



## HOLDING HOPE: INFANT-EARLY CHILDHOOD MENTAL HEALTH CONSULTATION IN EARLY ACHIEVERS



Washington State Department of  
**CHILDREN, YOUTH & FAMILIES**

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Washington State Department of  
**CHILDREN, YOUTH & FAMILIES**

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## Executive Summary

Second Substitute Senate Bill [5903](#) (2019) directed the Department of Children, Youth, and Families (DCYF) to contract with an organization providing coaching services to early achievers program participants, i.e., Child Care Aware of Washington (CCA WA), to provide statewide Infant-Early Childhood Mental Health Consultation (IECMH-C) to Early Achievers Quality Rating and Improvement System (QRIS) participants and coaches. State general funds were allocated to hire one mental health consultant for each of the six regions. DCYF was also required to submit a report on provided services and outcomes in collaboration with CCA WA.

The state investment was leveraged to access additional funding for key infrastructure needed by CCA WA to develop, implement, and evaluate this program. Private funding enabled CCA WA to hire an IECMH-C Program Director, contract The Athena Group to complete a formative evaluation during the program's initial year, and purchase foundational training for mental health consultants. Federal grant funding enabled the hiring of three additional mental health consultants.

The Early Achievers IECMH-C program was developed and implemented during the first months of the COVID-19 pandemic. While this impacted the timeline and model of implementation, the program has flexed in response to provider and coach needs. It has been invaluable support during the unprecedented stressors of the past year. An interim evaluation report from The Athena Group describes the developmental process and the activities and impacts of the program during its first seven months of implementation. This report provides a summary of key activities, information about the context within which this program is operating, and plans for scaling up the program as part of a more integrated statewide IECMH-C system.

## Introduction

### Purpose

Second Substitute Senate Bill 5903 directed DCYF to enter into a contractual agreement with an organization providing coaching to Early Achievers program participants to hire one qualified mental health consultant for each of the six agency-designated regions under Revised Code of Washington (RCW) [43.216.090](#). This statute:

- Requires that the mental health consultants support Early Achievers program coaches and child care providers by providing resources, information, and guidance regarding challenging behavior and expulsions.
- Allows the mental health consultants to travel to assist providers in serving families and children with severe behavioral needs.
- Requires that DCYF report, in coordination with the contractor, on services provided and the outcomes of the mental health consultants' activities by June 30, 2021.

### Infant-Early Childhood Mental Health Consultation (IECMH-C) Overview

Infant-Early Childhood Mental Health Consultation (IECMH-C) is an evidence-based approach that is focused on building adults' capacity to:

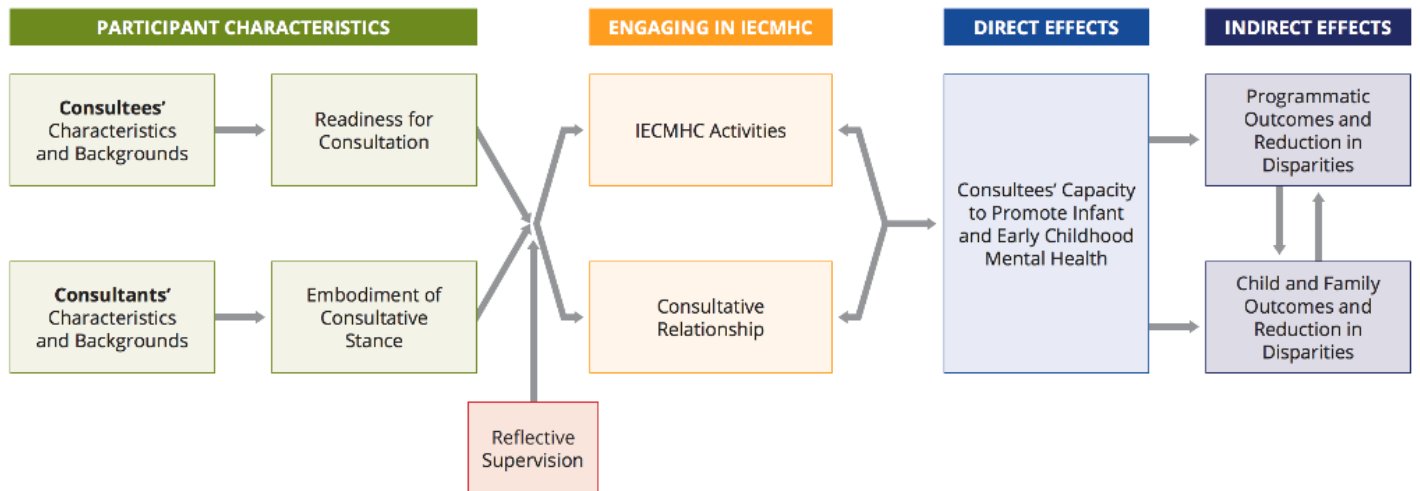
- Support all infants' and young children's emotional development.
- Prevent, identify, or reduce mental health challenges.<sup>1</sup>

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<sup>1</sup> ZERO TO THREE (2016). [\*Early Childhood Mental Health Consultation: Policies and practices to foster the social-emotional development of young children.\*](#)

IECMH-C connects a mental health professional with programs and professionals that work with young children and families. Through this collaborative partnership, caregivers become equipped to better understand the needs of children in their care. They gain knowledge and skills that increase their capacity to understand the behaviors through which children communicate their needs and to respond to these needs in ways that maximally promote young children’s social-emotional development (see Figure 1).

