995).

Research indicates that peer learning activities typically result in: (1) team-building spirit and more supportive relationships; (2) greater psychological well-being, social competence, communication skills, and self-esteem; and (3) higher achievement and greater productivity in terms of enhanced learning outcomes (Christudason, 2003). In a survey of one state's ECMH consultants, 83% reported that onsite, in-person meetings were "very helpful" (Vanegren et al., 2008).

Guidance: Although peer support meetings present valuable opportunities for consultants within ECMHC programs, these meetings must be structured thoughtfully to allow consultants to benefit from peer-to-peer learning and increase their skills.

There are various ways that peer support meetings can be effectively structured. For example, administrators may choose to facilitate quarterly technical assistance (TA) meetings and set up ongoing regional reflective supervision groups. Administrators may also choose to set up regular, dependable in-person opportunities for consultants

to get together. These can be half-day or all-day events. Some helpful hints for administrators to consider when planning TA meetings include:

- Set meeting dates one year in advance.

Consultants are busy, and if meeting dates are set well in advance consultants are more likely to attend.

- Identify a coordinator who will send out meeting notices and reminders.

Continual and timely reminders are important for keeping everyone updated on future meetings. In some programs, consultants may be hired mid-year due to funding streams or turnover and may not have been informed of the meeting dates. Therefore, regular communication is beneficial. Having the same person send out correspondence can alert consultants to promptly open e-mails or answer calls. If multiple people are sending correspondence, information can become cumbersome and overwhelming.

- Set consistent times and locations for the meetings.

If possible, try to find a location that is central for consultants who need to travel. Consultants may not always have ample funds to travel long distances.

- Set agendas for each meeting.

Having a prepared agenda that allows for some consistency across meetings will provide continuity and efficiency. For example, administrators might allow a short time at the onset of the meeting to do introductions, discuss state updates important to the program, and share any new evaluation or data collection information and then move into small group or peer-to-peer discussions.

- Have a consistent facilitator.

Having a state-level administrator or staff member prepare and facilitate these meetings sets a tone that consultants are valued. The facilitator, if consistent,

can also get a feel for the group dynamics and can follow up with information at subsequent meetings.

- Discuss topics that are relevant to the consultants.

It can be helpful to poll consultants on what topics they would like to discuss with peers, such as tips for involving families, engaging relative providers, talking to ECE providers about ECMHC services, and so on. These topics can then become the core of the agenda, and meetings can be consultant-driven.

Administrators might also take this opportunity to obtain feedback and advice on upcoming policy or practice changes.

- Follow up with consultants who are not in attendance.

To set a tone that these peer support meetings are important, it can be helpful to follow up with consultants who are not in attendance to inquire why they did not attend (and take any potential scheduling conflicts into consideration for future meetings) and to share any pertinent information discussed at the meeting.

ECMHC administrators may consider requiring consultant attendance contractually for a certain number or percentage of the TA meetings.

Although meetings are most beneficial, ECMHC programs may consider weaving in intermittent conference calls to support ongoing conversations among peers. These calls can be modeled after the in-person TA meetings in some respects, with dates set in advance, having a planned agenda, consistent facilitation, and so on. Regular calls can be shorter in length and can afford consultants an opportunity to “check in” with one another. Oftentimes using a round robin format to discuss topics of interest can be beneficial.

Reflective supervision groups also allow consultants time to reflect and learn with their peers. Reflective supervision groups are usually facilitated by an experienced administrative staff that is committed to, and knowledgeable about, mental health and educational practices. Reflective supervision groups provide a foundation for the development of coping mechanisms that help consultants understand and process the complex emotions that can arise in their work environments.

Typically, reflective supervision groups have approximately 8–12 regular members who meet together on a regular basis, at least one time per month. When setting up reflective supervision groups it can be helpful to consider:

- What is the purpose of the group?
- Who should be invited? Just ECMH consultants, or will consultants and/or practitioners from other agencies/fields also be included?
- Who will facilitate? Is this person qualified? (Do they have a mental health background? Do they have special Infant Mental Health Endorsement or meet guidelines set by state or local experts?)
- What will be the frequency, duration, and location of the meetings?
- Will the group be mandatory or voluntary?
- Is the information shared confidential?

The Michigan Association for Infant Mental Health has established guidelines for reflective supervision facilitators that may be useful to other programs establishing similar groups. These guidelines include:

- Agree on a regular time and place to meet.
- Arrive on time and remain open, curious, and emotionally available.
- Protect against interruptions (turn off the phone, close the door, etc.).
- Set the agenda together with the supervisee(s) before you begin.
- Respect each supervisee's pace/readiness to learn.
- Ally with supervisees' strengths, offering reassurance and praise as appropriate.
- Observe and listen carefully.
- Strengthen supervisees' observation and listening skills and suspend harsh or critical judgment.
- Invite supervisees to share details about a particular consulting situation, infant, toddler, family, and their own personal competencies, behaviors, interactions, strengths, concerns (keeping in mind all information is to be held confidential).

- Listen for the emotions that the supervisee is describing when discussing the case or response to the work (e.g., anger, impatience, sorrow, confusion, etc.).
- Respond with appropriate empathy.
- Invite supervisees to acknowledge and talk about any feelings awakened in the presence of an infant or very young child and parent(s).
- Wonder about, name, and respond to those feelings with appropriate empathy.
- Encourage supervisees to explore any thoughts or feelings they have about their work and about their responses to their work with very young children and families, as the supervisees appear ready or able.
- Encourage supervisees to explore any thoughts or feelings they have about the experience of supervision, as well as how that experience might influence their work and relationships with young children and their families.
- Reflect on the supervision/consultation session in preparation for the next meeting.
- Remain available throughout the week if there is a crisis or concern that needs immediate attention.

(MI-AIMH, n.d.)

Administrators should also consider the costs involved with reflective supervision groups. Some ECMHC programs may have staff within the contract agency that can provide facilitation at a minimal cost, but other programs will need to look for outside consultants to perform this duty. ECMHC programs might envelop the cost of reflective supervision groups into the administrative budget, or individual contractors may pay individually to take part in group supervision.

Self Assessment Indicator, Section D 4

<p>1. ECMHC projects describe mechanisms that are in place for peer support meetings.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p style="text-align: center;"><u>1</u> <u>2</u> <u>3</u></p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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5. Consultants Maintain a Caseload That Balances Program- and Child-Focused Work and Is Consistent with the ECMHC Model as Defined.

Consultants' caseload varies greatly based on the severity and complexity of the presenting challenges. According to a *What Works?* study by Duran et al. (2009), the caseloads of ECMH consultants varied across six study sites. However, half reported that they balanced a minimum of eight child/family-centered cases at one time with a maximum caseload of 12–18. Furthermore, consultants within two programs carrying child/family-centered caseloads reported carrying additional 2–3 ECE programmatic cases.

Guidance: Caseload considerations are complex, which makes it difficult for ECMHC programs to assign a fixed number of cases for a consultant to be carrying at any given time. Instead, many programs tend to recommend flexible ranges for consultants. ECMHC administrators want to uphold quality by maintaining realistic expectations for what consultants can and should be able to handle. Likewise, consultants want to do quality work and meet program requirements. Some questions ECMHC administrators might reflect on while thinking about caseload expectations include:

- What responsibilities does the consultant have beyond child/family-centered and programmatic consultation?

Some ECMHC programs have other requirements for consultants' time beyond child/family-centered and programmatic consultation, such as providing a certain number of social and emotional trainings for ECE providers and families. For example, in Michigan's Child Care Enhancement Program, each full-time consultant is required to provide a minimum of two 12-hour standardized social and emotional trainings in his or her community annually. Additionally, consultants are required to attend regular meetings with community members and to take part in monthly reflective supervision and technical assistance activities. Administrators need to consider these additional requirements when setting parameters and expectations around caseloads. In this program

example, administrators set a number of children to be served annually versus caseload requirements.

- Who is the service population?
 - Age range of children served

If ECMHC programs are serving children birth through five years and above, they may find that consultants are spending more time in sites to help assist with the varying ages of children and the developmental complexities that go along with supporting multiple age ranges.
 - Risk level of the families and ECE settings

Some ECMHC programs serve settings of varying quality or children and families at varying degrees of risk. Administrators and supervisors need to help consultants balance caseloads, not only to maintain a level of quality based on the needs of the ECE setting, staff, and families but also to maintain a level of self-preservation. For example, if a consultant is serving two or three very high risk and highly complex child/family-centered cases as well as several additional high-risk centers, that may be a heavy enough caseload until crisis situations ease up.
 - Type of ECE settings (i.e., center-based, family-home, relative providers, etc.)

The type of setting receiving ECMHC services can affect the consultant's time availability. For example, if a consultant is helping a large center with 6–8 classrooms and 15 or more staff, the time commitment will almost certainly be greater than that of a relative provider serving 2–3 children.
- Experience of the consultant

Seasoned consultants who have been consulting for several years have learned to balance their caseloads and busy schedules. Newer consultants may find they need time to shadow more experienced consultants and spend some time honing their skills and engaging in specialized training before taking on a full caseload. Administrators will

be key in providing helpful reflection opportunities to consultants so these types of decisions can be made together.

- How services are defined

Programs offer varying services and place emphasis on different types of consultation. For example, some ECMHC programs may focus on child/family-centered consultation and embed programmatic services within the context of the child/family-centered consultation. Consultants may also handle several child/family-centered consultation cases while also offering programmatic consultation to several other separate ECE settings. These types of intricacies should be determined and well thought out when determining consultants' caseloads.

Self Assessment Indicators, Section D 5

1. ECMHC projects clearly describe their program model.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. ECMHC projects describe caseload requirements for consultants and the rationale behind requirements set.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

6. The Overall Number of Consultation Visits Is Not Fixed But Is Responsive to the Needs of the ECE Provider and/or Family.

Rationale: Although limited information is available to help guide the dosage of ECMHC needed to produce positive outcomes, a few studies have garnered evidence that a longer duration of services can lead to positive outcomes. For example, preliminary evaluation results from Michigan's Child Care Expulsion Prevention Program suggest that greater improvements in child behavior, especially in the child care setting, were apparent with more visits and a longer duration of services (Carlson et al., in press). To individualize ECMHC services to meet the needs of children and their families, ECE providers, and program requirements, and to support consultant capacity, variability in consultation visits across ECMHC programs is quite common.

The duration and frequency of services are predominantly linked to the severity and complexity of the presenting challenges of the child or the ECE setting. For example, if a consultant is working with a child and family that has compounding challenges, such as possible developmental delays for the child, substance abuse issues in the home environment, and many quality challenges within the care setting, it is clear that the consultant may initially be involved at an intense level and then taper off as referrals are made and plans are put in place. It is hard to anticipate the length of service and number of consultations within such individualized services.

Important to note is that there is no set number of visits a consultant can make to ensure a quality relationship has been established. It is highly variable based on the consultant's stance and the openness of those involved. Ideally, ECMHC programs will build in mechanisms to support flexibility in terms of the requirements put forth to consultants regarding frequency and duration of services to meet unique needs.

Guidance: At the onset of services, consultants may find it helpful to give ECE providers and families' general guidance on the frequency and duration of services. This helps everyone to have preliminary expectations that are realistic, but at the same time it is important that this guidance has built in flexibility. For example, in some ECMHC programs the average length of consultation might be 3–6 months with weekly visits. As the consultant, family, and ECE provider talk, together they may decide that initially more frequent visits would be warranted due to the challenges at hand. Some

important questions for the consultant to keep in mind when talking to the ECE provider and family are:

For the ECE provider:

- “What days of the week might be best for me to come and visit your ECE setting?”
- “Typically in the ECE setting I like to observe for about ___ hours. How does that sound to you?”
- “Usually I visit once per week. What is your feeling about that considering the information we just discussed? Would more often be helpful?”

For the family:

- “How would you like me to keep in touch with you about progress at the ECE setting?”
- “How often would you like me to get in touch with you?”
- “Let’s talk a little more about home visits. As we discussed, if you are open to this, I can come and share some of the tips and strategies we are using at child care with you and also learn about some strategies that work at home to share with Sara’s teacher. If this is an option, how often would you like me to visit?”

As the case progresses and all of the people involved continue to talk, it may become evident that the consultation may need to end before the three months or continue past the six months, depending on progress. Sometimes new behaviors or concerns within the environment, the family, or the child are discovered several months into consultation, and plans may be revised and updated. Each case is highly variable and unique.

Although there seems to be variability among ECMHC programs in terms of the frequency and duration of consultation, several sites surveyed in the *What Works?* study indicated their average case would last about 3–6 months (Duran et al., 2009). Additionally, sites involved in the study reported that, on average, consultants made

weekly visits. Great variability in the amount of time spent per visit was found, averaging from 2 hours per week up to 16–20 hours per week.

Some ECMHC programs have formal agreements they share with ECE providers and families when services begin. These agreements may specify information on typical length of services, ECMHC services offered, the role of the consultant, and also any expectations consultants have from the persons receiving consultation (e.g., call if the child is ill on a scheduled observation date, be an active participant in the planning process, etc.). Sample memorandum of understanding forms are located in Appendix A (documents #2 & 3).

As shared in the Duran et al., *What Works?* studies (2009), San Francisco and Central Massachusetts have renewable year-long working agreements with ECE providers, and Boulder agrees to a two-year working partnership with a plan for transition built in. ECMHC programs might consider using similar agreements in their practices.

Self Assessment Indicator for Standard D 6

<p>1. ECMHC projects describe how case duration and frequency are responsive to the unique needs of families and ECE providers.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p style="text-align: center;"><u>1</u> <u>2</u> <u>3</u></p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Part II: Program and ¹State-Level Infrastructure

Section E. Local Infrastructure

1. *ECMHC Services Should Fit Into a Locally Identified “Continuum of Supports” for Children and Families.*

Rationale: The importance of a continuum of support when providing ECMHC services is well documented (Cohen & Kaufmann, 2005; Perry, Kaufmann & Knitzer, 2007). A continuum of support should reflect a “common vision of a community-based, family-centered, and culturally competent foundation of services and supports to meet individual needs” (Wishmann, Kates & Kaufmann, 2001, p. 7). It should span promotion through prevention, early intervention and treatment (Rosman, Perry & Pell, 2006, p. 13) and include a wide array of formal services as well as sources for informal supports.

A wide range of both professional helpers and “natural” helpers should be mobilized—grandparents, child care workers, neighbors, church members or others who understand and are willing to support young children and their families.

A continuum of support embraces families as the most important people in their children’s mental health development. It also acknowledges the importance of the quality of relationships that children begin to establish outside the family during their early years (Edwall, n.d.). At the local level the continuum would include the extended family and others identified from the caregiver network, including foster care, family supports, and social services. The continuum may include professionals from early childhood education; K-12 education, special education, mental health, child psychology, and pediatric medicine. The local community is critical in identifying a continuum to ensure common awareness, access, understanding and cross-referral among supports.

¹ In the standards there is a Section H related to State-level Infrastructure. This guide is for local program implementation; therefore Section H was not included in this resource.

Guidance: To prepare for this standard, programs can begin collecting information on the resources available from both the program and family perspectives and documenting this information. Recording the program's supports would help identify professionals, agencies, and partnerships in the community that support the healthy development of young children (from medicine, mental health, education, social services, etc). From the family perspective, supports would include individuals who have a significant role in the child's life, including parents, grandparents, other caregivers, etc. Some programs may choose to create a visual diagram of the supports to ensure that these stakeholders are supported and engaged.

To help develop a shared continuum of supports, it is helpful to start with a framework or template. See Appendix B (document #1) for a sample template. This tool has been customized to meet the needs of ECMHC programs. The columns identify the dimensions of the continuum of supports for children and their caregivers around early childhood mental health consultation. The rows allow the user to check if that dimension is present and record details about those services.

Once completed, the profile highlights strengths and gaps in the continuum of supports, as well as helps identify where early childhood mental health consultation services would fit. With this knowledge, ECMHC programs can better understand community capacity and respond, in ways such as deepening services, building alliances, initiating new services, and advocating for policy and programmatic changes. A completed profile can be integrated into a work plan to help guide an organization in program development and evaluation.

Self Assessment Indicators for Standard E1.

1. The ECMHC program has a clear understanding of the concept of continuum of supports	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC program has developed a profile of community resources within a continuum of supports for their community (e.g. diagram, map, document, etc.)	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
3. Stakeholders for the EMCH program have been involved in the process of developing a continuum of supports profile.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
4. The final profile is used in program development and evaluation.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

2. *Each State-funded ECMHC Project Will Have a Well-articulated Description of Their Consultation Model as Well as Procedural Guidelines, Such as Eligibility and Intake Procedures.*

Rationale: Well-articulated descriptions and procedural guidelines are foundational to a project's success. "Model clarity is a cornerstone of effective programs, helping to prevent role confusion among consultants and consultees, support consistency in service delivery, and create a necessary foundation for evaluation efforts" (Duran, Hepburn, Irvine, Kaufmann, Anthony, Horen & Perry, 2009, p. 48).

As programs design an evaluation plan for early childhood mental health consultation, it is important to think about the connections between specific services and activities, how they are going to be delivered and the desired outcomes. It is also helpful to articulate the "theory" or set of assumptions about how and why a particular set of strategies will lead to the desired outcomes.

It is important to distinguish the model of consultation used. In Maryland there are two models, one which is program-specific, and one which is child-specific with program supports. For example, for a program-focused consultation model, the theory of change for child-level outcomes would depend on the impact consultation would have on changing teachers' behaviors, classroom management strategies and routines. These "pathways" through which the effects of the intervention would manifest are the theory of change (Hepburn, Kaufmann, Perry, Allen, Brennan & Green, 2007, pp 17-18).

A program-specific model embeds the Mental Health Consultant (MHC) in classrooms where she/he observes the children, the caregiving environment and the adult-child relationships and consults with Early Childhood Education (ECE) providers. The classroom is the focal point. Once an ECE provider requests services, classroom and individual provider assessments are conducted to determine a plan of services for training and technical assistance. The outcome desired is to provide these staff with both skills and tools to ensure a healthy environment that promotes the social and emotional development of the children.

For the child-specific model, the MHC sees the individual child as the focal point, offering resources to the ECE provider and family to meet the child's needs. When an ECE provider has concerns about a child's overall development, a referral can be made. Once referred, a child is observed, often several times, and assessment is completed before an individual intervention plan is prepared. In addition to training and technical assistance for the ECE providers, other resources are accessed and provided, as well as possible referral(s) for additional services in the community. The supports in this model, while child-focused, do engage ECE providers, offer training and technical assistance, and promote a healthy environment for all children. More on child-focused consultation methods can be found in Section B, Standard 1.

Examples of social, emotional, behavioral or developmental issues that are commonly referred for ECMHC services are: aggression; lack of attention; anxiety; hyperactivity; withdrawal; disruption; lethargy; perceived depression; self-injury; or any other behaviors that are not developmentally appropriate or typical of children.

Whichever model is delivered, there are key components that should be in place. These are: a thoughtful and comprehensive logic model anchored in a researched theoretical framework (see Section F, Standard 1); guiding principles; clear delineation of eligibility criteria to establish reasonable expectations of ECMHC outcomes; positioning of ECMHC within a continuum of support (see Section E, Standard 1); and user-friendly intake procedures which emphasize a collaborative approach that is child-focused and family-engaged.

It is important to define what constitutes a case, the duration of services (how many weeks) and intensity (how many hours total), their location (ECE setting, home, other) as well as the roles and level of involvement of key stakeholders (ECE provider, family, ECMH consultants and other professionals). An example of an intake form is located in Appendix A (document # 22) and examples of a partnership Memoranda of Understanding are presented in Appendix A (documents # 2& 3).

Throughout all documents, it is important to display sensitivity to English language proficiency and cultural differences. These include print and digital materials, as well as communication skills of the MHC. Respecting cultural differences should be evident in policies, systems planning and direct services (Perry et al, 2007). Oversight of ECMHC programs should include representatives from cultures and ethnic groups represented and served in the community. These persons would serve as advisors on committees and/or boards for the organization. They would include parents, child educators, medical and social services personnel who serve children and families.

Key indicators for this standard would be first the presence of project materials, including brochures, website, stated guidelines, forms for referral and intake/admission, as well as any other documents (print or digital). Secondly, all project materials should reflect the theoretical framework underpinning the project as well as use language that is readable to all stakeholders, particularly families, and which is sensitive to culture and values around family and children. These theoretical underpinnings and an apparent sensitivity to culture (through language, respect for differing authorities, family dynamics, and community structures) are actually two measures of quality (Duran et al, 2009).

Guidance: There are several ways to prepare (Duran et al, 2009). One is to evaluate the marketing materials, such as fact sheets, website or brochures that describe the program and be sure that services match expectations as promised. Setting and promoting accurate expectations ensures greater understanding of what will and will not happen. When all involved understand the project accurately, their expectations are realistic and the outcomes are more favorably received. It reflects the adage “under-promise and over-deliver.”

Secondly, programs should enter into written contracts or memoranda of understanding (MOUs) with ECE providers/programs so that each party understands and commits to their roles and responsibilities. It could be important to craft these documents with legal counsel to be explicit and to

minimize misunderstanding or risk. Samples of MOU's are located in Appendix A (documents # 2& 3).

Lastly, it is important to define expectations early in the process. This involves questions between the MHC and those receiving services to clarify what is offered, what can be expected to happen during the consultation and the potential impact. A set of questions may be helpful to frame this process and allow for consistency. Sample questions might be:

- Do you have any other questions about what services we can provide?
- Do you understand the scope and the limits of our services?
- What other providers do you think we might need to engage to serve this child most effectively?
- How will we know when these services are working most effectively for this child?
- What else should I understand about working with this child that I have not asked?

The common elements for all the intake and MOU forms are clarity of purpose and outcomes, permission to provide services, termination options and statements of concern. Program-focused consultation collects data on the program characteristics; for the child-focused consultation, more demographics on the family are collected as well.

Self Assessment Indicators for Standard E2.

<p>1. The ECMHC program has materials documenting 1) program eligibility and intake procedures, 2) scope of services, and 3) referral process.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. ECMHC materials are culturally sensitive (e.g. language, community structures, family dynamics, authority roles and responsibilities).</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>3. Each case (classroom or child) has a signed agreement of consent with clear understanding of scope of services and termination processes.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

Section F. Data Collection, Evaluation, and Reporting Systems

1. *State-funded ECHMC projects may develop a logic model that details the possible resources, activities, theories of change, and outcomes for mental health consultation in terms of the child, family, staff, and the larger system of care.*

Rationale: As defined by the 2009 University Of South Florida Theory Of Change Logic Model Project, “the logic model development process allows system stakeholders to discuss desired system change, plan how to accomplish that change, and generate shared responsibility for the results. When logic models are revised and revisited at every step in program implementation, they are a significant tool for guiding change and understanding evaluation results. Logic models are also a useful device for continuous quality improvement, ensuring that program goals are being met through the strategies and interventions identified within the community's logic model.”

Program goals inform the logic model. When thinking of program goals, it is important to frame them in a format known as SMART. SMART is an acronym coined by Doran (1981) to describe goals that are specific, measurable, achievable, realistic and time-limited. There is great value in SMART goal setting to define outcomes more clearly and succinctly. An example of a SMART goal is “The XYZ Child Care Program will reduce the number of children who exit for behavioral challenges by 10 (50% reduction) by the end of the 2011 school year (June 30, 2011).”

When thinking about a program and its theoretical core, it is good to remember this guidance. “A program is a theory and an evaluation is its test. In order to organize the evaluation to provide a responsible test, the evaluator needs to understand the theoretical premises on which the program is based” (Weiss, 1998, p. 55). An EMCHC program is founded on the assumption that by providing consultation services to ECE providers and families, positive change will happen in the classroom that in turn will promote positive behaviors for those

children in the classroom. It is important to start with identifying those positive changes; what and how will children be different when consultation concludes? Why will these positive changes happen and on which theory of change are they based?

In practice, logic models link planned work with intended results in a systematic way that engages all stakeholders (Kellogg, 2001). It invites conversation among those invested in quality ECMHC services, within a service program as well as across programs in a community. By describing the elements of each resource and activity, persons in the service delivery model understand more fundamentally the components of each ECMHC service and how to collect meaningful data to measure what is done (outputs of services) and how it changes the quality of lives of children and families (outcomes).

A logic model graphically portrays the connections between social need and those services that respond to that need. It offers all stakeholders, including families, a way to communicate and understand how a program is structured. “In traveler’s terms, the logic model provides a map, beginning with current conditions (the starting point), linking these to a set of activities designed to address those conditions (the journey), which then are connected to short-term and long-term outcomes (the destination)” (Hepburn et al, 2007, p.18).

The following table decodes the terms of the logic model.

Table 9. Logic Model Terms

Logic Model Term	Translated
Program activities	Processes, tools, events, technology and actions
Outcomes	Specific changes in program participants’ behavior, knowledge, skills, status and level of functioning
Short-term outcomes	Attained within one to three years
Longer-term outcomes	Attained within four to six years

As the logic model is developed, sample key indicators (Kellogg, 2001, p. 15) are: a catalogue of the resources and actions needed to reach intended results; documentation of connections among available resources; planned activities and the results expected; and a description of the results in terms of specific, measurable, action-oriented, realistic and timed (SMART) outcomes. These form the building blocks of a logic model and should be crafted with input from as many stakeholders as possible (MHC, families, ECE providers, mental health professionals, educators, pediatricians, and others who interact with the families served in the local community).

Guidance: There are printed step by step guides for developing a logic model (Kellogg, 2001; Hernandez & Hodges, 2005). Organizations can choose to do this independently using one of the guides and following a process that aligns with their time and experience in this area. In addition, there may be external resources locally. United Way offices have promoted logic models for grant seekers in Maryland for a number of years. They may have resources or provide training to develop program capacity in this area. Academics and researchers do logic models. They may be able to offer in-kind services or may contract as consultants to help facilitate groups and oversee the theory and the design of the components.

The thinking behind the logic model starts with needs tied to children, their families and the environment. After generating a list, often expressed as challenges or gaps, the needs are aligned (both metaphorically and graphically) with the theory of change and the guiding assumptions of the ECMHC program. The next steps in the logic framework are the program activities. These are the processes, tools, technologies, events and actions which respond to the challenges and gaps as interpreted by the guiding theory and assumptions (Hepburn et al, 2007, p. 18). Outcomes, both short-term and long-term, are the results expected as measured in changes in behavior, knowledge, skills and functioning. Logic models used in ECMHC may look at differing perspectives, based on the stakeholder. It may be the child, family, staff/providers, and program (director/administrator).

An example of a logic model can be found in Hepburn et al., Early Childhood Mental Health Consultation, An Evaluation Toolkit (2007) in Appendix A pp 57-61. This toolkit can be found online at

<http://gucchd.georgetown.edu/products/ECMHCToolkit.pdf>

It presents the assumptions that guide the program philosophically at the top. Then the problem or issue is stated, framed by the community needs/assets and any other factors that influence the program design (influential factors). The outcomes are framed as outputs (data driven changes) as well as more global outcomes (quality of care and children fully ready in the social-personal domain). The bottom section sets specific strategies which need to happen to implement the program.

Self assessment indicators for Standard F1.

1. The ECMHC program has defined its philosophical framework and its program assumptions.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC program has prepared (independently or with consultation) a logic model of its early childhood mental health consultation program.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
3. The literature and e-text that describe the ECMHC program reflect the philosophical framework and assumptions.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
4. The logic model is understandable to families and community members.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

2. State-funded ECHMC Projects Will Report on Clear, Measurable Standards on a Periodic Basis, as Required by MSDE.

Rationale: MSDE, as the primary funding and policy setting authority for the local ECMHC programs in Maryland, sets Standards to monitor performance of the ECMH consultation programs they fund. Standard data collection and analysis, integrated into a well-crafted information system, are fundamental to best practice in program monitoring (Duran et al, 2009, p. 88). Data on program inputs and outputs provide information to understand potency of program services (how effective and of what quality they are) and are keys to sustainability (demonstrating that effectiveness to funders and users).

Guidance: The administrative data on the ECMH projects are collected through a monthly “Tally Sheet Report” submitted to MSDE. These data are descriptive in that they summarize characteristics of the ECMHC program as well as child-specific characteristics. Appendix B (document #2) has a blank copy of the current tally sheet, which is reported quarterly to MSDE. The data collected are date and status of partnership agreements, and the demographics of the ECE setting (accreditation, enrollment, staff and their credentials). For child-specific cases, additional data are collected on the demographics on the child (including whether receiving a child care subsidy) as well as certain details about the services (whether linked to other early intervention programs which have plans that must be implemented, the child’s placement, and availability of resources.)

These indicators are subject to change, as MSDE continues to refine its understanding of the many dimensions of ECMHC and as the field advances. School readiness remains one of the key outcomes of ECE. It is expected that the success of ECMHC services will be the retention of young children in ECE so that they enter school as kindergartners ready to learn.

Self assessment indicators for Standard F2.

1. The ECMHC program reports on all Standards requested by MSDE in an accurate and timely fashion.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC describes the goals of its program in ² SMART ways.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
3. These SMART goals are understood by family and community members who indicate by signing off on the goals.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

² SMART stands for: specific, measurable, achievable, realistic and time-limited.

3. *Each ECMHC Project Will Assess the Quality of Their Implementation and Use These Data to Guide Service Planning, and to Improve ECE Provider and Family Engagement.*

Rationale: Systematic and regular data collection is a powerful tool for program monitoring, quality improvement and, ultimately, sustainability (Duran et al, 2009, p.61). This outcome evaluation process should be ongoing and will assist in fully examining all elements when implementing ECMHC to determine if the model is working or not and how it can be improved to heighten the program's positive impact.

Another dimension of ECMHC program success is family engagement (Duran et al, 2009, p. 83). To do that requires time and effort to build trust, communicate effectively, and understand cultural and family dynamics. One of the primary roles in consultation is to initiate and sustain communication that promotes optimal family engagement.

Guidance: The most important first step in assessing quality is to identify both common and unique outcome indicators of quality performance. Ideally all stakeholders should be involved in the identification of these outcomes. To do this may involve time in conversation to study and select the outcomes that are most meaningful to that setting, using evidence-based practices in that selection process.

As programs begin a formal program evaluation process, there are key questions to consider. The key questions below in Figure 4 are from the EMCHC Toolkit (Hepburn et al, 2007, p36). These should be discussed and answered with program funders, administrators, staff and the community, including families who have used the services. The answers help frame the program evaluation process and tease out the indicators.

Figure 4. Key Questions for Formal Observation

Which process measures will truly capture whether or not our consultation program has been delivering the services we intended?

- ✓ Have the established process measures we are adopting been successfully used to track consultation services delivered in similar settings?
- ✓ Do we need to design and test some of our own measures, due to unique features of our program or consultant services?
- ✓ Are the tools we are considering user-friendly; that is will the staff who are providing process data be able to easily understand the measures and complete them?
- ✓ Is the package of process measures realistic in terms of staff time needed to fill them out?
- ✓ Do the tools actually address the outcomes we intend to produce through the consultation process?

Which outcome measures will successfully gauge the short- and long-term? consequences of the program?

- ✓ Is there evidence that the tools have been successfully used in other evaluation studies in early childhood settings?
- ✓ Have the reliability and validity of these measures been established?
- ✓ Are the measures we are considering sensitive enough to detect changes given the duration and intensity of our consultation program?
- ✓ Do we need to adopt measures that have norms for populations similar to ours, so that we can compare our outcomes to the scores of other groups?
- ✓ Are the tools culturally appropriate for the staff, children, and families in our program?
- ✓ Is the package of outcome measures realistic in terms of the staff members' and family members' time required to complete it?

Do the tools actually address the outcomes we intend to produce through the consultation process?

Examples of common quality indicators can be organized into four outcome areas based on stakeholders: program staff (including the MHC), ECE providers, families and children. Each stakeholder expects something different from ECMHC and is impacted differently; thus the outcomes vary.

Common quality indicators are found in best practices nationally and regionally. Unique indicators are those that are specific to one program that are tied to each community and those that reflect specific characteristics of the families served (military, itinerant, non-native English speakers, other, etc). These may include specific numbers of families served based on the characteristics above or other factors that one community considers critical to measure (e.g. score changes using a particular tool, such as the Preschool Mental Health Climate Scale or number of partners used in the delivery of services to show a continuum of care). Table 10 lists examples of outcomes by stakeholder group.

Table 10. Best Practice Outcomes and Unique Outcomes by Stakeholder

Stakeholder	Common Outcomes (Evidence Based)	Sample of Unique Outcomes
Program	Increased quality indicators Increased number of community program linkages Decreased job turnover	Increased quality indicators for special populations (military, non-English speaking, children with special needs)
ECE Provider	Increased skills for service success Increased skills for early intervention Improved communication with families/caregivers	Increased representativeness (service providers match characteristics such as language, race, ethnicity, gender)
Families/ Caregivers	Increased follow-through with referrals and services Decreased stigma toward mental health	Increased utilization of specific services recommended

	services Decreased stress in family	
Child	Increased school readiness Increased pro-social behavior Increased appropriate placements Decreased problem behaviors Decreased expulsion rates	Decreased frequency of expulsions for children of minority cultures

Source: Adapted from Duran et al, 2009, pp 89-90.

By selecting one outcome measure per stakeholder at a time, it is possible to build an incremental program evaluation process that is grounded in best practices, that measures nationally recognized common indicators, and that uses the local community to identify and measure unique indicators. Once an outcome indicator has been selected, it is important to look at tools to assess each of those measures. There are a variety of measures, which each collect specific information. A roster of instruments to measure outcomes can be found in *Early Childhood Mental Health Consultation, An Evaluation Toolkit*, Appendix C pp. 75-84. This document can be downloaded at: <http://gucchd.georgetown.edu/products/ECMHCToolkit.pdf>

[../AppData/Local/Microsoft/Windows/Temporary Internet Files/Low/AppData/Local/Microsoft/Windows/Mary/AppData/Local/Microsoft/Windows/Temporary Internet Files/Low/Content.IE5/SMX4RQS2/gucchd.georgetown.edu/products/72402.html](http://gucchd.georgetown.edu/products/ECMHCToolkit.pdf)

A sample satisfaction measure is presented in this same document in Appendix B, pp 71-72.

Data collection is not a single event. To measure the impact of an ECMHC program, data should be collected before (baseline) and after (follow-up) the consultation has been provided. Baseline and follow up data need to be collected systematically, in that the same tools administered by the same person should be used at the beginning of consultation and at the conclusion.

Strategies to engage family members revolve about building relationships. With sensitivity to culture, it is possible to identify which relationships are most powerful. Persons of authority vary from culture to culture. Sometimes it is a physician who can communicate the need for interventions with a young child (Duran et al, 2009, p.95), a respected elder in a family or community, or even a staff person who can broker among cultures due to the depth of relationships forged, often because of similarities of background (Duran et al, 2009, p.165). Materials to support family engagement strategies are included in a Best Practice Tutorial on www.echmc.org.

Families who are engaged tend to follow through with data collection and referrals to other providers; they report less stress in the family (anecdotally or through satisfaction surveys). Overall their understanding of mental health is improved so that the stigma is reduced (Cohen & Kaufmann, 2005).

Self assessment indicators for Standard F3.

<p>1. The ECMHC program will demonstrate annual assessment of the quality of the consultation using both process (satisfaction) and outcome measures (impact on children and their families).</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. Families and other community stakeholders are involved actively in identifying indicators of quality and key performance.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>3. Data are collected at baseline and following the conclusion of the intervention.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>4. Family engagement is measured through family participation in all phases of the consultation (willingness to participate and follow through on appointments and data collection).</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

4. *Standardized, Strengths-based Screening and Assessment Tools Will be Used to Track Outcomes for Children Referred for Child-focused Consultation Services. Data Will be Collected for Individual Children Once Parent Consent is Secured. These Data Will be Provided by the ECE Provider and Family When Possible at Initiation of Services and Then Again When Consultation Services are Completed. Norm- or Criterion- referenced Instruments Should be Selected That Reflect the Cultural and Ethnic Backgrounds of the Families Served by the ECMHC Projects.*

Rationale: In child-focused consultation, ECMHC services are expected to improve skills among staff and families” to prevent, identify, treat and reduce the impact of mental health problems among children” (Duran et al, 2009, p.1). Because the capacity of programs and systems are strengthened through ECMHC services, environments and behaviors are perceived as more positive. Data about both services and the outcomes of those services help to understand impact and effectiveness.

Guidance: The first step is to ensure that the parent/caregiver has consented. A sample consent form is located in Appendix A (document # 20). The common elements of each of these forms are that the family is informed, is voluntarily involved, and may choose to withdraw at any time. Other elements of Best Practice that should be included on consent forms are:

- the purpose and outcomes of ECMHC
- how data will be collected and used
- clear definitions of roles and responsibilities of all involved
- scope of confidentiality of the information

The most important measure of fidelity to the program model (Duran et al, 2009, p.48) is that realistic expectations of services and outcomes have been clarified for all stakeholders.

A pre- and post-services model tracks and analyzes these data at the initiation and conclusion of services. That means that when consent is granted, standardized tools for screening and assessment should be used before services start and after they conclude. Those tools must be asset-based, reflective of the cultural background of the family, and sensitive to language, tone and intention. For a list of child measurement tools see Appendix C in, *Early Childhood Mental Health Consultation, An Evaluation Toolkit* at, <http://gucchd.georgetown.edu/products/ECMHCToolkit.pdf>

Self assessment indicators for Standard F4.