Figure 1: IECMH-C Theory of Change<sup>2</sup>



While mental health consultants do not provide mental health treatment, their clinical expertise as mental health professionals enables them to understand emotional, relational, and biological factors that influence children’s behavior and the ways adults perceive and respond to those behaviors and to offer strategies that caregivers can use to cope with their own stress and other emotions. This support has been especially critical during the syndemic (the aggregation of multiple concurrent epidemics – e.g., COVID-19 and racism – that, combined, interact to exacerbate negative impacts on peoples’ health and well-being).<sup>3</sup>

### Impact of IECMH-C

To maintain employment and economic stability, most families require access to affordable, high-quality care for their young children. Families want confidence their children are safe, loved, and learning in the care of early childhood educators who can support their overall development. Early childhood education providers need support to help children thrive socially and emotionally through developmental stages that are challenging at times, and that can be disrupted by exposure to toxic stress, trauma, and developmental differences.

- Young children with disabilities, children who are Black, Indigenous, and People of Color (BIPOC), boys, and children who have experienced early childhood adversity are at increased risk of suspension and expulsion, which have harmful impacts on healthy development and education.
  - Parent interviews completed in the 2016 National Survey of Children’s Health found that 44.8% of preschoolers with autism also have at least one mental health condition.<sup>4</sup>

<sup>2</sup> Center of Excellence for Infant-Early Childhood Mental Health Consultation

<sup>3</sup> Hunter, A. & Horen, N. (March 2021). Infant and Early Childhood Mental Health Consultation in the Midst of a Syndemic: How does the field pivot? *ZERO TO THREE Journal* 41(3), 17 – 23.

<sup>4</sup> Kerns, Rast & Shattuck (2020). <https://www.psychiatrist.com/JCP/article/Pages/mental-health-conditions-in-youth-with-autism-spectrum-disorder.aspx>

- Children with a reported history of expulsion at the time of Early Childhood Education and Assistance Program (ECEAP) enrollment were 2.5 times more likely to have an Individualized Education Program (IEP) and up to 3 times more likely to have experienced at least one Adverse Childhood Experience.<sup>5</sup>
- National research has also revealed racial and gender disproportionalities in exclusionary discipline practices: rates of suspension and expulsion are higher among BIPOC children and boys.<sup>6</sup>

IECMH-C can have a powerful impact on the relational health and social-emotional well-being of children and their caregivers. Research indicates that when implemented effectively by qualified mental health consultants, IECMH-C outcomes include the following:<sup>7</sup>

- Improved teacher-child relationships.
- Increased teacher skills teaching social-emotional content.
- Decreased teacher stress and turnover.
- Improved child social-emotional well-being.
- Reduced child behaviors that adults find challenging to manage.
- Reduced rates of suspension and expulsion, particularly among boys of color.
- Fewer missed workdays for parents.
- Improved parent-child relationship.

While no evidence base currently exists regarding outcomes of IECMH-C to QRIS coaches, Washington State has an opportunity to contribute to the national evidence base through the CCA WA IECMH-C program and to build understanding about the efficacy of this intervention in improving child outcomes in the classroom.

### Legislative Action Related to IECMH-C

Recognizing its potential to promote social-emotional development during the uniquely critical first years of a child’s development and reduce disproportionate rates of suspension and expulsion from preschool settings, Washington State has increased its investment in IECMH-C over the past five years.

In 2017, [E2SHB 1713](#) included the requirement that DCYF establish a child care consultation program to connect child care providers with evidence-based, trauma-informed, and best practice resources that would support their ability to care for infants and young children exhibiting concerning behaviors or symptoms of trauma. DCYF hired an IECMH-C Program Manager to develop a plan for statewide IECMH-C in early care and education settings. The preliminary plan that was developed by the IECMH-C Program Manager included foundational infrastructure at the state level and fully-funded pilots for licensed child care providers in two DCYF regions. This proposal was included as Appendix R of DCYF’s 2019 report to the Legislature entitled [Expansion of Trauma-Informed Child Care in Washington State: Recommendations from the Trauma-Informed Care Advisory Group](#).

In 2019, [SB 5903](#) required that DCYF develop an IECMH-C model in consultation with public and private partners to ensure it would meet community needs in a culturally responsive manner, begin implementation in at least two regions, and phase up to full statewide implementation within four years. Ultimately, [2SSB](#)

<sup>5</sup> DCYF (2019). <https://www.dcyf.wa.gov/sites/default/files/pdf/reports/TICAG.pdf>

<sup>6</sup> U.S. Department of Health and Human Services, Early Childhood Training and Technical Assistance System (2018). [https://childcareta.acf.hhs.gov/sites/default/files/public/expulsion\\_tool\\_revised\\_june\\_2018.pdf](https://childcareta.acf.hhs.gov/sites/default/files/public/expulsion_tool_revised_june_2018.pdf)

<sup>7</sup> Center of Excellence for Infant and Early Childhood Mental Health Consultation. (2020). *Annotated bibliography: The evidence base for infant and early childhood mental health consultation (IECMHC)*.

[5903](#) significantly modified this section, requiring that DCYF contract CCA WA to develop and implement a new IECMH-C program for Early Achievers coaches and participating providers. State general funds were allocated for this program with the requirement that CCA WA hires one mental health consultant per region and that these staff provide IECMH-C to Early Achievers coaches and participating providers. DCYF leveraged this public investment to access private funding for essential infrastructure to support program development, implementation, evaluation, and integration into the broader IECMH-C system. During the initial year of implementation, private support from Perigee Fund covered the cost of the IECMH-C Director at CCA WA, the required formative program evaluation, and foundational professional development opportunities.

## IECMH-C Program in Early Achievers

In 2020, DCYF contracted CCA WA to provide IECMH-C services within the Early Achievers QRIS. Each of the CCA WA regional offices was subcontracted by CCA WA to hire one mental health consultant (MHC) to provide Infant Early Childhood Mental Health Consultation to Early Achievers participants in their region. In 2021, federal Preschool Development Grant Birth through Five (PDG B-5) funding for three additional MHCs was allocated to this program.