1. The ECMHC program is using strengths-based and culturally sensitive screening and assessment tools.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. These tools are used to collect data at minimum at baseline and at follow-up.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
3. Parents have been asked and consented to use of the tools.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

5. *Standardized Tools Will Gather Data on the Social-emotional Climate of the ECE Environment Receiving On-site ECMHC Services. Data on Changes Over Time in Teacher and Program-level Outcomes Will Also be Recorded for ECE Programs Receiving Consultation Services.*

Rationale: The social-emotional climate of the ECE environment impacts on the child and is the primary target of ECMHC (Cohen & Kaufmann, 2005; Duran et al, 2009; Hepburn et al, 2007). Section A, Standard 2 documents much of the foundational importance of social emotional health, which is defined by the Center on the Social Emotional Foundations for Early Learning (CSEFEL) as “the developing capacity of the child from birth through 5 years of age to form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways; and explore the environment and learn—all in the context of family, community, and culture.” (Yates et al, p.2). Yates and her team promote understanding climate through steps that involve careful observation

of the interactions between adults and children. The key tools are thoughtful looking, listening, questioning and looking again. “Using valid and reliable screening and assessment tools, gathering information across multiple environments and sources, and cultural sensitivity are all important considerations when screening and assessing infants, toddlers, and young children” (Yates et al, p.2)

Climates change over time due to the development of the children in the classroom as well as other dynamics such as changes in child placements (children leaving and entering), and changes in staffing (new teachers, new aides). Measuring changes in teacher and program level outcomes is critical to understanding the social emotional climate. One key process measure is the Staff/Provider Survey completed by the ECE provider in relation to the relationship and services provided by the ECMH consultant. See Appendix B in, *Early Childhood Mental Health Consultation, An Evaluation Toolkit* for a sample of this survey located on pp 73-74 <http://gucchd.georgetown.edu/products/ECMHCToolkit.pdf>

Guidance: To measure impact and changes over time, data should be collected first as a pre measure when the services are started and then in a systematic way as the ECMHC is provided. One effective measure of time is every four months and/or at conclusion. For example, services for one child may start in January; pre-services or baseline data are collected then. As services continue, data are collected in May and then services conclude in July, when post or follow-up data are collected. For this ECMHC, there would be three data points, January, May and July. For another ECMHC which begins in January and concludes in March, data would be collected in January for pre or baseline and in March for post or follow up. With this ECMHC of only three months duration, there would be two data points, January and March.

Tools that can help to measure pre and post data can be found in Appendix C, *Early Childhood Mental Health Consultation, An Evaluation Toolkit* at , <http://gucchd.georgetown.edu/products/ECMHCToolkit.pdf>

Self assessment indicators for Standard F5.

1. The ECMHC program is using standardized tools for assessment of the social-emotional climate.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The tools are selected to include both process (satisfaction) as well as program outcomes for children, ECE providers and families.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
3. Data are measured at baseline and systematically thereafter.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

6. *Consultants will keep track of the type and amount of consultative services provided as well as the number of referrals made to community resources.*

Rationale: Dosage in consultation services refers to the frequency, type and intensity of services provided. To understand impact and quality of services, dosage is important to measure. For the MHC, a log of services should provide the details needed to track dosage and then compare services to quality indicators. These measures can be tallied by MHC, ECMHC program and statewide as measures of the consultation process.

It is important to remember, too, that for many cases there are needs for services beyond what the MHC can provide (Duran et al, 2009; Perry et al, 2007). When referrals are made to other community resources, the continuum of care is operationalized (see Section E, Standard 1).

Guidance: In Maryland, through the ECMHC Evaluation Process, a log for tracking services has been developed, see Appendix B (document #3). It serves as a model for what key elements need to be collected and complements

the other types of logs sites may use. The key elements any log should have include service types (e.g. observing, modeling, consulting with the teacher, researching interventions, etc) and duration (number of minutes). By tracking these data, it is possible to tally numbers of services by type and duration of services by minutes (a measure of intensity).

One important item to track is referrals to other community services. One program in Maryland has a template of community services where referrals are commonly made. This format provides a checklist for referral and allows for write-ins so that additional options are considered, see Appendix B (document #4).

To keep families informed, a type of log may actually be a letter and may include a summary of activities that an ECMH consultant has performed in the setting. This complements but does not replace the log.

Self assessment indicators for Standard F. 6

<p>1. The ECMHC program tracks type and amount of consultative services.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p style="text-align: center;"><u>1</u> <u>2</u> <u>3</u></p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. The ECMHC program tracks the number of referrals to specific community agencies which support ECMH consultation.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p style="text-align: center;"><u>1</u> <u>2</u> <u>3</u></p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

7. *Consultees will be given the opportunity to provide systematic feedback on the quality of ECMHC services provided to ECE providers and families.*

Rationale: Systematic process feedback is one of several key indicators of the quality and success of a service (Hepburn et al, 2007). The key is to collect and analyze these data regularly, at minimum annually. Sources of these

data (consultees) are ECE providers, community partners and family members. Each group contributes an important perspective on the process, the interactions, and the outcomes.

Process measures assess how ECMHC is being delivered and if it is being delivered with fidelity to the theoretical framework (see Standard F1 above). Given that many consultations are dynamic and change as more information is gathered and analyzed, it is important to document the tools and processes that the consultant uses. Each should be used with fidelity and as conceptualized.

Other indicators to consider include the qualifications and experience of participating ECMH consultants (see Section C, Standards 1-5); the extent to which the consultant provided a set of services specified in the logic model (see Section F, Standard 1); the quality of relationships between ECE providers and the ECMH consultants; the willingness of a ECE provider or family member to refer others (families and other providers) for services (which may be an item on a survey); and the costs of the time and services of the consultant.

Feedback on quality may take many forms, such as verbal anecdotes, written letters to key staff or community publications, letters of support for grants, and formal surveys. Using a log is one way to document types of tools; however, it will be necessary to add case notes to explain changes in implementation and changes in process, explaining the key to documenting those changes. Satisfaction with services and outcomes is a key piece of feedback sought by most organizations.

Guidance: To be systematic, feedback should be sought in formal ways, usually written in print or digital formats. Respondents should have the option to have their response be fully confidential. The invitation to respond should be timed ideally to follow the conclusion of services. With strong relationships it may be possible to measure feedback at the end of services and then several months (3-6 months) later. This subsequent measure, while more challenging to collect as providers and families may be less likely to respond, does allow for

more time to elapse to measure impact more fully. Sample process and outcome measures can be found in *Early Childhood Mental Health Consultation, An Evaluation Toolkit* (2007) in appendices B and C. This toolkit can be found by going to:

<http://gucchd.georgetown.edu/products/ECMHCToolkit.pdf>

Once data are collected, it is important to review and compile responses to use as a tool for program improvement. Analyses will interpret scores of any tools as well as themes among comments. Outliers (those scores or comments that appear least frequently but may have value as an indicator of improvement) should be considered as well. One example of such an outlier may be a parent who comments that a consultation service was hard to understand for her based on language or cultural differences. Such a comment may be made only once but have great import for a program that is seeking to be representative of all cultures and languages in its community.

Self assessment indicators for Standard F7.

1. The ECMHC program invites feedback systematically from all consultees, ECE providers, community partners, and families.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC program selects tools that measure quality in both the processes and outcomes of the program.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
3. Data are collected and analyzed at minimum annually.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

8. *State-funded ECMHC Projects are Expected to Participate in Administrative Reporting to MSDE and Statewide Program Evaluations.*

Rationale: Funders have obligations to many stakeholders. At the state level, MSDE has responsibility to report both the Maryland Legislature as well as to the US Department of Education. To collect meaningful data from programs using their funds, they must determine the scope and frequency of administrative reporting. In accepting those funds, local ECMH programs commit to timely, accurate and thorough reporting and full participation in any evaluation processes the state requires (descriptive, analytical, and other).

Guidance: When requested by MSDE, it is important to attend all meetings explaining the data request and to keep in touch with the key contacts at the state level. Data needs may change over time and it will be important to be in touch and flexible to their needs. Forms may change as may frequency of collection.

Similarly, it will be important to capture data digitally and store it in formats that are easily retrieved and sent on demand. Many programs use Excel spreadsheets (in the Microsoft Office Suite) and set up the fields horizontally and the cases by identifiers vertically on the spreadsheet. In that way, they can sort cases quickly and easily as well as generate charts and summaries graphically. A sample spreadsheet of the current MSDE tally is in Appendix B, (document #2). It shows the current data fields of greatest importance at this time.

There was a statewide program evaluation conducted by MSDE with consultation from UMD and Georgetown University that launched in August 2009 with an anticipated end date of June 2011. All programs statewide have participated in various phases of the pre/post service evaluation, including data collection, process evaluation, and a separate exit study of children who exit ECE programs for behavior reasons. ECMH consultants collected information on the

ECE climate, the stresses of providers, the quality of relationships and the outcomes achieved by a variety of program models. The results yielded important information for the field nationally, as well as for the state of Maryland and the individual projects. Participation in such projects is encouraged to advance practice and understanding of the impact of ECMH consultation.

Self assessment indicators for Standard F8.

1. The ECMHC program reports to MSDE with accuracy and in a timely fashion.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC program reports all indicators as requested by MSDE.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
3. The ECMHC program participates in all program evaluation efforts as invited by MSDE.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

Section G. Linkages with Community-Based Services

- 1. Representatives of ECMHC Projects Should be Highly Visible Members of the Communities They Serve. Examples of Community Participation Could Include Attending Local Meetings, or Involvement With the Boards of Important Local Agencies.*

Rationale: To build and operationalize a continuum of support requires sustained working relationships. These relationships are the product of time and effort spent in meetings and other projects working toward common goals. Often these meetings focus on a problem for a specific child, a program need or a gap in community resources. By working together to solve these issues, ECMH consultants and other community members build trust as well as understanding of the resources and talents of others. With common understanding, finding solutions to common problems is much easier. Over time and effort, these relationships deepen beyond just solving the immediate issue to dreaming of ways to anticipate or prevent situations that create these issues.

Guidance: Examples of community visibility would be service on a local board or committee of an organization serving family needs. With time and as working relationships develop, it is possible to identify service gaps in a single organization as well as throughout the community. A specific example might be a community's lack of a clinical psychologist, which means that families in crisis who live there might not be able to access individualized mental health services. By working as a community board member and using a needs assessment process, that MHC can encourage the Board to explore funding for the clinical psychologist's position and to craft an employment package attractive enough to create a strong candidate pool. In this example, by working together, seeing common needs and believing that resources can be expanded, funding was sought and the right professional was hired to meet this community's need.

Local boards are populated with persons who share the mission and values of ECMHC. Visibility and purposeful activities with those board members keep the issue of ECMHC in the forefront of the thinking of the community's leadership.

Time to dedicate to community work is precious. It will be important to look at time available and to match volunteer effort accordingly. There are committees on which one can serve rather than taking a full board position. There are events that need volunteer assistance that may be one time per year; batching effort may be a better solution than working on a committee that meets monthly throughout the year. When selecting which volunteer role to play, it will be important to consider the following questions.

- Does the organization's mission align with mine?
- Will my volunteer effort raise the visibility of ECMHC and its impact on the community?
- Will I extend my network of community resources by this work?
- Can I balance time and effort to do the best I can to make a difference with the time I have available?

Self assessment indicators for Standard G1.

1. The ECMHC program has staff members who are visible in the community, serving on boards and/or attending key meetings.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The community the ECMHC program serves knows about the ECMHC program.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

2. *ECMHC Programs Should Undertake Community Outreach. Examples of Outreach Activities Include Contacting Center-based and Family Child Care Providers by Mail or Phone, Attending Open House Events at the Same Early Child Care Facilities, and Providing Brochures and Other Materials That Describe ECMHC Services to the Local Pediatrics Community.*

Rationale: Community outreach reinforces the continuum of supports by building relationships, solidifying referral processes, and increasing awareness of the value of ECMHC. When other community agencies and providers understand the scope of ECMHC services, referrals for ECMHC are more timely and accurate, and expectations are more realistic. As families and those who support them are aware and then understand ECMHC, there are greater opportunities to intervene and to provide services effectively.

Community is defined broadly to include others in education, health, medicine, social services, and family supports, as well as the community at large. The activities listed in Section E, Standard 2 are examples of print and social methods to use for contacts. These can be broadened to include email, website links, and other digital media. While media are powerful, attendance at local events (open houses, recognition and award ceremonies, and annual meetings) increases the likelihood that information is shared. With busy schedules, reading print or digital media can be less effective than having a conversation or making a presentation live to an audience that includes those who can refer and be a part of the continuum of support. Ultimately ECMH consultants with deep networks in the community can uncover service gaps and can act as advocates to secure funding and influence policy and practice.

Reaching families may require different strategies than reaching professionals. Parents may trust others in the community, such as leaders in faith, the school, or the neighborhood. This would mean targeting clear and easily understood messages to those audiences, possibly in simple language, alternate languages, or graphics.

Guidance: To prepare for this standard, it would be important to review what community outreach currently exists, by content and format. This should be done annually, as communities change and it is important to remain current. First define the audience(s)? Who needs to be reached? What message(s) about ECMHC by content are most easily understood by each audience to be reached? Does one community group need more information on results while another needs more information on the process? What format reaches which audience best? Does a blast email work for one group but a refrigerator magnet work for another?

Referrals by others may be the single most important link in the outreach process for family-driven services. Families listen to other families and those they respect. Reaching that network may involve parent groups, digital social media sites, announcements through the faith community and other ideas. This is a great occasion to engage a sample of parents as advisors, who can assist programs to reach families in the most effective and efficient ways.

Self assessment indicators for Standard G2.

1. The ECMHC program has assessed its current levels of outreach and the audience it seeks to target.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC program has engaged family members in its outreach efforts.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
3. The ECMHC outreach efforts use effective methods and content to reach the target audience and ensure they understand and are able to participate in ECMHC.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

3. *Relationships With Community-based Services Should be Established so Adequate Referrals for Direct Services Can be Made in a Timely Fashion.*

Rationale: Timeliness implies the earliest intervention possible. When a referral from other community-based services to ECMHC is made (or vice versa) and it is at the crisis stage, there is greater risk that whatever services are provided can be “too little too late.” With referrals made earlier when children are at risk, there is greater opportunity to assess and determine the best intervention. Also, the ECE provider is better positioned to implement the intervention. With earlier identification and intervention, there are more resources (time, energy of the ECE provider, decision-making options) to find the right intervention and most importantly to implement it.

When relationships are strong enough, referrals are seamless for the family, meaning that there are minimal duplicated activities (such as requests for extensive documentation, repeated story telling of the family situation, introduction of services that duplicate those that have been provided by others).

Guidance: Building relationships to refer across programs is the single most effective way to make referrals with other community-based resources. These may begin with a tour of each other’s facility and exchange of business cards, so that access to each other is quick and easy. Attending community meetings, serving on committees to achieve common goals, working on individual cases together are ways to build those relationships. Many communities publish in print or on line directories of community services for children and families. Measures of relationships that have cemented include service on boards together (each other’s or others in the community), willingness to write funding support letters, and cross referral tallies to solve common problems for families and children.

Self assessment indicators for Standard G3.

1. The ECMHC program has identified key community partners.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC program has developed working relationships with these community partners.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
3. Cross referrals are made with these partners in a timely fashion.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

4. *Formal Mechanisms Will be Established to Obtain Feedback on Children or Families Who are Referred for Additional Services and Support From Outside Agencies.*

Rationale: When additional services and support from external agencies are needed, a formal referral should be made, documented and followed. This parallels a case management framework for that child and family, so that the continuum of supports is reinforced and any needs that are addressed within the consultation process are monitored.

Guidance: A sample form to refer children to other outside agencies and resources is presented in Appendix A (document #15). It is important that families are kept informed of these referrals, confidentiality is assured, and communication among the service partners is accurate and timely. This ensures that services are coordinated to avoid duplication or “falling through the cracks” when a family is not served fully or in a timely fashion.

Self assessment indicators for Standard G4.

1. The ECMHC program has a documented process to refer children for other services and community resources.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
2. The ECMHC program refers children and families in an accurate and timely fashion.	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p>1 2 3</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

5. *To Facilitate Coordinated Individualized Care Plans (IFSPs and IEPs) for Qualifying Children and Families, It Is Recommended That ECMHC Programs Maintain Linkages With Local Infant and Toddlers Programs, Preschool Special Education Services, the Judy Centers and Family Support Centers. Linkages With Early Head Start and Head Start Programs as Well as Home-visiting Programs are Also Critical.*

Rationale: The need for linkages among the educational programs is important to promote the continuum of supports, as defined in Section F, Standard 1. Among the partners in the continuum of support, the local school system and its many services for young children need to be well connected and relationships established. These include personnel from the Infants and Toddlers programs (Part C) and the Pre-school Special Education (Part B). The other community early education programs with state/federal funding and mandates for integrated services include Head Start and Early Head Start, as well as Judith Hoyer Centers. Family supports through DHR Family Support Centers and any other home visiting programs (through Department of Health, Social Services or other agencies) again reinforce the continuum and integrate the needs of the child and the family.

Beyond the educational and social services agencies, it is important to build relationships with the pediatric health community as well. Community can play an important role in early identification of at-risk children and often doctors and health professionals communicate most effectively with families in certain cultures. Early identification of children and cross referral to other services can promote health and prevent crises for the child and family.

Linkages with home visiting are important, as families are engaged more intimately. Duran and her team (2009) found that, while not common, home visits promote a more holistic approach to ECMH consultation, collecting data from the home context that complements what families choose to share when interviewed. Seeing the child in context at home yields additional data for planning the most effective interventions, which often include the family.

Guidance: When establishing community contacts (for more information see Section A, Standard 11, Section B, Standard 7 & Section G, Standard 3), relationships with the ECE community of providers must include those who serve children with special needs. These programs often operate within the local public schools or agencies they designate within that jurisdiction. In addition to governmental programs that offer these services, there are nonprofits providing them as well. Linkages may take many forms, but the most critical are: 1) key points of contact; 2) understanding of eligibility and entrance criteria; 3) mechanisms to explore referrals informally to test if a child/family is appropriate; and 4) formal referral processes, including consents, referral forms, and tracking mechanisms to ensure that services are provided (see Appendix A, document # 15 for sample referral form).

The pediatric health community may not be as easily accessible. Individual practices often are not staffed to provide linkages deeply in the community around services to children with developmental delays (Fine & Mayer, 2006). It would help to start to make contact with physicians, child psychologists and child psychiatrists, particularly those serving children who are in the ECE settings.

Sharing information can lead to deeper understanding of how to meet the service needs of these children by using each other's resources to best advantage.

Home visiting can be a labor intensive dimension of EMCHC services. Scheduling and conducting the in-home observation can involve multiple contacts and additional travel time, particularly when consultants cover large geographical areas. However the value of these visits in many cases outweighs the costs in time and effort. They should be conducted as much as possible, particularly with those cases where a home visit would engage the family more effectively and would provide critical new information or corroborate other data collected at the ECE setting.

Self assessment indicators for Standard G5.