### Program Evaluation

The Athena Group was contracted by CCA WA to engage in formative evaluation of the IECMH-C program during its first year of design and implementation. The evaluation employed an equity lens, participatory approaches, and stakeholder engagement to answer questions regarding the program's impact and ensure it meets the needs of the families, providers, and communities engaged in these services. This included questions such as:

- What is and is not working well for those implementing and impacted by the program?
- What opportunities for future growth and adaptation of the program exist?

The Interim Evaluation report provided by The Athena Group (Appendix A) was submitted to DCYF in March 2021 for inclusion in this report. It provides a detailed description of the IECMH-C program development, including adaptations made in response to the COVID-19 pandemic and preliminary data related to IECMH-C services provided during the first seven months of the program's implementation. The Athena Group will provide a final evaluation report in Fall 2021.

### Program Development

#### Staffing and Hiring

In March 2020, CCA WA hired the IECMH-C Director. This position is responsible for overall program development and coordination, providing training and reflective supervision for the MHCs, and tracking and reporting program outcomes to DCYF as specified in the contract with CCA WA. By the end of the state fiscal year, MHCs were hired and had begun providing IECMH-C services in five of the six CCA WA regions: King/Pierce, Olympic Peninsula, Eastern, Southwest, and Northwest. Three additional MHCs funded by PDG B-5 were hired: two were hired by the regional office in King/Pierce, and a bilingual MHC who will be available to support Spanish-speaking providers statewide was hired by the Network office and reports directly to the IECMH-C Director.

#### Program Infrastructure

Because the IECMH-C Director has expertise in IECMH-C as a former manager in Arizona's Smart Support IECMH-C program and as the prior DCYF IECMH-C Manager, she was able to quickly establish the IECMH-C

program at CCA WA. The IECMH-C Director, CCA of WA’s data team, and external consultants collaborated to rapidly develop and operationalize a case management database. Written guidance was developed to support MHCs’ ability to use the database for HIPAA-compliant data entry and service documentation. The use of this data system began on July 1, 2020. It has been modified since that time to better capture the virtual work required due to the COVID-19 pandemic and to strengthen program reporting and monitoring capabilities. During the fall of 2020, the Program Director worked with the team of MHCs to adapt Arizona’s Smart Support Implementation Guide and service documentation forms to meet the unique needs of the CCA WA program such as mental health consultation to Early Achievers coaches and virtual service provision necessitated by the COVID-19 pandemic.

### Needs Assessment

At the direction of CCA of WA, which funded the evaluation with resources from Perigee Fund, the Athena Group administered a survey to all licensed child care providers. The survey was offered in English, Spanish, and Somali. They sent the survey to 4,766 providers, of which 1,454 providers responded (31%). Of the respondents, 90% were Early Achievers participants, and this group’s response rate was 35%. The results of this needs assessment can be found in The Athena Group's interim evaluation report (Appendix A).

### Program Implementation

The following are highlights of the activities of the MHCs in this program for July 2020 – February 2021:

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#### IECMH-C FOR EARLY ACHIEVERS PARTICIPATING PROVIDERS

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##### Referrals to IECMH-C (Providers and Individual Children)

- Total Number: 107
- Reasons (Multiple Concerns May Exist for Any One Referral)
  - Child/Family Concerns: 79%
  - Teacher Concerns: 39%
  - Director/Programmatic Concerns: 20%
  - Expulsion Risk: 21%

##### Child Care Sites that Received IECMH-C

- Total Number: 61
  - Child Care Centers: 78% (48)
  - Family Home Child Care: 22% (13)

##### Waitlist

- 1 Provider (King/Pierce)

##### MHC Activities

- Action Plans Completed: 45
- Referrals to Other Community-Based Services
  - For Children and Families: 100
  - For Directors and Teachers: 25
- Trainings: 11

##### Early Achievers Coach Consultation

- Hours Provided by MHCs: 409

A more detailed description of the program activities is in The Athena Group’s interim report (Appendix A).

## Barriers and Opportunities

**Referral System.** Referrals from Early Achievers Coaches were initially lower than expected. According to the Athena Group’s evaluation report, factors that contributed to low referral rates included Early Achievers coaches’ hesitance to refer providers who have limited capacity beyond struggling to keep their businesses operational, along with a lack of understanding of what IECMH-C is and when to refer a provider to this service. However, referral rates have steadily increased over time as CCA of WA has engaged in focused outreach and education and as participating providers have begun recommending the service to colleagues.

**Virtual Consultation.** Inability to visit providers and observe teachers, classrooms, and children in person has been problematic. Reliance on adult reports of problems without observing behaviors, including teacher-child interactions, increases the likelihood that MHCs are not fully addressing underlying issues.

**Racial Equity.** To support better understanding of the extent to which these services are equitably accessible and demonstrate equitable outcomes, future service data will be disaggregated by race/ethnicity. Efforts are underway to develop service eligibility and priority criteria that center on advancing racial equity.

**Infrastructure Resources.** Recent investments through the [Fair Start for Kids Act](#) increased resources for IECMH-C. This included a state investment to support the Holding Hope IECMH-C Director and a program manager to provide supervisory support from the Network office, six additional mental health consultants, and relevant workforce development supports. This is a critical and valuable investment in infrastructure. As the number of MHCs in the program increases, additional resources will be needed at the network and regional offices to meet the supervisory, administrative, and other operational costs associated with this growth.