<p>1. The ECMHC program has linkages and shares information and referrals with early childhood education and development programs such as Infants and Toddlers, Preschool Special Education, Judy Centers, Early Head Start and Head Start and Family Support Centers.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. The ECMHC program has linkages and shares information and referrals with the pediatric health providers in the community.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>3. The ECMHC program conducts home visits, particularly on those cases needing additional data for planning and implementation of services.</p>	<p>1=Not Met; 2=Partially Met; 3=Fully Met</p> <p><u>1</u> <u>2</u> <u>3</u></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

References

- Akon, A., Ramler, M., & MacLennan, K. (2003) Evaluations of Early Childhood Mental Health Consultation in Child Care Centers. *Early Childhood Education Journal*, 31(2), 91-99.
- Allen, M. D. (2008). Attributes of effective Head Start mental health consultants: A mixed methods study (Doctoral dissertation, Portland State University, 2008).
- Allen, M. D., Brennan, E., Green, B., Hepburn, K., & Kaufmann, R. (2008). Early childhood mental health consultation: A developing profession. *Focal Point*, 22(1), 21-24.
- Brauner, C.B.; Stephens, B. C. (2006). Estimating the Prevalence of Early Childhood Serious Emotional/Behavioral Disorder: Challenges and Recommendations. *Public Health Reports* 121: 303-310
- Bennet, T. (2001). *Differing Diversities: Cultural Policy and Cultural Diversity*. Strasbourg: Council of Europe
- Buysse, V., & Wesley, P. W. (Eds.) (2006). *Evidence-based practice in the early childhood field*. Washington, DC: ZERO TO THREE Press.
- Campaign for Children's Health Care. Children and youth with special health care needs (April, 2007). <http://www.childrenshealthcampaign.org/assets/pdf/Children-with-Special-Needs.PDF>
- Center for Early Childhood Mental Health Consultation. Georgetown University Center for Child and Human Development. <http://www.ecmhc.org/index.html>
- Center on the Social and Emotional Foundations for Early Learning. (n.d.). Research synthesis: Infant mental health and early care and education providers. Retrieved, May 21, 2010 from http://www.vanderbilt.edu/csefel/documents/rs_ecmhc.pdf
- Center for the Study of Social Policy (2004). Key program elements; family support services. http://www.cssp.org/uploadFiles/01_Family_Support_REV4.pdf
- Carlson, J., Mackrain, M., Van Egeren, L., Brophy-Herb, H., Kirk, R., Marciniak, D., Falvay, S., Zheng, Y., Bender, S., & Tableman, B. (2010). Implementing and Evaluating a Statewide Early Childhood Mental Health Consultation Approach to Preventing Child Care Expulsion for Children Birth to Five. Manuscript submitted for publication.

- Chang, H.N.-L. (1993). *Affirming children's roots: Cultural and linguistic diversity in early care and education*. San Francisco: California Tomorrow
- Christudason, A. (2003). *Peer learning*. Center for the Technology Leadership. University of Minnesota. No. 37. <http://www.cdctl.nus.edu.sg/success/sl37.htm>
- Cimino, J., Smint, B.J., & Tracy-Stainback, K. (2007). Evidence-based competencies for promoting social and emotional development and addressing challenging behavior in early care and education settings. JFK Partners; University of Colorado Health and Sciences Center and the Colorado Department of Human Services, Division of Mental Health.
- Cohen, E., & Kaufmann, R. (2005). Early childhood mental health consultation. DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Cohen, J., Onunaku, N., Clothier, S., & Poppe, J. (2005). Helping young children succeed; Strategies to promote early childhood social and emotional development. Zero to Three.
- Cooper, J.; Aratani, Y.; Knitzer, J.; Douglass-Hall, A.; Masi, R.; & Banghart, P.; (2008). Unclaimed Children Revisited, The status of children's mental health policy in the United States. New York, NY: Columbia University, National Center for Children in Poverty.
- Cooper, J., Masi, R., & Vick, J. (2009). Social emotional development in early childhood, what every policy maker should know. National Center for Children in Poverty. Retrieved May 24, 2010 from http://www.nccp.org/publications/pdf/text_882.pdf
- Copple, C., & S. Bredekamp, eds. (1997). Developmentally appropriate practices in early childhood programs serving children from birth through age 8. 3rd ed. Washington, DC: NAEYC
- Crane, K. & Mooney, M. (2005) *Community Resource Mapping*. National Center on Secondary Education and Transition (NCSET). <http://www.ncset.org/publications/essentialtools/mapping/default.asp>
- Doran, George T. (November, 1981) There's a S.M.A.R.T. way to write management's goals and objectives. *Management Review*, (70)11.
- Dunlap, G., Carr, E. G., Horner, R. H., Zarccone, J. & Schwartz, I. (2008). Positive behavior support and applied behavior analysis: A familial alliance. *Behavior Modification*, 32, 682-698.
- Duran, F., Hepburn, K., Irvine, M., Kaufmann, R., Anthony, B., Horen, N., & Perry, D. (2009). *What works? A study of effective early childhood mental health consultation*

- programs*. Washington, DC" Georgetown University, Center for Child and Human Development.
- Duran, F., Hepburn, K., Kaufmann, R., Le, Lan., Allen, M.D., Brennan, E., & Green, B. (n.d.) Early Childhood Mental Health Consultation, Research Synthesis. http://www.vanderbilt.edu/csefel/documents/rs_ecmhc.pdf
- Edwall, G. (n.d). Early Childhood Mental Health: The Continuum of Care. Minnesota Association's for Children's Mental Health. http://www.macmh.org/info_resources/articles/glenace_article.php
- Fenichel, E. (Ed.). (1992). Learning Through Supervision and Mentorship to Support the Development of In-fants, Toddlers and their Families: A Source Book. Washington, D.C.: Zero to Three.
- Fine, A. & Mayer, R. (December, 2006) *Beyond Referral: Pediatric Care Linkages to Improve Developmental Health*. The Commonwealth Fund. <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2006/Dec/Beyond-Referral--Pediatric-Care-Linkages-to-Improve-Developmental-Health.aspx>
- Florida State University Center for Prevention and Early Intervention Policy. (2006). *Mental Health Consultation in Child Care and Early Childhood Settings*. pg. 19.
- Gilkerson, L. (2004). Reflective supervision in infant-family programs: Adding clinical process to nonclinical settings. *Infant Mental Health Journal*, 25(5), 424-439.
- Gilkerson, L. (2004). Irving B. Harris distinguished lecture: Reflective supervision in infant-family programs: Adding clinical process to nonclinical settings. *Infant Mental Health Journal*, 25, 424-439.
- Gilliam, W. S. (2005). *Prekindergarteners left behind: Expulsion rates in state prekindergarten systems*. New Haven, CT: Yale University Child Study Center.
- Gilliam, W. S., & Shahar, G. (2006). Prekindergarten expulsion and suspension: Rates and predictors in one state. *Infants and Young Children*, 19, 228-245.
- Gokhale, A. (1995). *Collaborative Learning Enhances Critical Thinking*. Journal of Technology Education. Volume7, Number 1.
- Harms, T., Clifford, R.M., & Cryer, D. (2004). Early Childhood Environmental Rating Scale. New York, NY: Teachers College Press.
- Harms, T., Cryer, D., & Clifford, R.M. (2006). Infant Toddler Environmental Rating Scale. New York, NY: Teachers College Press.

- Harms, T., Cryer, D., & Clifford, R.M. (2007). *The Family Child Care Environmental Rating Scale*. New York, NY: Teachers College Press.
- Harms, T., Jacobs, E.V., & White, D.R. (1995). *The School Age Care Environment Rating Scale*. New York, NY: Teachers College Press.
- Harrell, A., Burt, M., Hatry, H., Rossman, S., Roth, J., Sabol, W., (n.d.) *Evaluation Strategies for Human Services Programs, A Guide for Policymakers and Providers*. The Urban Institute: Washington, DC.
- Heffron, M. C. (2005). Reflective supervision in infant, toddler, and preschool work. In K. Finello (Ed.), *Handbook of training and practice in infant and preschool mental health* (pp. 114-134). San Francisco: Jossey-Bass.
- Hepburn, K.S., Kaufmann, R.K. , Perry, D.F., Allen, M.D., Brennan, E.M., Green, B.L. (2007). *Early childhood mental health consultation*. Washington, DC: Georgetown University, Technical Assistance Center for Children's Mental Health; Johns Hopkins University, Women's and Children's Health policy Center; and Portland State University, Research and Training Center on Family Support and Children's Mental Health.
- Hernandez, M. & Hodges, S., (2005) *Crafting Logic Models for Systems of Care: Ideas into Action*. [Making children's mental health services successful series; no. 216-1-rev]. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies.
- Isakson, E., Higgins, L., Davidson, L., & Cooper, J. (2009). Indicators for social-emotional development in early childhood, a guide for local stakeholders. National Center for Children in Poverty. Retrieved on July 7, 2010 from http://www.nccp.org/publications/pdf/text_882.pdf
- Johnston, K. & Brinamen, C. (2006). *Mental health consultation in child care*. Washington, DC: Zero to Three.
- Kaufmann, R., (n.d.) A framework for early childhood mental health consultation in a system of care. National Technical Assistance Center for Children's Mental Health, Washington D.C: Georgetown University, Center for Child and Human Development.
- Johnson K, Knitzer J, Kaufmann R. (2002). Making dollars follow sense: Financing early childhood mental health services to promote healthy social and emotional development in young children. New York, NY: The National Center for Children in Poverty, Mailman School of Public Health, Columbia University; 2002. *Promoting*

the emotional well-being of children and families, Policy paper no.4. Available at: http://www.nccp.org/pub_pew02d.html. Retrieved on May 3, 2010.

Johnson, K.; Knitzer, J. (2005). [Spending smarter: A funding guide for policymakers and advocates to promote social and emotional health and school readiness](#). National Center for Children in Poverty, Columbia University Mailman School of Public Health. pg. 9

Johnston, K. & Brinamen, C. (2006). Chapter 1. Mental Health Consultation in Child Care: Transforming Relationships Among Directors, Staff and Families. Zero to Three Press: Washington, D.C.

Koralek, D. (2005). *Caring for Infants and Toddlers*. Washington, DC: Teaching Strategies.

Lentini, R., Vaughn, B. J., & Fox, L. (2008) *Creating Teaching Tools for Young Children with Challenging Behavior* [CD-ROM]. (Technical Assistance Center on Social Emotional Intervention, University of South Florida, 13301 Bruce B. Downs Tampa, FL 33612

Mackrain, M., & Marciniak, D. (2007). Chapter 5, Child and Family Centered Consultation. Unpublished manuscript.

Mann, Tammy (1998) *Promoting the mental Health of Infants and Toddlers in Early Head Start: Responsibilities, partnerships, and supports*. Zero to Three, 18(2), 37- 40.

Michigan Association for Infant Mental Health. Southgate, MI. page on Endorsement overview: http://mi-aimh.org/endorsements_overview.php

Michigan Association for Infant Mental Health (n.d.). Best practice guidelines for reflective supervision. Southgate, MI.

Mincic, M., Smith, B.J., & Strain, P. (2009). Administrator strategies that support high fidelity implementation of the pyramid model for promoting social-emotional competence & addressing challenging behavior. Technical Assistance Center for Social Emotional Intervention. Retrieved May 5, 2010 from http://www.challengingbehavior.org/do/resources/documents/brief_administrator.pdf

Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy Press.

- National Association for the Education of Young Children (2005). Position Statement: Code of Ethical Conduct and Statement of Commitment.
<http://www.naeyc.org/files/naeyc/file/positions/PSETH05.pdf>
- National Association for the Education of Young Children (2009). Position Statement on Developmentally Appropriate Practice.
<http://www.naeyc.org/files/naeyc/file/positions/position%20statement%20Web.pdf>
- NAEYC Update. (Fall, 2009) NAEYC Accreditation and Quality Rating and Improvement Systems. 10(2)1.
- National Center for Cultural Competence (2006) *A Closer Look at Culture*.
<http://www11.georgetown.edu/research/gucchd/nccc/documents/pptculture.pdf>.
- NCSET (National Center on Secondary Education and Transition. Community Resource Mapping Tool 4: *Scanning the Resources. Essential Tools - Community Resource Mapping*.
<http://www.ncset.org/publications/essentialtools/mapping/step2.asp>
- Nelson, F. 2009. Developmental screening of infants and toddlers. Achieving the Promise of a Bright Future series. Washington, DC: ZERO TO THREE.
www.zerotothree.org/devscreening
- Norman-Murch, Trudi (1996) Reflective Supervision as a Vehicle for Individual and Organizational Development. *Zero to Three Bulletin* October/November, 17(2). *Zero to Three*: Washington, DC.
- Parlakian, R.(2001). Look, listen & learn: Reflective supervision & relationship-based work. Washington, DC: *Zero to Three*.
- Parlakian, R., & Seibel, N.L. (2001). *Being in charge: Reflective leadership in infant/family programs*. Washington, DC: *Zero to Three*.
- Perry, D., Kaufmann, R. & Knitzer, J. Eds. (2007) *Social and Emotional Health in Early Childhood: Building Bridges between Services and Systems*. Baltimore: Paul H. Brookes Publishing Company.
- Perry, D., Trivedi, P. & Duran, F. (October, 2009) *Early Childhood Mental Health Consultation (ECMHC) Standards for the State of Maryland*. Georgetown University, Center for Child and Human Development.
- Perry, Deborah F., & Kaufmann, Roxanne K. (2009, November). *Policy brief: Integrating early childhood mental health consultation with the Pyramid Model*. Tampa, FL: Technical Assistance Center on Social Emotional Intervention for Young Children. Retrieved January 6, 2010, from
<http://www.challengingbehavior.org/do/resources/briefs.htm>

- Pflieder, J. (2002). 8 Characteristics That Define Relationship-Based Work in Reflective Supervision. Child Mental Health. Head Start Bulletin #73. HHS/ACF/ACYF/HSB.
- Raver, C., & Knitzer, J. (2002). Ready to enter: What research tells policymakers about strategies to promote social and emotional school readiness among three- and four-year old children. New York, NY: National Center for Children in Poverty. nccp@columbia.edu
- Rosman, E., Perry, D.F., & Pell, K.L. (2006) *Early Childhood Community Partnership System Evaluation 2005-2006*. (Available from Anne Arundel County Local Management Board, 1 Harry S. Truman Parkway, Suite 103, Annapolis, MD 21401).
- Sandall, S., Hemmeter, M.L., Smith B.J., & McLean, M.E. (EDs.) (2005) DEC recommended practices: A comprehensive guide for practical application in early intervention/early childhood special education. Missoula, MT: Division for Early Childhood.
- Satcher, D. (December, 1999). *Mental Health: A Report of the Surgeon General*. Washington DC: Government Printing Office.
- Strain, P., & Dunlap, G. *Being an evidence-based practitioner*. Retrieved on May 5, 2010 from http://www.challengingbehavior.org/do/resources/documents/rph_practitioner.pdf
- University of South Florida. (2009) *Theory of Change Logic Model*. (<http://logicmodel.fmhi.usf.edu/theoryofchange.html>).
- Van Egeren, L., Zheng, Y., Carlson, J., Brophy-Herb, H., Kirk, R., Tableman, B., et al. (April, 2009). *Preventing children's expulsion from childcare: Variations in consultation processes in a statewide program*. Poster presented at the Society for Research in Child Development Conference, Denver, CO.
- W.K. Kellogg Foundation. (2001) *Using Logic Models to Bring Together Planning, Evaluation and Action: The Logic Model Development Guide*. Battle Creek, MI: Author.
- Weiss, C. H. (1998) *Evaluation: Methods for studying programs and policies*. (2nd Ed). Upper Saddle River, NJ: Prentice Hall.
- Wilcox, M.J. & Weber, C.A. (2001). Relationship-based practice in early intervention. Washington, D.C.; Poster presentation at the NAEYC National Institute for Early Childhood Professional Development

Wishmann, A., Kates, D. & Kaufmann, R. (March, 2001) *Funding Early Childhood Mental Health Services and Supports*. Georgetown University Child Development Center.

Yates, T., Ostrosky, M., Cheatham, G., Fetting, A. Shaffer, L. & Santos, R. (2008) *Research Synthesis on Screening and Assessment Social-Emotional Competence*. The Center on the Social and Emotional Foundations for Early Learning, Vanderbilt University.
http://www.vanderbilt.edu/csefel/documents/rs_screening_assessment.pdf

Yoshikawa, H., & Knitzer, J. (1997). *Lessons from the field: Head start mental health strategies to meet changing needs*. New York: National Center for Children in Poverty.

Zero to Three. <http://www.zerotothree.org>

Glossary

Assessment—The process of gathering an array of information about a child’s strengths and needs from caregivers, across environments, and using various methods of observation for the purpose of making evaluative or diagnostic decisions. (Kaufmann & Hepburn, 2007).

Capacity building—To improve or increase the ability of early childhood programs to address the social and emotional needs of young children (Cohen & Kaufmann, 20005).

Child/family centered consultation—Early childhood mental health consultation services that address the factors that contribute to a child’s strengths and challenges in the early childhood setting (Cohen & Kaufmann, 2005).

Collaborative relationship—A productive working relationship between a mental health consultant and an early childhood professional which allows them work together to solve problems (Cohen & Kaufmann, 2005).

Confidentiality—Assurance that a person’s identity will not be revealed before, during, or after data collection (Sieber, 1998).

Consultant (ECMHC) — Also called **Early Childhood Mental Health Consultant**. The professional who provides early childhood mental health consultation to Early Care and Education (ECE) providers.

Consultative stance—Consultant “way of being”; ten identified elements: mutuality of endeavor, avoiding the position of expert, wondering instead of knowing, understanding another’s subjective experience, considering all levels of influence, hearing and representing all voices, the centrality of relationships, parallel process as an organizing principle, patience, and holding hope (Johnston & Brinamen, 2006).

Consultee – Person receiving EMCH consultation services; may be family member of ECE provider.

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

Early Care and Education (ECE) Directors— (also called **Program Directors, Administrators**) – Those persons in charge of Early Care and Education (ECE) programs provided in centers or in family-based settings.

Early Care and Education Providers (ECE Providers) — (Also called **Teacher, Child Care Provider**). Center-based and family child care providers who receive consultation services from MSDE/Maryland Family Network (formerly MCC) funded projects. These

may be classroom staff (teachers and assistants) in center-based Early Care and Education (ECE) programs, their directors, and family child-care providers.

ECMHC Program Directors— The directors of the Maryland sites where Early Childhood Mental Health Consultation is provided. Some are housed independently and some are in the Resource Centers.

Evidence based practice—A body of scientific knowledge about service practices or the impact of clinical treatments of services on the mental health problems of children and adolescents (Hoagwood, Burns, Kiser, Ringelsen, & Schoenwald, 2001).

Families— those who act as legal guardians of the children referred for Early Childhood Mental Health Consultation.

Logic model—A systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan, and the changes or results you hope to achieve (W. K. Kellogg Foundation, 2004)

Outcomes—The specific changes in program participants' behavior, knowledge, skills, status and level of functioning. Short-term outcomes should be attainable within 1 to 3 years, while longer-term outcomes should be achievable within a 4 to 6 year timeframe (W. K. Kellogg Foundation, 2004).

Outputs—The direct products of program activities and may include types, levels and targets of services to be delivered by the program (W. K. Kellogg Foundation, 2004).

Programmatic consultation—Early childhood mental health consultation that focuses on improving the quality of the early childhood program or agency and assists the program to address challenges that impact more than one child, family, or staff member (Cohen & Kaufmann, 2005).

Promising practices—Interventions that are believed to be effective, but have not been established as an evidence-based practice through randomized control trials.

Reflective Supervision— Reflective supervision addresses the emotional content of the consultant's work, and attends to relationships and the complex interactions between relationships (between the consultant and supervisor, consultant and caregiver, consultant and parent, parent and caregiver, and parent and child).

Screening—A brief procedure, often completed universally and at regular intervals using a standardized tool, to identify children who may need further assessment or evaluation for developmental or other concerns, such as social emotional development. (Kaufmann & Hepburn, 2007).

Survey—A set of questions designed to determine the attitudes, beliefs, and behavior of a population of people.

Appendix A- Forms for Part I

Appendix A, Document 1- Lower Shore Early Intervention Project: Do's and Don'ts

As Behavior Interventionists for the Lower Shore Early Intervention Program (LSEIP), here are some of the things we do and some of the things we don't do in the child care setting...

- We reinforce the teacher/provider in her role.
- We are there to facilitate age-appropriate social and emotional growth.
- We will be there to help implement new behavior strategies.
- We provide materials for the child care setting and for home that reinforce skills we are targeting.
- We provide mental health information to teachers and parents.
- We offer monthly mental health trainings at the Lower Shore Child Care Center for “core of knowledge” and other credits.
- We work individually with the child to promote social and emotional growth.
- We can provide weekly social/emotional class lessons as needed.
- We work confidentially.
- We don't diagnose but we can offer insights as to what we think is going on.
- We are not extra staff at a child care program.
- We aren't there to take over the classroom.
- *We do not or cannot “fix” a child's behavior in a day or two; progress may take weeks.*
- *When we implement a strategy, the strategy needs to be used consistently and extensively (not just once or twice or even a few times) in order for it to be effective!*

Appendix A, Document 2- Lower Shore Early Intervention Project: Memorandum of Understanding

Dear _____ at _____ Child Care:

March 1, 2010

Thank you for your willingness to work with the Lower Shore Early Intervention Program. We are pleased to be partners with you in promoting healthy social and emotional growth in the children in your care.

As behavior interventionists, we:

- Assess a child's social-emotional development, while taking a close look at behavior issues.
- Help create and implement new behavior strategies.
- Provide materials for the child care setting and for the child's home that reinforce skills we are targeting and behaviors we are addressing.
- Reinforce the provider/teacher in her role.
- Facilitate age-appropriate social and emotional growth.
- Provide mental health information to providers/teachers and parents, including mental health resources in the community
- Work with the child to address behavior concerns and to promote social-emotional growth.
- Provide weekly social/emotional class lessons as needed.

However, we won't be:

- We won't be acting as extra staff at a child care program.
- We won't be diagnosing, though we can offer insights on what we think is going on with a child.
- ***We won't be "fixing" a child's behavior in a day or two, or even a week or two; progress takes time. When we implement a strategy, we expect the strategy to be used consistently and extensively (not just once or twice) in order for it to be effective.***
- We won't continue offering services if providers are not "on board" or in compliance with recommendations.

The length of our services will be determined on a case-by-case basis. We encourage providers not to dismiss a child until we have been able to work with him/her for at least four weeks. Please note: Our work is confidential. We will discuss a child's progress only with those whom the parent or guardian has authorized. We encourage child care providers to do the same.

Please don't hesitate to call us with any questions or concerns: 410-677-6590.

Director's/Provider's Signature

Print Name

LSEIP Program Manager Signature

Print Name

Appendix A, Document 3- CCEP Child Care Agreement to Participate Form

Child Care Program Name: _____ Date: _____

The _____ (Name of CCEP Program) is operated by _____ (Local Agency Name) through a grant administered by the Great Start Regional Resource Center and funded by the Early Childhood Investment Corporation (ECIC). CCEP consultants provide two types of consultation:

1. **Child-family centered consultation** for parents and child care providers who wish to assist a child from birth to five years of age who is having behavioral difficulties at child care. This type of consultation involves: child observation and assessment; development of a Positive Child Guidance Plan by the child's team (parent; provider and consultant); and training and support for parents and providers to implement the plan.
2. **Programmatic consultation** to promote the social-emotional development of all infants, toddlers and preschoolers in a child care program. This type of consultation involves: program assessment, development of a programmatic action plan, and training and support for staff to implement the plan.

As a participant in CCEP services, your child care program has the following rights:

1. To receive fair, non-discriminatory services that respect the dignity of all staff.
2. To receive confidential services.
3. To receive free and voluntary services.
4. To receive quality services that are regularly evaluated.
5. To terminate services at any time.
6. To decide whether or not to implement programmatic recommendations made by the consultant.

As a participant in CCEP services, your child care program has the following responsibilities:

1. To maintain the confidentiality of the children and families receiving CCEP services.
2. To make child care rooms available for observation by the CCEP consultant.
3. To be available for phone or face-to-face consultations, including parent-provider meetings, if applicable.
4. To contact the CCEP consultant if it is necessary to cancel observations or meetings.
5. To implement those strategies agreed upon by a child's team and written in a Positive Child Guidance Plan, if applicable.

As a representative of _____ (Child Care Program Name), I understand our rights and responsibilities and agree to participate in CCEP services as outlined above.

Name/Title

Signature

Date

Appendix A, Document 4- PERKS Consent for Services Form

AUTHORIZATION FOR MY CHILD TO RECEIVE SERVICE

Beginning on _____ has been selected to receive supportive services from the staff of PERKS/Child Care Choices. A PERKS specialist will be assigned to work with the child care provider/program on a regular basis.

Our staff will assist the child care provider/program in their efforts to support your child’s healthy social and emotional development and may use any of the following methods to help him/her:

- Observing your child’s behaviors and interactions and giving feedback to the child care provider/s.
- Coaching child care provider/s on positive ways to work with your child, especially when he or she exhibits challenging behaviors.
- Modeling/leading group activities to increase your child’s social skills and readiness for kindergarten.
- Providing child care provider/s with training tailored to their needs.
- Interacting with your child and modeling appropriate positive adult-child interaction.

Our staff is also available to assist your family in the following ways:

- Answering your questions on child development and providing referrals to services that may assist your family or child.
- Referring you to parent workshops that may be of help to you and your child.
- Meeting with you and your child care provider together when needed.
- Communicating information about your child with professionals who you request be contacted by staff or consultants. (Please see Consent to Release/Receive Information Form).

In signing this Authorization Form, I, as the parent or guardian, understand that:

- I consent to have my child observed and screened to have services rendered as needed.
- I will participate in the Individual Action Plan Agreement process to ensure the appropriate services are implemented for my child through the child care program, including meet with project staff to complete necessary paperwork in the beginning and when the case is being closed.
- I may revoke my consent at any time.
- I have received a copy of the project brochure from the child care provider.

Please complete the lower portion of this form by _____. If you have questions or want some help, feel free to contact the staff person at 301-662-4549 or 410-751-2917.

I consent to have my child, _____, participate in the supportive

Child’s Name (please print)

services which PERKS/Child Care Choices offers at _____.

Parent/Guardian Name (please print)

Parent/Guardian Signature, Date

Appendix A, Document 6- Observation form

Staff consult on Child- M-PIR 1: _____

Date of Consultation _____

Parent consult on Child- M-PIR 2: _____

Parent/Child Name:

Section 2- Mental Health Consultation:

A. Observation /Discussion:

Parent/Child Name _____

B. Recommendations/Notes:

Signature _____

Date: _____

MH Consultant

Section 3- Follow-up:

Appendix A, Document 7- Introducing CCEP Services to All Families in Your Care

Dear Child Care Provider,

We are writing to encourage you to inform the families you work with that you have invited _____ (program name here) consultants to come into your program to help promote the social-emotional development of the children in your care. Please send a brief letter to each family or put a note in your parent newsletter, saying something like this:

We know it's important to you that your child enters Kindergarten ready and eager to learn. Research shows that young children who can get along well with others and experience and handle feelings in healthy ways, are likely to feel good about themselves and do well in school. These crucial abilities are referred to as social-emotional skills.

In our county, we are fortunate to have a consultation service called the _____ (CCEP Program Name). _____ consultants have special expertise in promoting the social-emotional development of children from birth to five years. We would like you to know that we have invited _____ consultants to work with our child care program. So, if you should happen to see a consultant observing one of our child care rooms or talking with one of our caregivers, you will know that he or she is here to help us do everything we possibly can to promote the social-emotional development of all of the infants, toddlers and preschoolers in our care.

*The _____ consultant also is available to help when a child has behavioral difficulties in child care or when there's a question about a child's development, but **only** if the parent requests this service. If you should ever wish to use this free consultation service for your child, you should know that the consultant is required to keep all information confidential unless you give permission to share it with someone else. If you'd like more information about the _____ program, please ask your child's caregiver or call the program directly at _____ (phone number).*

Also, in order to protect the confidentiality of the children in your program who are referred for _____ services, please **do not**:

1. Use a name when consulting with us about a child whom you are considering referring; use the child's gender and age only (e.g., a boy who is 4 years old).
2. Point out other children in the room whom you would like us to observe.
3. Talk with us about a child when other parents are nearby.
4. Use children's last names on lists for our services that are available for others to see - use initials only.

Please talk with us if you have any concerns. We value your referrals and are glad that we can work together to help children have a positive child care experience

Appendix A, Document 8- Example of a Programmatic Planning Form

**Child Care Expulsion Prevention
PROGRAMMATIC ACTION PLAN**

Child Care Site Name: _____ Today's Date: _____

Person(s) Present: _____

Program Element	Strengths	Goals	Strategies	Supplies/ Materials Needed	Assigned Person	Target Date
Supportive Relationships						
Partnerships with Families						
Activities and Experiences						
Daily Routine						
Environment/ Program						
Resources						

Other Planning Ideas: _____

Date, Time and Location of Next Meeting: _____

Appendix A, Document 9- Sample Plan of Action Form- Montgomery County ECMHC

PLAN OF ACTION



Consultant Name:		Program Name:	
Date Partnership Agreement Signed:		Classroom where these interventions will be used:	
Date of this Action Plan:			
Date Service(s) Ended:			
GOALS	INTERVENTIONS	OUTCOMES (to be completed at end of services)	
Consultant Signature:		Director/Provider Signature:	
Date:		Date:	
Parent Signature:		Teacher Signature:	
Date:		Date:	

Appendix A, Document 10- Baltimore City Child Care Resource Center-Partnerships Model of Services

Partnership's Models of Services

The Early Intervention Project is dedicated to partnering with Baltimore City Child Care Centers and Family Child Care Providers to continue providing young children with optimal services and opportunities for school readiness and healthy development. The partnerships promote and create linkage for the purpose of informing the community of the resources available and creating a referral system for individual children in need of additional services. When a center or family provider chooses to participate in a partnership with the Early Intervention Project the following models of service are available to them:

1. **Individual Child Services** – This model of service takes a look at the social-emotional development of an individual child who has been referred for services. Each child is observed, assessed and an individual intervention plan completed for service. Additional resources and referrals are provided as deemed necessary as well as training and technical assistance is provided for the child care providers to meet the needs of the individual child. Requirement for a child to be referred to the Early Intervention Project is one whom the child care provider has any concerns about the child's development overall.

Example: If a child care provider has a concern about a child's speech or language development the importance of referring them to this project is based on the fact that if a child had problems communicating then this ultimately will affect a child's social and emotional well-being. If the child is in need of a referral to Infants/Toddlers Program or Child Find the referral will be made in addition to the services available by this project.

 - A. The length of time services are rendered varies depending on the individual child's needs as well as the child care provider's needs.
 - B. All individual children receiving services are required to have parental consent before any services are provided.
 - C. Child care providers are required to complete paperwork and notify all parents of partnership participation.
 - D. Effectively collaborate in partnership with the project's Interventionist to provide these services to the individual children.
2. **Center-wide Training and Technical Assistance Services** – This model of service looks at the social-emotional environments and provides training and technical assistance to child care providers to include all areas of social-emotional development for the children in their care. The process is started by classroom environmental assessments as well as individual caregiver assessments to determine the service plan for training and technical assistance. Training and technical assistance is provided during class time as well as during nap time. In addition some of the training and technical assistance can be done in a staff meeting or small groups. The goal and purpose of this particular service is to provide staff with the tools and skills to ensure the healthy social and emotional development of children.
 - A. The length of time services are rendered varies depending on the size of the child care center/family child care home as well as the individual needs of the direct child care providers.
 - B. Child care providers are required to complete paperwork and notify all parents of partnership participation.
 - C. Effectively collaborate in partnership with the project's Interventionist to provide these services in your center or family child care home.

Social/Emotional Based Community and BCCRC Training Services – This model provides child care providers the opportunity to join our mailing list to receive newsletters, brochures, and flyers with the latest

information on trainings in the community and through BCCCRC on topics related to social and emotional development, recent articles on social and emotional development and other pertinent information related to the work being done through the Early Intervention Project

Appendix A, Document 11- Montgomery County ECMHC Partnership Agreement



Early Childhood Mental Health Consultation Services Partnership Agreement

With: _____ (program name)

Crisis: _____ Short-Term: _____ Long-Term: _____

ECMHC Mission

Healthy social and emotional development plays a key role in a child's ability to enter kindergarten ready to learn. In order to succeed, the child needs to function within group settings, interact positively with peers and adults, control impulses, exhibit self-confidence and be willing to take risks in learning new and often challenging tasks. The Department of Health and Human Services, (DHHS), Early Childhood Consultation Services, will increase the capacity of Montgomery County child care providers and parents to meet the social, emotional and developmental needs of young children, from birth to five, especially those who may need additional supports, with a culturally sensitive strength-based approach.

With this philosophy and purpose in mind, DHHS, Early Childhood Services, and _____ (program) agree to be partners in enhancing services for young children.

Our Program Will:

- (1) Meet with the consultant each week to review concerns and progress.
- (2) Obtain Partnership Notification forms from parents prior to consultant beginning to work in the target room and ensure that parents of children receiving child-focused consultation authorize services prior to their initiation.
- (3) Work with consultant to complete the Preschool Mental Health Climate Scale, the Devereaux Early Childhood Assessment (DECA), Satisfaction Questionnaire and/or other forms as needed for program administration.
- (4) Collaborate with the consultant by allowing classroom observation, sharing information about individual children, implementing suggested strategies and coordinating team meetings.
- (5) Immediately address any health and safety concerns brought to our attention, including reporting suspected child abuse or neglect. I understand that our program is expected to comply with all licensing regulations (COMAR 13A.15.01-.15 or 13A.14.02).

Early Childhood Consultant Will:

- (1) Offer the opportunity to participate in the University of Maryland Evaluation Study.
- (2) Work with child care providers to develop a Plan of Action, and evaluate progress at least every three months.
- (3) Spend up to ____ hours per week working with the child care program.

- (4) Provide crisis intervention and consultation for parents whose children participate in this program.
- (5) Screen and evaluate the social and emotional needs of the children and "mental health climate" in the classroom.
- (6) Consult with child care providers about classroom management and environment and individual children if authorized by the parent.
- (7) Consult with the licensed family child care provider, child care center director and/or assistant director once a week.
- (8) Provide referrals to other agencies for training, mental health and medical evaluations and coordinate services if needed.

Partnership Agreement Term - The duration of consultation services is proposed for a period of _____ beginning on _____ and ending on _____. This agreement may be renewed or cancelled based on available funding, progress made on the plan of action or outstanding health and safety issues that have not been corrected.

Director's signature

Consultant's signature

Date

Date

Appendix A, Document 12- Sample of a Completed Infant Toddler Action Plan (MI CCEP)

Child Care Site Name: ABC Child Care

Today's Date: 10/16/06

Person(s) Present: Ms. Johnson (Director), Ms. Susan (Lead Child Care Provider in toddler room), Ms. Karen (Child Care Assistant in toddler room), Ms. Deborah (Lead Infant Child Care Provider), and Mr. Cameron (CCEP Consultant)

Program Element	Strengths	Goals	Strategies	Supplies/ Materials Needed	Assigned Person	Target Date
Supportive Relationships	<ol style="list-style-type: none"> 1. Uses primary caregiving. 2. Offers responsive care by hugging, rocking and holding children throughout the day. 3. Responds quickly and consistently to children's cries and cues. 	<ol style="list-style-type: none"> 1. To allow infants and toddlers to use comfort items during the day. 	<ol style="list-style-type: none"> 1. Ask parents to bring in a comfort item for their child to put in their cubby. 2. Let children know that their comfort items are always available. 	<ol style="list-style-type: none"> 1. Cubby bins for a few new children. 2. New name labels for cubbies. 3. Letter to parents asking for comfort items. 	Ms. Johnson	10/20/06
Partnerships with Families	<ol style="list-style-type: none"> 1. Greets parents at arrival and departure. 2. Uses multiple ways of communicating with parents. 	<ol style="list-style-type: none"> 1. To learn more about each child's family culture. 	<ol style="list-style-type: none"> 1. Schedule parent meetings to learn more about the children's families. 	<ol style="list-style-type: none"> 1. Simple questionnaire to use at parent meetings. 	Primary caregivers	Schedule by 10/22/06 Hold by 11/20/06
Activities and Experiences	<ol style="list-style-type: none"> 1. Allows time in the day for children to play independently and in groups. 2. Offers ample time for indoor and outdoor play. 3. Offers a variety of sensory activities. 4. Fosters security by doing some things in the same way every day (e.g., singing a goodbye song at close of day). 	<ol style="list-style-type: none"> 1. To increase caregivers knowledge about social-emotional development of the children in their care. 	<ol style="list-style-type: none"> 1. Conduct training series on infant, toddler and preschooler social-emotional development. 	<ol style="list-style-type: none"> 1. Training materials and equipment (VCR/monitor, LCD projector, laptop). 	Ms. Johnson agrees to schedule Mr. Cameron agrees to conduct training and bring materials and equipment	10/25/06 11/15/06
Daily Routine	<ol style="list-style-type: none"> 1. Provides smooth transitions from one activity to the next. 2. Provides flexibility in the schedule to respond to individual child's needs. 3. Allows enough time for routines and transitions. 	<ol style="list-style-type: none"> 1. To use personal routines as opportunities to connect with children. 	<ol style="list-style-type: none"> 1. Caregivers agree to sing, talk and engage in eye contact with children at diapering, feeding, etc. times throughout the day by using cue cards placed in the room. 	<ol style="list-style-type: none"> 1. Ask parents about their children's favorite songs and games. 2. Create song and game cards. 3. Post the cards around room as cues to remember! 	Ms. Johnson agrees to draft a letter Caregivers agree to create the cue cards	Letter drafted and sent by 11/01/06 Cue cards made and posted by 11/30/06

Environment/ Program	<ol style="list-style-type: none"> Provides an environment that is safe from harm, (e.g., outlets are covered). Displays family photos where children can see and touch them. Has duplicates of favorite toys and items. 	<ol style="list-style-type: none"> To provide furniture, fixtures and play materials that reflect those found in the child's home. 	<ol style="list-style-type: none"> Ask parents to send in a picture of a room in which their child likes to play and one item from home to use in care setting. 	<ol style="list-style-type: none"> Buy disposable cameras for parents. Draft letter to parents. Make pictures into collages; hang at child's eye level. 	<p>Ms. Johnson</p> <p>Ms. Johnson</p> <p>Caregivers</p>	<p>11/01/06</p> <p>11/01/06</p> <p>11/15/06</p>
Resources	<ol style="list-style-type: none"> Works with the local health department to provide annual well-child checks onsite. Partners with local library for field trips and with another child care site for biweekly book exchanges. Works with the local school district to help kids transition to Pre-K programs. 	<ol style="list-style-type: none"> To link with resources to apply for a child care equipment grant. To link with additional training resources for building global program quality. 	<ol style="list-style-type: none"> Meet with the local child care resource and referral (R&R) specialist. Meet with the local school district education coordinator and university-based training coordinator. 	<ol style="list-style-type: none"> Update written materials (e.g. brochure) about child care site and make copies to share with R&R specialist and trainers. 	<p>Mr. Cameron agrees to get contact info to Ms. Johnson</p> <p>Ms. Johnson agrees to set up meetings and update materials</p>	<p>10/20/06</p> <p>11/01/06</p>

Other Planning Ideas:

Ms. Johnson expressed interest in seeing the new early learning standards issued by the state Department of Education. Mr. Cameron agreed to send her the address for the web site where the documents are posted and to schedule a time to review the standards together by 12/01/06.