## Statewide IECMH-C System

### Context

The new IECMH-C program through CCA WA is developing in the context of a broader IECMH-C landscape. Mental health consultants are embedded in many settings, including educational school districts (ESD), community behavioral health agencies, private and group mental health practices, local health jurisdictions, early intervention agencies, and the child care resource and referral network, CCA of WA. Many of these mental health consultants provide IECMH-C for other early childhood and family-serving systems such as child welfare, early intervention, home visiting, social services, and behavioral health in addition to early care and education.

IECMH-C has been utilized statewide for decades within Head Start and ECEAP. Head Start and ECEAP performance standards require providers to access IECMH-C from consultants who meet specified mental health qualifications. Sites use funding in their grant or contract to purchase this service.

Other initiatives and projects provide funding for local pockets of IECMH-C as well. Project LAUNCH, a Substance Abuse and Mental Health Services Administration (SAMHSA) grant, currently funds IECMH-C in Cowlitz, Wahkiakum, and Lewis counties. Best Starts for Kids funds IECMH-C in King County as part of the larger Child Care Health Consultation project, and Seattle-King County Public Health also funds IECMH-C for the Seattle Preschool Program. DCYF’s ECLIPSE (Early Childhood Intervention and Prevention Services)



contracts include the provision of IECMH-C within two therapeutic child care programs in King and Yakima counties. Within the Early Achievers system, Child Care Development Fund (CCDF) infant toddler quality set aside also funds IECMH-C to early learning providers that serve children on subsidy and provide early care and education to infants and toddlers.

While we have data about the number of licensed child care providers in Washington State, including licensed capacity, and some data about children receiving care through specific programs (such as Working Connections Child Care Subsidy, Child Welfare Subsidy, ECEAP and Early ECEAP, and ECLIPSE), no statewide data regarding the full IECMH-C workforce is systematically collected. Current efforts at DCYF include mapping the Washington State IECMH-C landscape across programs and initiatives, assessing the needs of mental health consultants and recipients of IECMH-C services, and creating a more integrated and accessible statewide system utilizing key infrastructure such as professional development and coordinated referral pathways.

### Building an Integrated Statewide IECMH-C System

Through recent workgroups, interviews, and a survey, the broader field of MHCs has identified a need for the state to support the integration of IECMH-C across all programs where it is provided within early childhood and family-serving systems (e.g., child welfare, early intervention, home visiting, social services, early care and education, and behavioral health) in order to maximize resources, quality, and impact. They requested systems-level infrastructure that will:

- Center equity and diversity in all aspects of this work.
- Ensure an adequately prepared and supported IECMH-C workforce that is reflective of the professionals and families served.
- Provide flexible guidance for service implementation and evaluation that is aligned with national best practice standards.
- Create a predictable and equitable funding model for IECMH-C across programs.
- Ensure coordination of these services across the many programs in which IECMH-C is provided.

This community input informs our plans to build a more integrated statewide IECMH-C system in early care and education. To ensure that services are consistently coordinated, culturally and linguistically responsive, and aligned with national best practice standards, DCYF must build an integrated statewide system of IECMH-C across programs, supporting all mental health consultants engaged in this important work regardless of how their work is funded or who the recipient of the services is. Key recommendations include state investments in workforce development, implementation guidance, and coordinated referral pathways.

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*“There is a lack of structure in the field to deliver services. There is a need for a manual ... and a best practices framework such as tools to use to observe, evaluate, and track goals and monthly meetings with IECMH consultants around the state to develop such model ... [T]here should be a foundational best practice framework for this type of work so new consultants have some guidance. I feel very alone at my agency.”*

*– Participant, DCYF Survey of IECMH Consultants (2020)*

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## Conclusion

Expanding the Early Achievers IECMH-C program to better meet demand requires an increased number of MHCs providing IECMH-C, continued funding for the centralized program director at the CCA WA network office, and additional funding for supervisors at the regional offices as warranted by program growth. Expansion should involve scaling up this program in a manner that is flexible and responsive to community need as determined by provider numbers and demand overlaid with other indicators of highest need.

The following aspects of system integration and program growth will also be areas of focus in the immediate future:

1. Identification of elements of IECMH-C that can be provided virtually long-term as part of a hybrid remote/in-person approach to service delivery.
2. Clarification of roles and responsibilities of all coaches and consultants supporting early childhood education providers to prevent duplication of services, streamline decision making regarding referrals, and facilitate greater efficiency and more effective collaboration.
3. Increase the number of MHCs for the Early Achievers IECMH-C program.
4. Improved accessibility through coordinated referral pathways to ensure providers, coaches, and families all know who is available to provide the IECMH-C they need across the programs they participate in.

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## Appendix A: The Athena Group Interim Evaluation Report



# HOLDING HOPE

Infant-Early Childhood Mental Health Consultation

*Provided by Child Care Aware of Washington*

## Infant-Early Childhood Mental Health Consultation (IECMHC) Interim Evaluation Report

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**Child Care Aware of Washington**

**March 1, 2021**



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# INTRODUCTION

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## Background

Infant and Early Childhood Mental Health (IECMH) Consultation is an evidence-based mental health prevention service that enhances the capacity of those who provide direct care for young children and their families. Consultation assists child care directors and teachers in understanding the social and emotional development of children; identifying and addressing the mental health needs of children and their parents; assisting with environmental changes; and identifying appropriate referral resources; and increasing the capacity to link families to needed mental health services. These services are provided through in-person support and reflective consultation, reflective group learning, training, and education.