Ms. Johnson also expressed an interest in learning more about social-emotional screening and assessment tools. Mr. Cameron agreed to arrange for a practitioner from the mental health agency to come in and talk about different tools and how they can be used in child care.

Date, Time and Location of Next Meeting:

The team agreed to reconvene on 12/07/06 at 4 pm at ABC Child Care, Room B to review progress and revise plan if needed.

Appendix A, Document 13- Sample Family Questionnaire (MI CCEP)

To be completed by consultant and parent

The first meeting with a parent (or other family member) should be a time to get acquainted, to help the parent feel comfortable with you, and to explain the CCEP consultation process. The following are suggested questions that can be used to build a relationship with family members and gather important data in order to understand what is going on for the child. The questions have been sequenced so that the parent describes the child's strengths and history before focusing on the behavior concerns, but it is not always necessary to ask all of the questions. Information gathering should be a natural conversation. It's important to assess the parent's relationship with the child, so note how the parent talks about the child while responding to your questions.

What Parent Wants from CCEP

1. What information do you feel is important for me (this consultant) to know?
2. What are you expecting from CCEP services?
3. What do you hope happens as a result of this referral?

Child Care History

4. How long has your child been in his/her current child care program?
5. Is this the only child care arrangement you have right now or is your child also cared for by other child care providers (e.g., at other times of the day)?
6. Has your child ever been in any other child care settings? If so, when and where?
7. Has your child ever been asked to leave a previous child care program?

Family Strengths, Resources, Supports

8. Who is in the family/home?
9. What are you family's strengths?
10. What are (if any) the current stressors for the child/family?
11. Who can you turn to if you need support?
12. Is your child receiving any other outside services?

Child Strengths and Preferences

13. What are your child's strengths and abilities? (Refer to *Social and Emotional Milestones of Children Birth to Age 5*.)
14. What are your child's likes and preferences (activities, foods, toys, and people)?
15. What is your child like at home? Mood? Behavior?
16. What's a good day with your child?
17. What is the hardest part of the day?

18. What are you most proud of about your child?
19. What is your child's favorite place to play?
20. What roles does your child frequently engage in during play?
21. What activities do you most like to share with your child?
22. How do you see your child compared to other children?
23. Does your child have any fears or worries we should be aware of?
24. What does your child do when upset and how is your child best comforted?


Developmental History/Medical Issues

25. Was your child born prematurely?
26. Developmental milestones - communication, gross motor, fine motor, and problem-solving domains
27. Medical concerns
28. Lead level testing
29. Current sleeping and eating patterns

Behavior Concerns and Needs

30. What is the reason for referral? What behavior are you concerned or worried about?
31. What does the behavior look like? How often? How intense? How long does it last?
32. When does the behavior occur? Not occur?
33. What might be contributing factors? What makes it better or worse?
34. What have you tried to make this situation better? What worked? What didn't work?

Appendix A, Document 14- Daily Communication Sheet- Infant/Toddler (Devereux)



Daily Communication Sheet

Child's Name: _____ **Date:** _____

Diaper Changes:			
Time	Wet	Dry	BM



Sleeping:	
From	Until

Eating:		
Time	What	How Much

Activities:
Sounds or words used today:
Favorite activities today:
What I tried that was new today:
Something that made me smile today:
A problem I solved today:

150 Reproducible Forms for Early Care and Education Programs

Appendix A, Document 15- Referral Form

	
<h1>The Early Intervention Project</h1>	
<p>Growing Happy Healthy Children</p>	
<h2><u>Referral Form</u></h2>	
<p>Dear Parent(s)/Caregiver,</p>	
<p>After initial assessment, screening and observation, it is the recommendation for more in-depth evaluation to be completed. Below you will find the contact information for those referrals needed marked with a check. Please call and schedule an appointment with them to assist your child in getting the services they need. Feel free to contact me for additional information or assistance in completing this process at _____.</p> <p>Let us know when you have gotten an appointment with the agency. Sincerely,</p>	
<p>Early Childhood Consultant</p>	
<p><input type="checkbox"/> The Hearing and Speech Agency 5900 Metro Drive Baltimore, MD 21215 410-318-6780 Reason: _____</p>	<p><input type="checkbox"/> University of Maryland Center for Infant Study - Secure Starts 701 W. Pratt St. Baltimore, MD 21201 410-328-1111 Reason: _____</p>
<p><input type="checkbox"/> Baltimore City Public Schools Child Find Office of Preschool Rm. 26 2500 E. Northern Parkway Baltimore, MD 21214 443-984-1011 Reason: _____</p>	<p><input type="checkbox"/> Bayview Community Psychiatry Program Birth to Five Clinic 4940 Eastern Ave Baltimore, MD 21224 410-550-0104 Reason: _____</p>
<p><input type="checkbox"/> Baltimore City Infants & Toddlers Program 10 W. Eager Street Baltimore, MD 21201 410-396-1666 Reason: _____</p>	<p><input type="checkbox"/> The Loyola Clinical Centers Psychological Services 5911 York Road, Suite 100 Baltimore, MD 21212 410-617-1200 Reason: _____</p>
<p><input type="checkbox"/> Kennedy Krieger Institute 707 N. Broadway Baltimore, MD 21205 443-923-9400 Reason: _____</p>	<p><input type="checkbox"/> The Loyola Clinical Centers Audiology and Speech Services 5911 York Road, Suite 100 Baltimore, MD 21212 410-617-1200 Reason: _____</p>
<p>Additional information: _____</p>	
<p>Early Intervention Project</p>	<p>March 2010</p>

*Appendix A, Document 16- ECMHC Job Description (MI CCEP)***TITLE: EARLY CHILDHOOD MENTAL HEALTH CONSULTANT**

GENERAL SUMMARY: This is a professional position providing early childhood mental health consultation (ECMH) prevention services to help adults nurture the social and emotional development of children birth through age five in licensed, registered and enrolled child care (prioritizing enrolled providers), and to improve the quality of care across settings. The ECMH consultant will consult with families and child care providers caring for children with social-emotional-behavioral challenges that put them at risk for expulsion from child care settings or impact their success within care. The ECMH consultant also will consult with providers on ways to strengthen their overall program or home caregiving practices to promote the social-emotional development of all of the children in their care. The ECMH consultant will serve licensed child day care centers, licensed group day care homes, registered family day care homes, enrolled day care aides, and relative care providers in _____ County. The ECMH consultant will function as part of the Early Childhood and Family Services team, under the supervision of the Project Supervisor.

RESPONSIBILITIES

Responsibilities include, but are not limited to, the following:

1. Provide child/family-centered consultation when providers or parents have concerns regarding the social-emotional development of a particular infant, toddler or preschooler.
2. Observe and assess young children with social-emotional-behavioral risk or challenges.
3. Work with parents and providers to develop an action plan that identifies appropriate strategies/interventions for a child who needs individual support.
4. Provide coaching and mentoring for the adults to help them implement the plan.
5. Make referrals of children and their families to appropriate outside services when necessary.
6. Provide discussion and training opportunities for providers and families to help them develop new skills that will enable them to understand and more effectively support the social-emotional development all children, including those with behavioral issues (e.g., may include observation, role-modeling, etc.)
7. Provide programmatic consultation as part of a child referral on certain elements of a child care program to address specific issues that affect more than one child, staff member and/or family.
8. Closely collaborate with other early childhood providers to integrate the ECMH consultation program within child care settings in the community.
9. Heighten community awareness of the mental health needs of young children in early care and learning settings.
10. Promote and market the CCEP program regionally.
11. Assist in program implementation and reporting, as required by funding source.

Appendix A, Document 17- ECMHC Interview Questions (MI CCEP)

ECMH Sample Interview Questions

Prior to Interview:

Need-

1. Three Professional references
2. One writing sample or publication done solely by applicant (i.e. article in the MIAIMH Crier, case study, child report (w/identifying information blacked out)
3. Updated Resume

ECMH Interview Questions:

Philosophical Approach

1. Tell us about how you involve families in your work
2. Describe what you think a consultants role is in a child care setting and with a family
3. How might this role differ from your prior clinical work (if applicable)
4. How do you feel you might approach this change in approach?
5. Tell us about mental health principles that are important to your work (i.e. relationship based, strength based, family centered, etc)
6. Tell us your thoughts on using a culturally sensitive approach in your work
7. How do you think families you have worked with in the past might describe your work together?

Mental Health and Early Childhood Developmental Experience

1. Describe your mental health work with infants, toddlers, preschoolers and families
2. Do you have Michigan Association for Infant Mental Health endorsement?
3. Describe your experience with reflective supervision (how has it been helpful?)
4. What kinds of early childhood mental health screening and assessment tools are you proficient in using (child focused, environment focused, other)?
5. Describe the specialized mental health training you have had regarding infants, toddlers and young children.
6. Describe the developmental knowledge/expertise you have regarding young children.
7. Tell us about some of the strategies you have used to support adults working/caring for young children (any evidence base?)
8. Tell us about your experience with observation and facilitating the planning process for young children with families and caregivers.

Training Experience:

- Describe the training that you have delivered (topics, audience type, size of audience)
- Describe the trainings that you have developed
- Are you comfortable/experienced using technology within training
- What software programs do you use regularly and which are you proficient in using?

- How comfortable are you with training?

Professional Skills:

- Describe your experience working with technology- what software programs do you use regularly?
- What written documents have you produced? (ask for work sample)
- Describe your experience with coordinating projects/meetings
- Describe how you like to organize a new project
- What is your familiarity with other early childhood programs? (i.e. Head start, Part C- Early On, etc)
- Describe how your work experience has involved mentoring and coaching others.
- Have you ever had to market a new program? How do you feel about doing outreach to generate referrals?
- Describe your ability to meet deadlines and work under pressure
- Describe your ability to take initiative
- Describe your ability to complete paperwork and keep records
- What level of supervisory support do you feel that you need or would like?

Personal Attributes:

- Describe your personal strengths
- How do you tend to deal with challenging work situations?

Professional Goals:

- Where do you see yourself in 5 years?
- What motivates you professionally?
- Why are you interested in this position?
- If you were offered this job would you accept?
- Why should we hire you?
- Do you have any questions or concerns that you would like to discuss?

Appendix A, Document 18- Sample Program Flyer


Quality Services and Well-Trained Consultants

The Maryland Department of Education (MDE) is proud to announce the implementation of the Maryland Early Childhood Mental Health Consultation Project. This project is a statewide effort to provide high-quality, evidence-based services to young children and their families.

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Maryland's Early Childhood Mental Health (ECMH) Consultation Project:

Helping children remain in stable, quality child care arrangements



"The support I received was just amazing... This was the last resort for two of my children. I can't say enough about the amazing team around my child care..."

— Early Care Provider served by the Anne Arundel County ECMH Project, Arundel Child Care Connection



"Our little ones who have been diagnosed with disabilities are more readily welcomed by daycare providers when...they can count on the on-going ECMH support...or their parents. Several of our parents have commented that being able to keep children in quality daycare has allowed them to remain employed."

— Karen Goldman-Katten, Director
Lower Shore Child Care Resource Center

LOCAL EARLY CHILDHOOD MENTAL HEALTH PROJECTS BY REGIONAL JURISDICTION

Demps Program (Anne Arundel)	410-221-1700
Early Intervention Project (Baltimore City)	410-686-1000 ext. 206
Autism Network (Baltimore County)	410-810-1700 ext. 1281
Child Care Initiative (Baltimore County)	410-511-3301
Child Care Outreach (Baltimore County)	301-802-8444
Autism Network (Baltimore County)	410-810-1700 ext. 1281
CARE Center (Baltimore County)	410-313-3233
Lower Shore Early Intervention Program (Somerset/Wicomico/Worcester Counties)	410-777-6000
Child Care Outreach & Training	301-777-6000
Project WIN Prince George's County	301-770-6500
Eastern Maryland Project Child Care (Howard/Talbot/Wicomico Counties)	301-350-0040
Upper Shore Project Right Step (Carroll/Washington/Worcester Counties)	410-822-5400 ext. 311
Project WIN Maryland APELL for Children	301-733-0800

Nancy S. Diamond
State Superintendent of Schools

Marin O'Malley
Governor

James H. Cox/William A. Pridmore
State Board of Education

DEPARTMENT OF EDUCATION
1515 BROADWAY, BALTIMORE, MD 21202
MarylandPublicSchools.org

December 2008

About the Project

The project started in 2002 as a three-year pilot called The Early Intervention Project in Baltimore City, and Project Right Step in five counties on the Eastern Shore. The pilot project goals included:

- Promoting good mental health practices and services to young children and their families;
- Identifying and working proactively with children who may have developmental, social, emotional, and behavioral concerns;
- Helping young children acquire the social and emotional skills necessary to enter school ready to succeed; and
- Supporting children and families in need of more intensive mental health services to appropriate support programs.

An evaluation report completed in 2005 by Dr. Deborah F. Perry, Director of Research at Georgetown University's Center for Child and Human Development, included many positive findings, such as:

- Nearly 50% of children at risk for emotional/behavioral problems in their child care placement early care children were reported during the three-year pilot at each site;
- Approximately 70% of all children at both sites had improved social skills;
- Reductions were seen in the highest rates of problem behaviors; and
- Child care programs that received consultation services showed positive changes in teachers' behaviors and improvement in the classroom environments.






2008-2009 Project Highlights

Child Care Program Consultation Services were received by:

- 305 Child Care Centers;
- 80 Family Child Care Providers;
- 11 Head Start/Early Head Start sites;
- 25 Pre-K/Kindergarten Classrooms; and
- 40 Non-regulated Child Care (Day Care) centers providing, developmental, and behavioral services.

Child Care Program Consultation Services were provided to over 600 individual children. Services included:

- Social/Emotional Assessments;
- Direct Coaching Services; and
- Referrals to community intervention programs such as the Infant and Toddler Program, Child First, Therapeutic Playgroups or other community early childhood mental health practices.

Over the course of the pilot, 47 Direct Coaching visits provided to staff and parents on behalf of mental health consultants.

Over the years, the need for early childhood mental health services has been on the rise. The ECMH Consultation Project works to increase public awareness of the importance of a child's emotional/behavioral development, particularly as it relates to school readiness. Regional project sites maintain telephone help lines, distribute publications and resources, and partner with stakeholder agencies to inform child care providers and families about the availability and benefits of early childhood mental health services.

Today, child care providers and parents across the state can access ECMH Consultation Project services free of charge. Services include:

- Observation and assessment of children and the child care environment using research-based tools;
- Partnering with child care providers to deliver systems, monitoring, and coaching to help create environments that better support the social and emotional needs of young children;
- Increasing child care staff skills in addressing the social and emotional needs of children to improve readiness for school;
- Working with child care providers to help screen and serve children with behavioral and mental health needs; and
- Supporting parents with strategies and resources.

"Thanks for all your hard work of this center with our daughter...we really think you have some good ideas here...this is one of the best uses of our tax dollars..."

— Father of a young child served by Project WIN in Prince George's County

The material was produced by the Maryland State Department of Education, Division of Early Childhood Development.

*Appendix A, Document 19- How Will ECMH Work For My Family (MI CCEP)***HOW WILL ECMHC SERVICES WORK FOR MY CHILD AND FAMILY?**

Infants, toddlers and preschoolers are usually referred to (name of ECMHC program) because of challenging behaviors that are causing problems at child care. (PROGRAM NAME) services are provided by trained early childhood mental health consultants who know that challenging behaviors don't mean that a child is "bad" – just that the child is trying to tell the adults in his life that "something isn't right."

It's the consultant's job to work with the child's parents and child care provider to identify the child's strengths, figure out what the underlying reason for the challenging behaviors might be, and then come up with ideas to help the child. There are typically six parts to consultation services:

1. Referral and Intake

If your child is referred to (PROGRAM NAME), the (PROGRAM NAME) consultant will ask you and your child care provider some questions about your child, explain how (PROGRAM NAME) works, and answer any questions you may have.

If you decide to try (PROGRAM NAME), you will sign a form giving the (PROGRAM NAME) consultant your permission to work with you and your child. You may also sign a form giving the consultant your permission to share certain information with certain people. You can withdraw from (PROGRAM NAME) services at any time.

2. Collecting Information about Your Child

Once the (PROGRAM NAME) consultant has your permission to work with you and your child, the consultant will begin to pull information together to get some ideas about what may be causing your child's challenging behaviors. He or she will:

- a. Talk with you and your child care provider about your child's strengths and challenging behaviors.
- b. Ask you and your child care provider to fill out a questionnaire about your child's strengths and challenging behaviors.
- c. Observe your child at the child care program several times.
- d. Observe your child at your home, if you agree to this.
- e. Pull all of this information together in a way that makes sense and share it with you and your child care provider.

3. Meeting to Develop a Positive Child Guidance Plan

Once the consultant has pulled some information together, he or she will arrange an informal meeting with your child's team. Your child's team will include you, your child care provider, your

(PROGRAM NAME) consultant, and anyone else you would like to invite. At the meeting, the team will look at the information the consultant has collected and talk together about what may be causing your child's challenging behaviors. Then the team will come up with a plan to help your child. The plan will have clear, specific goals for your child, based on his or her particular strengths. It will also have strategies for the child care provider to try and strategies for you to try. As the child's parent, you are the one who knows your child best, so you will have a very important part in helping to create the plan.

4. Support for You and Your Child Care Provider to Put the Positive Child Guidance Plan into Action

After the Positive Child Guidance plan is developed, the consultant will be there to help you and your child care provider try the strategies that the team agreed to put into action. The consultant or provider will contact you at least once a week (at a time that's convenient for you) to let you know how things are going, and of course you can contact the consultant whenever you like. It may take several weeks, even several months, for you and your child care provider to make the changes that will lead to improvements in your child's behavior. The consultant may arrange follow-up meetings to re-work the Positive Child Guidance Plan if it appears that different strategies may be needed.

5. Referrals to Outside Services as Needed

Sometimes you and the rest of the team will agree that it would be best to refer your child somewhere else for additional evaluation or services. For example, you all may wonder if your child has a speech and language problem and decide to send him or her to a speech and language therapist for an evaluation. The consultant can help you with these referrals – if it turns out your child does need additional help, it's important to get it as soon as possible.

6. Conclusion of (PROGRAM NAME) Services

When it appears that the goals for your child are being met, the consultant will arrange for another meeting so that the team can decide if it's time to conclude (PROGRAM NAME) services or to keep on going. If it's time to conclude, the team will make a transition plan to finish up any loose ends. Even after (PROGRAM NAME) services are concluded, you can still feel free to contact the consultant if any questions come up.

What Families Say About (PROGRAM NAME)

Here's what other parents have said about their experience with (PROGRAM NAME) services:

“I am more patient with my son and have more structure in his routine. I also pick battles so as not to be overly negative with him. The emotional support was the best thing about our experience with (PROGRAM NAME). The daycare made me feel

like the behavioral problems in school were 100% my fault. The consultant helped me to realize that we all needed to work together to help him.”

- “The consultant was someone who could observe, be objective and provide positive feedback and suggestions.”
- “I understand my daughter’s behavior better and realize that some of the things reported to me at her former daycare are just normal for her age.”
- “If Ms. Jennifer (our (PROGRAM NAME) consultant) hadn’t had anything to do with it, I don’t think we would have made it. God bless you, Ms. Jennifer.”
- “We need more people like our (PROGRAM NAME) consultant who has the heart and soul to really help the consumer. She really helped me and my son get the help needed and now he is in school and doing well.”

FREQUENTLY ASKED QUESTIONS ABOUT (PROGRAM NAME)

1. Will my child be labeled if he or she gets help from (PROGRAM NAME)?

No. (PROGRAM NAME) is a prevention program, not a treatment program. (PROGRAM NAME) consultants will not label or diagnose your child.

2. Will I have to pay for (PROGRAM NAME) services?

No. (PROGRAM NAME) services are free to you and your child care provider.

3. Will information that I tell the (PROGRAM NAME) consultant be shared with others?

The consultant won’t share any information unless you give your permission in writing.

4. Why does the (PROGRAM NAME) consultant want to do a home visit? What is she looking for?

The consultant needs as much information as possible in order to figure out what might be causing a child’s challenging behavior. A young child can’t explain what’s going on, so the consultant must rely on what the parents and child care provider tell her. The consultant also relies on her own observations of how the child interacts with other people. Being able to observe the child at child care **and** at home can be very helpful. For example, the consultant may find that the parent and the provider are responding very differently to the child’s challenging behaviors. If this is the case, the consultant can help the parent and provider work together to be more consistent in how they respond to the child. However, home visits are optional.

5. Will my child have a mental health “record” if we use (PROGRAM NAME) services?

No. Because (PROGRAM NAME) is a prevention service, not a mental health treatment service, the children and families we serve are not officially entered into the mental health system.

6. Will you plan for my child without including me?

Never. Parents are the most important people on the (PROGRAM NAME) team. We look to you to help us learn about and plan for your child. All ideas are generated from shared conversation.

7. Am I the only parent getting this kind of service?

Absolutely not. There is a huge demand for (PROGRAM NAME) services. Child care providers across the country say that the number of infants, toddlers and preschoolers with challenging behaviors keeps increasing and that they want consultation and training to do a better job of caring for these children.

*Appendix A, Document 20- Consent for Services (PERKS Program)***AUTHORIZATION FOR MY CHILD TO RECEIVE SERVICE**

Beginning on _____ has been selected to receive supportive services from the staff of PERKS/Child Care Choices. A PERKS specialist will be assigned to work with the child care provider/program on a regular basis.

Our staff will assist the child care provider/program in their efforts to support your child's healthy social and emotional development and may use any of the following methods to help him/her:

- Observing your child's behaviors and interactions and giving feedback to the child care provider/s.
- Coaching child care provider/s on positive ways to work with your child, especially when he or she exhibits challenging behaviors.
- Modeling/leading group activities to increase your child's social skills and readiness for kindergarten.
- Providing child care provider/s with training tailored to their needs.
- Interacting with your child and modeling appropriate positive adult-child interaction.

Our staff is also available to assist your family in the following ways:

- Answering your questions on child development and providing referrals to services that may assist your family or child.
- Referring you to parent workshops that may be of help to you and your child.
- Meeting with you and your child care provider together when needed.
- Communicating information about your child with professionals who you request be contacted by staff or consultants. (Please see Consent to Release/Receive Information Form).

In signing this Authorization Form, I, as the parent or guardian, understand that:

- I consent to have my child observed and screened to have services rendered as needed.
- I will participate in the Individual Action Plan Agreement process to ensure the appropriate services are implemented for my child through the child care program, including meet with project staff to complete necessary paperwork in the beginning and when the case is being closed.
- I may revoke my consent at any time.
- I have received a copy of the project brochure from the child care provider.


Please complete the lower portion of this form by _____. If you have questions or want some help, feel free to contact the staff person at 301-662-4549 or 410-751-2917.

I consent to have my child, _____, participate in the supportive


Child's Name (please print)

services which PERKS/Child Care Choices offers at _____.

Appendix A, Document 21- Release of Information



PERKS



CONSENT TO RELEASE/RECEIVE INFORMATION

Parent(s)/Guardian Name: _____ **County:** _____
Parent (s)/Guardian Street Address: _____ **Telephone #:** _____
 _____ **Fax #:** _____
Parent(s)/Guardian E-Mail Address: _____ **Cell Phone #** _____
Child's Name: _____ **Birth Date:** _____ **Sex:** _____

1. PERKS/Child Care Choices has my permission to exchange information with the following professionals or agencies:

<input type="checkbox"/> send to	Agency/Individual: _____
<input type="checkbox"/> receive from	Address: _____
<input type="checkbox"/> verbally discuss	_____
	E-Mail Address: _____
	Telephone #: _____ Fax #: _____

<input type="checkbox"/> send to	Agency/Individual: _____
<input type="checkbox"/> receive from	Address: _____
<input type="checkbox"/> verbally discuss	_____
	E-Mail Address: _____
	Telephone #: _____ Fax #: _____

2. Information to be exchanged:

<input type="checkbox"/> Name and Contact Information	<input type="checkbox"/> Clinician's Report
<input type="checkbox"/> Assessment Information	<input type="checkbox"/> Reason for Referral
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Medical Records
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

3. Reason this information is being shared: _____

4. This authorization is valid until _____ (Date)

5. I may revoke this authorization at anytime.

6. _____

Parent's Signature	Relationship to Child	Date
_____	_____	_____


Appendix A, Document 22- Intake Form- PERKS

<p>Partnerships for Emotionally Resilient Kids A program of Child Care Choices, Mental Health Association of Frederick County</p> <p style="text-align: center;"><u>Parent Intake Form</u></p>		
I. Family Information		
Parent Name: _____ Child's Name: _____		
Home Street Address: _____		
City: _____ State: _____ County: _____ Zip Code: _____		
Phone: _____ home _____ work _____ cell _____		
Family's Ethnic Background: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/ Pacific Islander		
<input type="checkbox"/> African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other: _____		
Child's Date of Birth: _____ Child's age: _____ Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
II. Child Care Arrangements		
Child Care Program Name: _____		
Facility Type: <input type="checkbox"/> Center <input type="checkbox"/> Family Child Care <input type="checkbox"/> Early/Head Start <input type="checkbox"/> PreK <input type="checkbox"/> Other _____		
How long has your child been at this child care program? _____		
Has your child been in other child care programs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, how many different placements? _____ How long ago was the most recent placement? _____		
III. Concerns		
What are your concerns about your child?		
<input type="checkbox"/> Aggressive <input type="checkbox"/> Lack of Attention <input type="checkbox"/> Anxious <input type="checkbox"/> Hyperactive <input type="checkbox"/> Withdrawn		
<input type="checkbox"/> Disruptive <input type="checkbox"/> Seems Depressed <input type="checkbox"/> Other: _____		
Does your child have any medical problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____		

When did behavioral concerns begin? _____		
Are there any significant changes in the child's life? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please describe _____		

IV. Other Services		
Has your child been assessed? If so, by whom? _____		
Is your child receiving any services other than PERKS? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please specify: <input type="checkbox"/> Infant & Toddler <input type="checkbox"/> Child Find <input type="checkbox"/> Other _____		
Do you receive Child Care Subsidy from the Department of Social Services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your child receive Medical Assistance from the State of Maryland? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your child have an Individual Family Support Plan or Individual Education Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
FOR OFFICE USE ONLY		
CHILD ID: _____ EIS Initials: _____ Date: _____		

Appendix A, Document 23- Sample Caregiver Information/intake form-Montgomery County ECMHC Program



Caregiver Information Form

PROGRAM/PARTNERSHIP INFORMATION

Initial Input Date: _____ Last Update: _____ Program ID: _____

Center/Family Child Care Provider Name: _____

Type of Provider: _____

Program Address: _____

Program Phone: _____

Assigned Consultant: _____

Date Partnership Initiated: _____

POPULATION SERVED/STAFF INFORMATION

Total Number of Children Enrolled in Program: _____ Total Number of Classrooms in Program: _____

Total Number of Classroom Staff in Program: _____ Accredited Yes No If yes, by: NAEYC MSDE

Number of Credentialled Program Staff: _____ Inclusion Project: Yes No

PEP Pilot: Yes No CSE/PFL Training Participant: Yes No

INDIVIDUAL CHILD INFORMATION

Child's ID: _____	Child's Zip Code: _____
Date Enrolled in ECMHC Consultation Project: _____	Status of Child's Case: _____
Child Receiving Child Care Subsidy: Yes <input type="checkbox"/> No <input type="checkbox"/>	IFSP: Yes <input type="checkbox"/> No <input type="checkbox"/>
Child Needed Referral to Another Resource: Yes <input type="checkbox"/> No <input type="checkbox"/>	IIP: Yes <input type="checkbox"/> No <input type="checkbox"/>
Type Care: _____	Appropriate Resource Available?: Yes <input type="checkbox"/> No <input type="checkbox"/>
Child's Age & Gender: _____	Child's Race: _____
	Child's Placement: _____

*Appendix A, Document 24- Sample Child Plan*Child Care Enhancement Program**Positive Child Guidance Plan – EXAMPLE****Child's Name:** Sara Jones**Age:** 27 Months**Date:** 10/14/06**People Present:** Mrs. Jones (mother), Ms. Thomas (teacher) and Ms. Smith (consultant)**A. DECA-IT scores****A/R= 39 (Area of Need)****Self-Regulation= 35 (Area of Need)****Initiative= 46 (Typical)****B. Description of Behavior- Biting****C. Function of Challenging Behavior(s)** (the “why” behind the challenging behavior; the outcome that results):

Our team's best guess is that Sara bites other children to remove them from her personal space when she is angry.

D. Child's Strengths (skills and preferences to build on):

1. Sara often looks to her parents and caregiver for a sense of security as she explores.
2. Sara asks familiar adults to help her with challenging tasks (reaches out to adult with a favorite book).
3. Sara smiles and bounces up and down when playing with or seeing other children.
4. Sara hugs, smiles at and runs to familiar adults.
5. Sara smiles and laughs when she accomplishes tasks on her own.
6. Sara says “No” when she does not want to participate in something.
7. Sara is able to focus on an activity.
8. Sara can calm down with the help of a familiar adult.
9. Sara likes to look at pictures - she gravitates to visual cues.
10. Sara loves all kinds of music.

D. Goal(s) for Child (the changes we want to see; alternatives to the challenging behavior) & Strategies (what we agree to do to help meet goal(s) and prevent challenging behavior)

Social Emotional Area	Goal #	Caregiver	Family	Consultant	Target Date
Attachment	1-Build social interaction with other children	a. Stay in close proximity to Sara during large group and free choice time.	a. Stay close by when Sara has friends over to offer support and encouragement.		Ongoing
		b. Model ways to initiate interactions and to express feelings.	b. Model ways to initiate interactions (role play using toys at home) and to express feelings (tell Sara how you are feeling and narrate what she may be feeling).	b. Do some role playing and modeling at child care and at home.	Ongoing
Self-Regulation	2- Handle frustration	<p>a. Introduce social story on feelings and “what to do when I get mad” at circle time - let children practice.</p> <p>b. Introduce conflict resolution strategies (the pretzel, STAR, breathing) - have Sara practice and use these strategies when she gets upset - have visual cues up in the room.</p>	<p>a. Read social story from child care with Sara before bedtime - talk with her about feelings.</p> <p>b. Have friends over to play once a wk and model ways to reduce and deal with conflict using conflict resolution techniques - let Sara teach a friend a technique from child care (e.g., the pretzel).</p>	<p>a. Assist with writing a social story, model use at large group time, support caregiver and the parent (home visit) to use story.</p> <p>b. Provide training to child care staff and parents on conflict resolution.</p>	<p>By 11/1/06 w/ ongoing support</p> <p>Training by 12/1/06, then ongoing support to use strategies</p>

Self-Regulation	3- able to transition	a. Shorten time children have to wait for turns.	a. When asking Sara to wait, use a timer.	a. Provide article on toddler expectations to child care staff and parent.	10/20/06
		b. Communicate transitions ahead of time to Sara.	b. Communicate transitions ahead of time to Sara.	b. Model how to communicate transitions both at care and at home - give a one-page tip sheet on transitions.	10/20/06
		c. Use a picture schedule.	c. Use a weekly picture schedule with real pictures at home so Sara knows when and where she will be going.	c. Provide resource on how to make and use picture schedules - link to web site with free pictures.	10/25/06
Other- Build parent/teacher relationship		a. Make several home visits to see what works for Sara at home and what her special interests are.	a. Set aside time to meet with Sara's teacher once a week to discuss progress.	a. Provide in-service for child care staff on building relationships with parents.	Begin home visits by 11/1/06 In-service by 12/1/06
Other- Resources	1	a. None at this time	a. Send a few pictures of Sara's family to child care as well as a few special items to put into the cozy, safe area.	a. Link caregiver and family up with the local early intervention program that is offering training on biting.	10/20/06

F. Immediate Intervention Strategies (what we agree to do when the challenging behavior occurs):

Remember to **FLIP** it around!

1. Stay calm. Move to the children and get down on their level.
2. Describe the **Feelings** and behaviors you see. "Sara, I can see that you are angry at Linda - you bit her."
3. Share the **Limits**. "The rule in our room is that we do not hurt (bite) our friends."
4. **Inquire**. Ask an open-ended question to encourage problem solving. "What can we do to fix this?"
5. **Prompt** Sara. Suggest a calming activity to help with emotional regulation. "What if we tried playing with something else like play dough or bubbles?"
6. Respond to the child who was bitten. Offer comfort through actions and words. "I am sorry you are hurting; let's get some ice." Then help to redirect the child.
7. Go back to Sara to discuss and role play how she could use picture prompts the next time she is angry.
8. Write an incident report.

G. Date, Time, Location of Next Meeting:

11-14-06, 5:30 pm, ABC Child Care, Room B

Parent/Guardian Signature Date

Caregiver Signature Date

Consultant Signature Date

Appendix B- Forms for Part II

Community Resource Mapping Tool (adapted from NCSET and Wishmann et al, 2001, p. 19-20)

Task: Identify and define each resource and map its connection to Early Childhood Mental Health resources.

Definitions:

Purpose: Identify the purpose/mission of the organization, project, program, or initiative

Target population/number served: Identify the specific population served and eligibility requirements

Services and Activities: Match according to the left column and then check those activities or services provided by this organization, project, program, or initiative (e.g., community education, screenings, assessment, technical assistance, training, counseling, etc.).

Partnering agencies: Identify other agencies and organizations with which this organization, project, program, or initiative currently partners. If possible, state the purpose of the partnership.

Expected outcomes: Indicate what this organization, project, program, or initiative hopes to achieve; identify its strengths in meeting the needs of children and their families/caregivers.

Other: Identify other relevant information about each organization, project, program, or initiative (e.g., funding sources, planning cycles, number of children served, names of decision-makers, etc.).

Mapping Resources by Continuum of Supports

Place organization, project, program or initiative name linked to mission/purpose. Other Data may be collected by review of literature/website and by personal interview as possible.

	Resource Name	Purpose/Mission	Target Population and Eligibility	Services and Activities	Partnering Organizations	Expected Outcomes	Other
Prevention and Early Intervention Services							
Risk assessment							
Screening							
Community education and outreach							
Prenatal care							
Pediatric services							
Consultation for families and caregivers							
Parenting skills							
Pre-parenting skills							
Teen pregnancy prevention							
Nutrition							

	Resource Name	Purpose/Mission	Target Population and Eligibility	Services and Activities	Partnering Organizations	Expected Outcomes	Other
Health care							
Substance abuse prevention							
Clinical Services							
Assessment and Evaluation							
Diagnosis							
Home visiting							
In-home services							
Crisis intervention							
Individual and group therapy							
Family therapy							
Play therapy							
Substance abuse treatment							
Medication management							
Behavior management							
Occupational therapy							
Physical therapy							
Communication							

	Resource Name	Purpose/Mission	Target Population and Eligibility	Services and Activities	Partnering Organizations	Expected Outcomes	Other
(speech, language, hearing)							
Community Services							
Child care (full-year, nontraditional hours, and sick child care)							
Therapeutic nurseries and preschools							
Therapeutic foster care							
Transition to school							
After school and summer programs							
Social supports (communities of faith,							

	Resource Name	Purpose/Mission	Target Population and Eligibility	Services and Activities	Partnering Organizations	Expected Outcomes	Other
indigenous supports)							
Women's shelters							
Recreational opportunities							
Playgroups with mental health support							
Inclusive neighborhoods and communities where differences are welcomed							
Police training on abuse, neglect, and family violence							
Court-linked services for pre-divorce counseling							

	Resource Name	Purpose/Mission	Target Population and Eligibility	Services and Activities	Partnering Organizations	Expected Outcomes	Other
Teen pregnancy services							
Family and Caregiver Support Services							
Case management/service coordination							
Respite services							
Transportation							
Employment assistance							
Housing							

	Resource Name	Purpose/Mission	Target Population and Eligibility	Services and Activities	Partnering Organizations	Expected Outcomes	Other
Parent hotlines							
Pre-service education							
Parent support groups							
Family resource centers							
Advocacy services							
Tailored supports for grandparents							
Family-controlled emergency funds							
Infrastructure and Training							



	Resource Name	Purpose/Mission	Target Population and Eligibility	Services and Activities	Partnering Organizations	Expected Outcomes	Other
Provider networking							
Teambuilding							
Multi-disciplinary and cross-disciplinary training							
Cross-cultural training							
Family and caregiver training							
Systems level collaboration							
Clinical supervision							
Grievance and appeals process							

	Resource Name	Purpose/Mission	Target Population and Eligibility	Services and Activities	Partnering Organizations	Expected Outcomes	Other
Mediation and conflict resolution							