Evidence-based research suggests that when implemented effectively, IECMH consultation:

- Improves teacher-child interactions and the overall quality of the classroom climate for all children.
- Results in the reduction of teacher-reported behavioral problems,
- Improves pro-social behaviors among children, and reduces child expulsions, particularly among boys of color.
- Decreases teacher stress, lowers rates of teacher turnover, and a reduces the time families miss work.<sup>1</sup>

In 2017, under direction of the Legislature, the Department of Children, Youth, and Families (DCYF) began planning for a statewide expansion of Mental Health Consultation. In 2019, the legislature provided funding for the first state supported IECMH consultation program, to be implemented by DCYF in partnership with Child Care Aware of Washington (CCA of WA).<sup>2</sup> Private financial support from Perigee Fund is also funding the cost of the IECMHC Director at CCA of WA and the formative program evaluation required under the statute.

## Evaluation Scope and Methodology

This formative evaluation is intended to support and inform development of the IECMHC program through its first year by providing evaluative information on program design and implementation.

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<sup>1</sup>Evidence for IECMH Consultation: Duran et al. (2009). What works?: A study of effective early childhood mental health consultation programs. Washington, DC: Georgetown University Center for Child and Human Development; Hepburn et al (2013). Early childhood mental health consultation as an evidence-based practice: Where does it stand? ZERO TO THREE, 33, 5.; ZERO TO THREE, 2016. Early Childhood Mental Health Consultation: Policies and practices to foster the social-emotional development of young children. Washington, DC, ZERO TO THREE.; SAMHSA's Center of Excellence for IIECMHC; and Indigo Cultural Center Report on Smart Support, Arizona's MH Consultation System.

<sup>2</sup> Senate Bill 5903, Section 7

The evaluation is employing an equity lens, participatory approaches and stakeholder engagement. The evaluation is also supporting development of quantitative and qualitative data collection methods that will enable the program to manage and report on early and longer-term outcomes. Evaluation results will be used to inform DCYF, CCA of WA, and community partners as they seek to understand how to effectively expand robust, high quality IECMH consultation in the Washington state licensed child care system.

The evaluation objectives are to answer the following questions:

- What is working well and what is not working as well for those impacted by the IECMH consultation pilot (e.g., families, child care providers, and Early Achievers Coaches)?
- What is working well and what is not working as well for those implementing the IECMH consultation pilot (e.g., the IECMH consultants, the CCA of WA system, and DCYF)?
- What is the impact of the IECMH consultation pilot to date? What is the potential for impact should implementation continue?
- What are we learning about what we need to continue, stop, change, or grow in order to have a strong IECMH consultation system in Washington state, which meets the needs of families, providers, and communities? (Learnings might be in the realms of policy, financing, program design, consultant activities, qualifications, or training, etc.)
- Given what we are learning in this pilot, how might IECMH consultation in Washington state continue to grow?

The evaluation is using participatory approaches, stakeholder engagement and an equity lens to answer these questions. These participatory methods include:

- Close collaboration with the MHC Program Director and Mental Health Consultants (MHCs) to co-develop the theory of change and logic models that elevate the knowledge of MHCs; integrate the expertise of evaluation consultants; and offer multiple opportunities and methods for input from evaluation participants.
- Development of an Advisory Committee that includes key stakeholders including state and regional partners and at least one provider to support evaluation design and interpretation of results.
- Applying developmental evaluation techniques to gather and iteratively analyze evaluation data and feedback as program rollout and development occurs.
- Focus on minimizing MHC burden by collecting data through existing team meetings and electronic methods and conducting interviews and other more intensive data collection when needed to understand complex issues as well as detail on regional variation.
- Collaboration with MHCs and Program Director to co-design evaluation plan and interpret results through regular meetings and check-ins as well as opportunity to review draft reports.

# PROGRAM DEVELOPMENT PROGRESS

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The purpose of this Interim Evaluation report is to provide an update on program implementation including information on program development, results of a needs assessment for IECMH consultation services, services delivered, and early outcomes. Also included in the report are the results of a brief literature review on IECMH Consultation evaluation practices and outcomes.

## Initial Program Development Activities

### Staffing and Hiring

CCA of WA was able to fully launch the IECMH Consultation Program and begin providing direct services within a relatively short period of time, especially given that the program was initiated just at the onset of the Covid-19 pandemic. CCA of WA hired the IECMHC program director in March 2020. The Director's depth and breadth of experience in infant-early childhood mental health consultation enabled development of a clear vision and plan for both program design and operations that enabled the program to hit the ground running. Additionally, CCA of WA's strong existing relationship and well-established service delivery network with its regional partners

#### PROGRAM DEVELOPMENT HIGHLIGHTS

- ✓ Director and five regional MHCs hire, and services began immediately.
- ✓ Launched case management and reporting database.
- ✓ Developed implementation guidelines and procedures.
- ✓ Engaged in a year-long formative program evaluation.
- ✓ Developed a program Logic Model and Theory of Change for Provider and Coach consultation.

facilitated the timely onboarding of qualified Mental Health Consultants (MHCs) in nearly all regions. Within four months (by July 1, 2020) MHCs had been hired and consultative services had begun in five of the six CCA WA regions: King/Pierce, Olympic Peninsula, Eastern, Southwest, and Northwest.

Additionally, the qualifications and experience

of the mental health consultants themselves enabled direct service delivery to begin almost immediately after being hired. The pandemic and pivot to virtual operations necessitated a highly flexible response to hiring, onboarding and launching the program, as well as a responsive and proactive approach toward meeting the social emotional and mental health needs that have arisen among Coaches and providers.