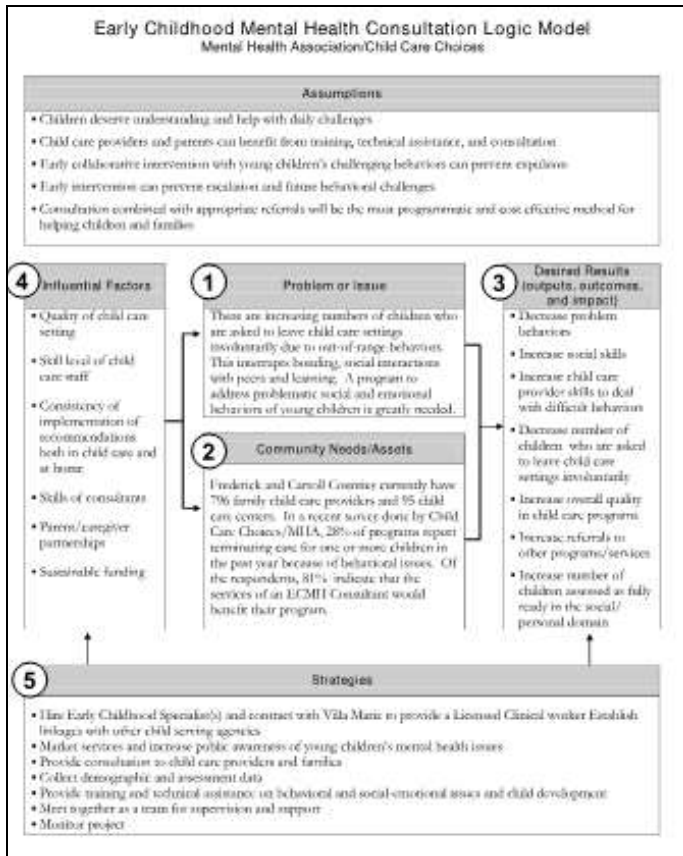
Appendix B, Document 3- Log for tracking services

ECMHC Evaluation Service Log						
Individual Mental Health Consultation-Specific Classroom Site Visit						
Consultant Name: _____		Consultant ID Code: _____				
Name of ECE Provider: _____		Consultation ID Code: _____				
	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6
Date:						
Total Minutes On-Site Consultation:	<input type="radio"/> 0-15 min <input type="radio"/> 15-30 min <input type="radio"/> 30min-1hr <input type="radio"/> 1hr-2 hr <input type="radio"/> 2hr-4hr <input type="radio"/> 4hr-8hr	<input type="radio"/> 0-15 min <input type="radio"/> 15-30 min <input type="radio"/> 30min-1hr <input type="radio"/> 1hr-2 hr <input type="radio"/> 2hr-4hr <input type="radio"/> 4hr-8hr	<input type="radio"/> 0-15 min <input type="radio"/> 15-30 min <input type="radio"/> 30min-1hr <input type="radio"/> 1hr-2 hr <input type="radio"/> 2hr-4hr <input type="radio"/> 4hr-8hr	<input type="radio"/> 0-15 min <input type="radio"/> 15-30 min <input type="radio"/> 30min-1hr <input type="radio"/> 1hr-2 hr <input type="radio"/> 2hr-4hr <input type="radio"/> 4hr-8hr	<input type="radio"/> 0-15 min <input type="radio"/> 15-30 min <input type="radio"/> 30min-1hr <input type="radio"/> 1hr-2 hr <input type="radio"/> 2hr-4hr <input type="radio"/> 4hr-8hr	<input type="radio"/> 0-15 min <input type="radio"/> 15-30 min <input type="radio"/> 30min-1hr <input type="radio"/> 1hr-2 hr <input type="radio"/> 2hr-4hr <input type="radio"/> 4hr-8hr
<i>Summary of Support Provided: Fill in the bubble to all that apply</i>						
Conduct observation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consult to parent(s) re: child specific issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consult to teacher(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consult to director and/or owner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Model classroom behavior management techniques	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Train in formal workshop	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Referral or collateral consultation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Before/After Site Visit Consultation Time						
Additional minutes spent on consultation in addition to actual site visit time (excludes travel)						
Source: Adapted from Louisiana Service Log			Adapted October 26, 2009			

Appendix B, Document 4- Checklist of Referral Sources

	
<h2>The Early Intervention Project</h2>	
<h3><u>Referral Form</u></h3>	
<p>Dear Parent(s)/Caregiver,</p>	
<p>After initial assessment, screening and observation, it is the recommendation for more in-depth evaluation to be completed. Below you will find the contact information for those referrals needed marked with a check. Please call and schedule an appointment with them to assist your child in getting the services they need. Feel free to contact me for additional information or assistance in completing this process at _____.</p> <p>Let us know when you have gotten an appointment with the agency.</p> <p>Sincerely,</p>	
<p>Early Childhood Consultant</p>	
<p><input type="checkbox"/> The Hearing and Speech Agency 5800 Metro Drive Baltimore, MD 21215 410-318-6780 Reason: _____</p>	<p><input type="checkbox"/> University of Maryland Center for Infant Study - Secure Starts 701 W. Pratt St. Baltimore, MD 21201 410-328-1111 Reason: _____</p>
<p><input type="checkbox"/> Baltimore City Public Schools Child Find Office of Preschool Rm. 26 2500 E. Northern Parkway Baltimore, MD 21214 443-984-1011 Reason: _____</p>	<p><input type="checkbox"/> Bayview Community Psychiatry Program Birth to Five Clinic 4940 Eastern Ave Baltimore, MD 21224 410-550-0104 Reason: _____</p>
<p><input type="checkbox"/> Baltimore City Infants & Toddlers Program 10 W. Eager Street Baltimore, MD 21201 410-396-1666 Reason: _____</p>	<p><input type="checkbox"/> The Loyola Clinical Centers Psychological Services 5911 York Road, Suite 100 Baltimore, MD 21212 410-617-1200 Reason: _____</p>
<p><input type="checkbox"/> Kennedy Krieger Institute 707 N. Broadway Baltimore, MD 21205 443-923-9400 Reason: _____</p>	<p><input type="checkbox"/> The Loyola Clinical Centers Audiology and Speech Services 5911 York Road, Suite 100 Baltimore, MD 21212 410-617-1200 Reason: _____</p>
<p>Additional Information: _____</p>	
<p>Early Intervention Project</p>	<p>March 2010</p>

Appendix B, Document 5- Sample logic model



WORK STATEMENT NARRATIVE

Michigan's Child Care Expulsion Prevention (CCEP) Program

Early Childhood (0-5) Mental Health Consultation Services

Child Care Expulsion Prevention is an early childhood mental health approach that is enveloped into child care settings to include, center-based, family home, group home, relative and day care aide providers. The overall goal is to promote the social and emotional well-being of infants, toddlers, preschoolers and the adults that care for them thereby creating a systems change and preparing young children for school readiness and life success.

CCEP mental health consultants will provide early childhood mental health consultation services to child care providers, parents, infants, toddlers and preschool children using techniques appropriate to the child care setting and the home. Specifically, the mental health consultants will:

A. Provide *programmatic consultation* within the care setting to improve the overall social and emotional quality of services and promote skills across a universal level; for all children. CCEP consultants offer *programmatic consultation* for providers that wish to strengthen a particular aspect of their program affecting the social-emotional quality of care. For example, a provider may request strategies to: strengthen parent-provider partnerships; reduce stress during transitions; promote social-emotional competence during activities and daily routines; intervene with children who are acting out; create a more nurturing physical environment; teach children to resolve conflicts; etc. Through training and coaching, the consultant assists the provider in assessing the situation, creating a Programmatic Action Plan, implementing the Plan, and evaluating how well it works.

Consultants will:

- 1) Provide specialized training in the area of social and emotional well-being as requested by the caregiving site.
- 2) Serve child care centers, group homes, family homes, relative providers and in-home aides, prioritizing services to providers who care for children receiving Department of Human Service child care subsidies.
- 3) Track the total number of children attending participating sites.
- 4) Track the total number of child care staff working within participating sites.

Consultants cannot serve other federally or state-funded early childhood programs outside of child care, although CCEP programs can invite care providers from state and federal programs to attend CCEP trainings and quarterly meetings.

CCEP consultants will follow the processes for programmatic consultation set forth in Chapter 6 of the draft CCEP Manual. CCEP programs will use all of the required forms as stipulated by the Department of Community Health.

- B. Provide standardized **Core Training Modules** for parents, child care providers and other early care and education professionals within the county served.

Each CCEP program will provide a minimum of two series of four standardized social and emotional trainings, called CCEP Core Training Modules. These CCEP Core Training Modules are based on best practice and research. These trainings will occur across all of the CCEP programs as part of CCEP programmatic services. These are the services provided that enhances the overall social and emotional quality of child care settings for all children.

All training modules will be 3 hours in length and will utilize standardized materials. They will be offered on days and at times that best meet the needs of child care providers and parents. All trainings will cover the 0-5 age range with a heavy emphasis on infants and toddlers. Learning outcomes will be clearly identified for each module. The four core modules are listed below.

1. Foundations of Social and Emotional Development

Participants will learn about, observe and begin to understand and recognize critical social and emotional milestones of children ages 0-5.

2. Challenging Behavior

Participants will learn about and practice planning for universal prevention strategies that benefit the social and emotional health of all children as well as strategies to assist children with challenging behaviors

3. Conflict Resolution

Participants will be trained utilizing a conflict resolution approach designed for young children aged 18 months to six years. The approach is based on six simple mediation steps that child care providers and parents can use with children during emotionally-charged conflict situations. The steps are: (1)

Approach calmly, stopping any hurtful actions; (2) Acknowledge children's feelings; (3) Gather information; (4) Restate the problem; (5) Ask for ideas for solutions and choose one together; and (6) Be prepared to give follow-up support.

4. Caring for the Caregiver

Participants will learn about adult caregiving characteristics that build trust and support healthy relationships with very young children. They will reflect and engage in learning experiences that connect them with their own culture, values, and belief in regards to care giving practices. Lastly, participants will set realistic, measurable goals for themselves that will enhance the quality of the social and emotional care they provide.

Consultants will track:

- 1) Number of trainings completed, by the core module title
- 2) Number of parents attending
- 3) Number of formal child care providers attending
- 4) Number of informal child care providers attending
- 5) Number of other early care and education professionals attending
- 6) Training evaluation surveys for all participants

Training evaluations will be entered into an excel data base and reported to state at the close of each quarter.

In addition to the CORE Modules, CCEP consultants will provide social and emotional related trainings that are individually requested by child care sites.

Consultants will track:

- 1) Number of social and emotional specialized trainings
(Separate from CCEP standardized Core Trainings)
- 2) Number of formal child care providers attending trainings
- 3) Number of informal child care providers attending trainings
- 4) Number of parents attending trainings

C. Provide **child/family centered consultation** within the care setting and through home visits to address the issues which challenge a child's ability to succeed in a

child care setting. Consultation includes intake, observation and assessment, development of a Positive Child Guidance Plan, support for parents and providers to implement the Plan, and conclusion of services. Specifically, consultants will track:

- 1) Age of child at time of referral
- 2) Gender, race, ethnicity of child
- 3) Presenting problems as indicated by the child care provider and the parent(s) and or guardian(s) at time of referral and at summary of service
- 4) Number and duration of consultations per child with parents and providers
- 5) Whether or not child receives DHS child care subsidy
- 6) Other DHS services the family received
- 7) Outcome status of placement and interventions used

Other information may be collected as stipulated by the Department.

Consultants cannot serve children in Head Start, Early Head Start, MSRP and other federally or state-funded early childhood programs unless the child is also in a separate child care program to include licensed child care centers, licensed child care group homes, registered child care family homes and DHS enrolled relative care providers and day care aides.

CCEP consultants will follow the processes for child/family centered consultation set forth in Chapter 5 of the draft CCEP Manual. CCEP programs will use all of the required forms as stipulated by the Department...

- D. Utilize **evidence-based tools** in the provision of consultation. Consultants will use the tools as stipulated by the Department in conjunction with the MSU evaluation and CCEP Initiative.
- E. Participate in **one-on-one reflective supervision** that is on-going and supportive. Consultants will engage in a minimum of 24 hours of reflective supervision within the fiscal year (example 2 hours per month). Reflective supervision entails the building of a positive relationship between staff and supervisor by engaging in open, nonjudgmental and consistent dialogue. Both supervisor and supervisee are active participants in listening and engaging in thoughtful questioning. Reflective supervision must be provided by individuals that are knowledgeable about early childhood mental health consultation and early childhood educational practices.

Consultants will track:

- 1) Number or reflective supervision sessions they participate in.
- 2) Number of hours per reflective supervision session (per staff)

Administrator will:

- 1) At the beginning of the contract year, record the qualifications of the person providing ongoing reflective supervision. If reflective supervision is not currently available, the administrator will describe the strategy to be used to secure it, utilizing an outside consultant, if necessary.
 - 2) Be responsible for ensuring with MIAIMH that the person providing reflective supervision qualifies to provide this support.
 - 3) Be responsible for ensuring that the person providing reflective supervision is knowledgeable about CCEP consultation practices.
 - 4) Be responsible for oversight and ensuring consultants maintain Level II endorsement.
- F. Will have a Masters Degree and endorsement through the Michigan Association for Infant Mental Health.
- 1) **ALL** consultants hired to do CCEP services must have a Master's degree in social work, psychology, or a related field. License or license-eligible preferred.
 - 2) All current (hired prior to 2007-2008 fiscal year) consultants providing CCEP services need to maintain Level II MI-AIMH endorsement.
 - 3) All consultants hired in the 2008-2009 fiscal year must attain Level II MI-AIMH endorsement by September 30, 2009.
 - 4) Consultants will be responsible for tracking and reporting on progress made toward meeting CCEP staffing qualifications, including MI-AIMH endorsement and educational degree (when applicable).
- G. Utilize MDCH **technical assistance** intended to develop an early childhood mental health system that is built on a strong foundation of common principles and practices. Project staff will use technical assistance as needed and as described below:
- 1) Consultants (or their administrators) will attend 100% of the quarterly technical assistance meetings held in Lansing.
 - 2) Administrators and consultants will attend 100% (Eight out of eight) meetings of the Training and Evaluation Committee held via phone. At least one representative per program will attend and be responsible for sharing results with staff that were unable to attend.
 - 3) Consultants will use technical assistance on a consistent basis (minimum contact one time per month) in addition to attending the quarterly technical assistance meetings.

- 4) Consultants and administrators will consistently use ongoing technical assistance provided on implementing the evaluation of the CCEP initiative. Where possible, this technical assistance will be provided as part of the regular meetings outlined above, but additional technical assistance may be provided on-site, by e-mail, or by phone. It is essential that the effectiveness of CCEP services and the evidence-based practices on which they are built be demonstrated, so collaboration with the Michigan State University Evaluation Team will be required over the next two years.

- H. Will **collaborate** with other early childhood agencies and providers, as they are critical to successfully integrate a CCEP project within a child care setting. Each CCEP project has an advisory committee / community team, including a range of early childhood providers who collaborate to implement CCEP by providing guidance to the project, making referrals to the project, serving as referral sources from the project, and publicizing the project. It is imperative that the CCEP project work collaboratively with other agencies that have established relationships with child care, primarily the Michigan 4C Association and Michigan State University Extension.

Consultants will track:

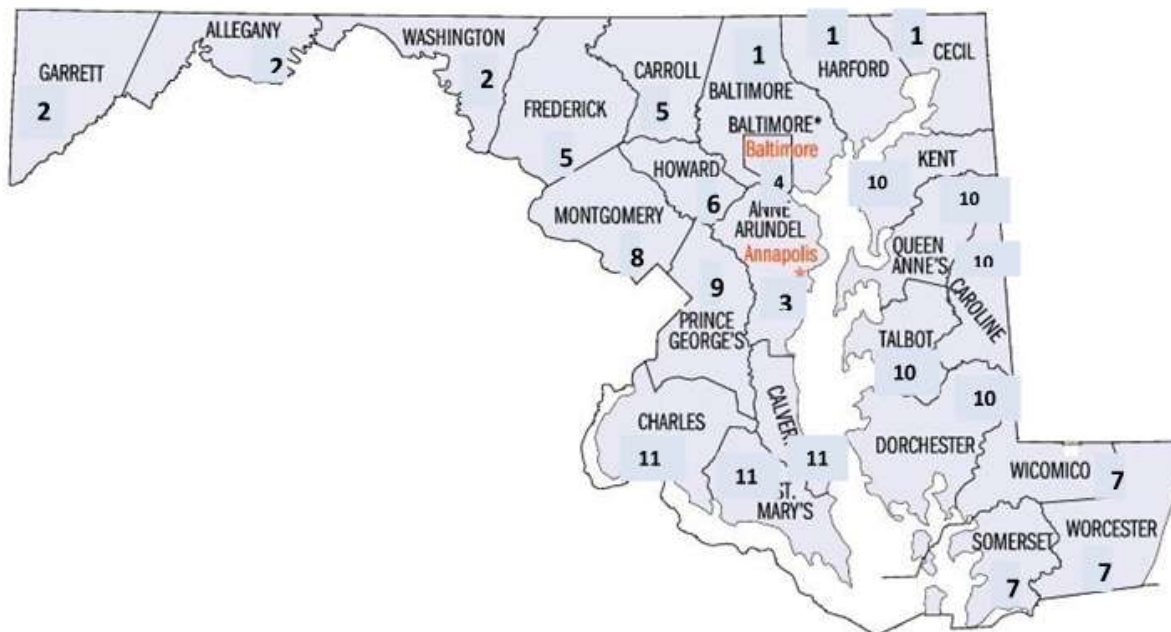
- 1) Number of advisory team meetings held
 - 2) Agencies represented on the advisory team
 - 3) Meetings held with Michigan 4C Association
 - 4) Meetings held with Michigan State University Extension Office staff
 - 5) Meetings held with Great Start Collaboratives
- I. Focus their efforts on the following priorities for fiscal year 2008-2009. Overall, the priority of CCEP will be to assist providers and families in addressing the needs of children most vulnerable to expulsion or withdrawal from child care due to mental health related concerns. Other special priorities for fiscal year 2008-2009 are to:
- 1) Serve more children aged birth to three years.
 - 2) Serve more relative and day care aides.
 - 3) Increase number of children served who receive DHS child care subsidies.
 - 4) Increase number of child care settings served that care for children receiving DHS child care subsidies.
 - 5) Build relationships across systems to include, but not be limited to, Great Start Collaboratives, MI4C, MSUE and MI-AIMH.
 - 6) Contribute to the evaluation of the services to ensure quality and demonstrate that it is built on evidence-based practices.

Appendix C- List of MSDE funded

ECMHC Projects

List of Regional ECMHC Programs in Maryland

1. Abilities Network
2. Apples for Children
3. Arundel Child Care Connections
4. Baltimore City Child Care Resource Center
5. Child Care Choices
6. Child Care Resource Center Howard County
7. Lower Shore Childcare Resource Center
8. Montgomery County Department of health and Human Services
9. Prince George's County Resource Center
10. Project Rights Steps
11. Southern Maryland Child Care Resource Center



For more information:
Maryland State Department of Education
Division of Early Childhood Development
200 West Baltimore Street, 10TH Floor
Baltimore, Maryland 21201
410-767-8959