### *Workforce Qualifications and Development*

The MHC areas of experience and expertise are consistent with the qualifications recommended for IECMH Consultation professionals by the Center of Excellence for IECMHC. All of the MHCs hired have advanced degrees and experience in providing mental health consultation or Coaching in early childhood programs or Title 1 schools. They also have a range of experience in highly



relevant areas including serving diverse populations, relationship-based therapy for young children and families, provision of ECMHC in Head Start settings, supervision of MHC teams, infant mental health specialization, mental health services embedded in First Nation communities, and trauma-informed approaches. The Central region has experienced difficulty recruiting a Mental Health Consultant because of challenges finding candidates who meet both the region's professional qualifications and cultural and linguistic requirements (Spanish fluency). These latter requirements are needed to ensure the position is both equitable and effective. Catholic Charities of Central WA continues to search for potential candidates to fill their position. Several rounds of recruiting and interviewing yielded either unqualified applicants or candidates who dropped out of the process due to COVID-related or personal circumstances. They have expanded their advertising for the position and have temporarily engaged a qualified consultant to temporarily contract to provide MHC services until a permanent consultant is hired for the region.

### *Reflective Supervision practice*

Consultants all have a designated supervisor within their regional hiring agencies, in most cases the Regional Coordinator, with whom they meet regularly. In addition to this administrative supervision, the IECMHC Director has provided regular individual and group reflective supervision and professional development to the team members since they were first hired. Reflective Supervision and supporting MHC core competencies in reflective practice are a foundational element of Mental Health Consulting. Reflective Supervision/Consultation (RSC) is distinct from administrative and/or clinical supervision in that it includes shared exploration of the parallel process: attention to all of the relationships, including the ones between practitioner and consultant, practitioner and parent/teacher, and parent/teacher and child. RSC for consultants provides them with a space to step back, process their work, develop reflective skills and identify potential strategies to support providers and coaches. Other the key objectives of RSC include:

- Forming a trusting relationship between consultant and practitioner.
- Asking questions that encourage details about the infant, parent, and emerging relationship.
- Remaining emotionally present.
- Teaching/guiding and Nurturing/supporting.
- Fostering the reflective process to be internalized by the practitioner.
- Exploring the parallel process and allowing time for personal reflection.

Since the first quarter of program operation, March through June 2020, the IECMHC Director has provided a total of 57.5 direct hours of individual and group reflective supervision and professional development with the team of MHCs. For Fiscal Year 2021, from July through December 2020, the Director provided an additional 46.5 hours of group reflective supervision and 95.1 hours of individual supervision and professional development.

### *Professional Development*

The MHC team continues to engage in self-study and group reflection on relevant readings and on-line trainings on the various competencies and guiding principles of IECMHC, and other relevant

topics including attachment, trauma, reflective practice, professional ethics, virtual service delivery, and others. Examples of other professional development the MHCs are engaging in:

- Self-study and group discussion of relevant readings and on-line trainings on the various competencies, components and guiding principles of IECMHC.
- Training opportunities for Mental Health Consultation practice through the Center of Excellence for IECMHC, the Early Childhood Knowledge and Learning Center (ECKLC) and others.
- Regional and state-wide offerings such as the Elevate Conference.

Two of the MHCs (King/Pierce and Northwest WA) applied for and were accepted into the ECHO training series offered through the Center of Excellence for IECMHC, which is notable given that there were over 100 applicants nationwide for a cohort of 15 participants. The ECHO series will run from January – June 2021. Further, our MHC serving Eastern WA has been accepted into the Advanced Clinical Training in Infant Mental Health through the Barnard Center at the UW, a program which will run for 15 months starting in March 2021.

## Development of Program Infrastructure

Ensuring a solid foundation for a new program includes developing strong infrastructure, including a clear program purpose, design, policies and procedures, and systems and resources needed to support and inform effective program management. These are reflected in the Georgetown Center of Excellence (CoE)'s Four Essential Building Blocks of a successful IECMHC program. Because this is a formative evaluation, the Evaluation Team is supporting some of these core program development efforts by facilitating reflective discussions with the MHC Director and Consultants and capturing key learnings from program rollout activities. The developmental evaluation approach we are using is especially applicable and effective given the dynamic conditions in which the IECMHC program launched, and the need to be responsive to the environment (responses to child/family, provider and coach mental health concerns arising during the ongoing pandemic and social unrest). developed. The evaluation efforts to inform and support program infrastructure development are discussed below.

### *Logic Model Development*

One of the first tasks of the Evaluation Team was to work with the program Director and MHC team to facilitate development of a program Logic Model and confirm the Theory of Change (ToC). This was a high priority because having a both a clear ToC and Logic Model are crucial aspects of sound program design, development, operations, and future planning. A ToC develops a high level understanding of program purpose: identifying the long term outcome the program is working to achieve, *what* needs to change, and *how* that change will occur. A Logic Model builds on this foundation, creating an understanding of the continuum of connections between everyday program activities, program goals and long term outcomes and identifying performance measures. Both are important for all programs, but especially for new programs such as this, because they provide a guide for making core program development design decisions that are aligned with a clear

purpose in mind. They also serve as a foundation for future growth and expansion as well as ongoing monitoring, and evaluation.

Over the course of three workshops in September and October the Evaluators worked with the MHC team to develop an initial Logic Model. The ToC for providing MHC services to child care Providers was already largely defined because this program design is modeled after the Arizona Smart Support program, which follows the evidence-based design developed by the Georgetown University Center of Excellence. For this component of the program the Evaluators facilitated group discussions and reflective activities to identify and build a shared understanding around the specific activities of MH Consultants and the short and longer term changes and outcomes they are working towards.

The Washington model is uniquely different from other IECMHC models across the country in that Early Achievers Coaches are an intentional component of program delivery. They are responsible for determining when Providers, families or children on their caseloads would benefit from mental health consultation and are currently the primary source of referrals to the MH Consultants. Additionally, it is envisioned that in some cases MHCs will engage in partnership with a Provider's Coach so that the Coach can help support MH consultation efforts. Because there are no program models around the country that are directly comparable, CCA of WA, the program Director, MHC team, and state and regional program partners are in the process of developing this model. To provide a foundation for this work, the Evaluation Team used the Logic-Modeling and Theory of Change workshops to begin defining and developing clarity around:

- How the Coaches' child care program expertise and Coach-Provider relationships can be integrated into the MH Consultation system.
- How the MHC program can support Coaching efforts.
- How these efforts will connect with achieving the short and longer term goals of the MHC program and overall child care quality improvement efforts.

#### *Development of case management and reporting systems.*

CCA of WA was able to develop and operationalize the case management database needed to support the program very rapidly, within three months of the Director coming on board (June 2020). This was due to the program Director's extensive prior experience with Arizona's Smart Support MHC program, deep understanding of the operational and case management data needed to support the program, and CCA WA's successful engagement of their data team and external consultants to develop and adapt the IMPACT system. The MHCs were trained in data entry, written guidance was developed to document all applicable consultation activity in IMPACT, and MHCs began using the system on July 1, 2020. The data system was developed based on the understanding the program would be providing on-site consultation and needed to be modified to capture the work being done during virtual consultation during the pandemic. The program Director is currently working with the CCA WA Data and Evaluation Director and MHCs to refine data entry protocols and strengthen program reporting and monitoring capabilities, particularly around referrals, outreach, action planning and tracking focus participants. The Evaluation Team is

providing assistance to help ensure the database can effectively capture data needed to support program monitoring measures (per the Logic Model), as well as information needed for this formative evaluation and future outcome evaluations.

### *Policies and procedures:*

During the fall of 2020, the MHC team developed comprehensive draft Implementation Guidance for IECMHC service delivery. In developing this Guidance, procedures and forms for service delivery, the Director and MHCs leaned on and learned from the Implementation Guidance developed by Smart Support, Arizona's evidence-based program, upon which the CCA of WA service delivery model is in part based.

The Guidance outlines step-by-step guidance for implementation of the various levels of IECMHC service – including Child/Family, Classroom/Teacher, Programmatic and Coach/Systems level consultation and support. It includes guiding principles for best practice as well as adaptations for service delivery during the Pandemic. It also includes links to national resources and draft forms for service delivery. This draft guidance reflects a point in time and will undergo ongoing revision to reflect input from DCYF, MHCs and other system leaders, translation of program forms/materials into multiple languages, and changes as the program adapts and grows. At this time the Evaluation Team is using the IECMHC Implementation Guidance and Database User Guide as a frame of reference for service delivery and program development. During the second half of this evaluation, the Evaluation Team will be using it to assess effectiveness of program policies and procedures.

## **NEEDS ASSESSMENT RESULTS**

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The Georgetown CoE for IECMHC created a template for a needs assessment to help drive development or strengthening of an IECMHC model. The Needs Assessment for this report was developed based on that framework with additional considerations for the Coach consultation and unique system work conducted through this program. This Needs Assessment includes the following sections, with attention to how the ongoing pandemic influences needs and system capacity:

- The Infant and Early Childhood Landscape
- Mental Health Needs of the Children Served
- Early Childhood Workforce (Providers and Coaches)
- Mental Health Consultant Workforce Perspective
- Early program referral data

## **Landscape Scan of Need and Supply of IECMHC**

According to DCYF's federal PDG grant needs assessment, prepared before the pandemic, there were 126,214 children ages 5 and younger served by licensed childcare in Washington State. In

addition, there are 22,828 slots for children ages 3-4 in ECEAP and Head Start. Based on established IECMH consultation programs and raw numbers of children, there was a significant gap in mental health supports for children and providers before the pandemic. This gap is even wider now as emotional well-being needs have increased at the same time that some providers have had to permanently close, and others to reduce capacity to slow the spread of COVID-19.

The number of MH consultants and programs serving early learning providers in Washington has been slowly growing over the last 10 years but is far short of the number needed to reach the thousands of child care providers and children. In 2011, the Department of Children, Youth, and Families (formerly the Department of Early Learning) launched an infant-toddler consultation project (later named the B3QI, Birth-Three Quality Initiative) that focused on delivering different types of consultation services, including limited mental health consultation to providers serving infants and toddlers through state subsidy. The program serves nearly 20,000 children, however, most infant-toddler consultants are not able to use the full IECMH consultation model as outlined by the Center of Excellence for IECMH Consultation, given other duties. Home visiting programs serve over 7,000 children and Therapeutic Childcare (ECLIPSE) serves an additional 747 children. Head Start and ECEAP have some MHC supports embedded, though MHC practices, scope and dosage vary considerably across programs throughout Washington. King County and Best Starts for Kids provided additional funding for some mental health consultation as part of the Child Care Health Consultation (CCHC) efforts, reaching nearly 1,000 providers (including non-licensed Family Friend and Neighbor sites) in 2019 in King County.<sup>3</sup> It is unknown how comprehensive these other MHC supports are and whether they are based on the full IECMH consultation model, which includes classroom focused, provider-focused, and child-focused mental health consultation as

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*I'm wondering if there are mental health consultants at no cost for child care providers, besides 1 person for 700 providers in our region who works with child/provider/family?*

Early Achievers Coach

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recommended by the Center of Excellence for IECMH. Despite embedded MHC supports in Head Start and ECEAP, and the growing efforts of the King County CCHC efforts, the vast majority of child care providers in WA do not have access to mental health consultation services.

IECMHC caseload standards typically suggest one consultant for 8-10 providers or classrooms at a time. With CCA of WA's current consultant staffing of six MHCs, the estimated ratio is 1 MHC to 890 providers, which is far short of the need and will make

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<sup>3</sup> Best Starts for Kids 2019 Annual Performance data: <https://www.kingcounty.gov/depts/community-human-services/initiatives/best-starts-for-kids/data/0-5.aspx> and Best Starts for Kids downloadable report, page 13. [https://www.kingcounty.gov/~media/depts/community-human-services/best-starts-kids/documents/BSK\\_2019\\_AnnualReport.ashx?la=en](https://www.kingcounty.gov/~media/depts/community-human-services/best-starts-kids/documents/BSK_2019_AnnualReport.ashx?la=en)

consultation inaccessible for many providers. Additionally, the pandemic has reduced the supply of licensed providers at the same time the need for mental health consultation increased and demand for new supports for school-age children exploded across the state. CCA of WA reports that there was a 200 percent increase in calls seeking childcare after K-12 schools closed in 2020. At the same time, up to 24 percent of all licensed providers reported closing at some point after March 2020. Washington State DCYF analysis indicates that closures have been uneven across the state and that capacity may have been lost among Head Start and ECEAP programs because of a shift away from on-site services during the pandemic, and lower onsite program capacity to meet public health requirements. For child care providers who have remained open, there have been significant pressures that may increase the need for mental health consultation, particularly as challenging behaviors and new age groupings may have become necessary to support families' child care needs.

The pandemic has prevented onsite mental health consultation and allowed only virtual consultation, increasing caseload capacity temporarily and allowing MHCs to focus more on adult regulation, crisis management and social emotional support and training.

## **Mental health needs of programs, staff, families/children**

As part of the 2019-20 Early Achievers Evaluation, the Athena Evaluation Team administered surveys of all licensed child care providers in the state as well as all Early Achievers staff (Leads, Professional Development Coordinators, and Coaches). The team also conducted a number of focus groups with Early Achievers staff and Providers. The surveys included a set of IECMHC-specific questions designed to assess the need for mental health consultation and other social-emotional supports among Providers and Coaches. These topics were also touched on during focus group discussions.

The evaluators obtained important feedback on the significant stressors the pandemic has placed on the child care system, as well as long standing concerns and challenges around the difficulties Providers and Coaches experience with being able to effectively respond when teachers, families, or children experience social or emotional challenges, trauma, racial and social injustices. The Evaluation Team joined several MHC team meetings to collaboratively develop survey questions and to jointly interpret and make meaning of the findings.

Analysis of the surveys, discussions and interviews with the MHC director and team, and data on referrals and cases show a high level of need for Mental Health Consultation and related supports for child care providers, staff, and families/children. Early Achievers Coaches also have a high level of need for mental health consultation information, skills, and tools that would improve their ability to understand when mental health consultation would be beneficial for a provider on their caseloads, and to effectively partner with their region's MHC.

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*Social and emotional needs from staff due to social injustice, and family dynamics happening within their own families with COVID. Children are experiencing these needs, and...need more intervention. Needs would be MHC, and interventions along those lines.*

Early Achievers Coach

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### ***Provider and Staff Need for Services and Operational Support***

Both child care Providers and Early Achievers Coaches expressed a high need for additional supports to better meet the social emotional needs of children, especially in the areas of managing and supporting **children with challenging behaviors**, supporting **adult wellbeing and emotional regulation**, identifying when there is a **risk of expulsion**, and conducting **behavioral and developmental screenings**. Other indicators of need are the high number of coaches reporting that few providers ask for help before expelling a child, and the large number of coaches and providers who do not feel very prepared to support and engage families in problem solving around challenging behaviors. Key highlights from the survey results include:

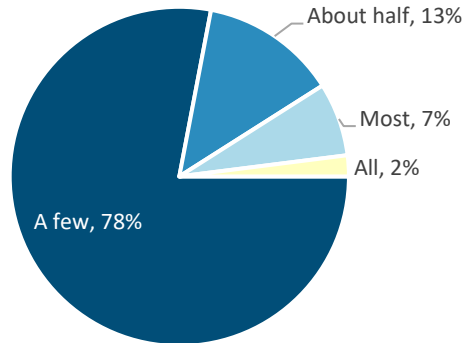
A sizeable proportion of providers say they struggle with challenging behavior or do not feel prepared to engage families around problem solving.

- Nearly one-quarter of Providers reported that they **struggle with difficult or challenging child behavior** with *half, most, or all* of their enrolled children. 36 percent report having only *some* or *no confidence* in handling children's behavioral challenges.
- Over 41 percent of Providers feel only *somewhat* or *not at all* prepared to engage families around problem solving/individualized planning related to behavioral challenges.

## Exhibit 1

### Nearly one-quarter of providers report struggling with difficult or challenging behaviors with at least half of enrolled children.

What proportion of children enrolled in your program present behaviors that you or your staff struggle with?



*Source: Early Achievers 2020 Provider Survey, all providers*

### Providers report a lack of access to services with varying regional needs.

- **60 percent** of Providers report needing mental health consultation, inclusion, or social emotional/behavioral supports. In the Olympic Peninsula region, 64 percent of providers report needing this type of support and the rate is 63 percent for the Central region.
- **57 percent** of Providers report needing special education or early intervention resources. In the Eastern region, 61 percent of providers report a need for these services and the rate in the Olympic Peninsula region is 60 percent.
- **56 percent** of Providers report that they need increased access to a Nurse Consultant or Childcare Health Consultant to support children's health, development, or behavior concerns. In the Central Region, 65 percent of providers reported that they did not have sufficient access to a nurse consultant, followed by 59 percent in the Eastern region and 56 percent in Northwest Washington.



## *Pandemic Impacts on Social Emotional Health and Well-Being of Children*

Some providers felt that things had calmed down since the early days of the pandemic, with gradual improvements in emotional well-being for children, families, and staff. In open-ended comments about the social-emotional well-being of children in their care, a few providers were positive, often emphasizing their hard work to keep changes and new processes such as hand washings and mask wearing as easy as possible for the children and families they serve. However, the majority of providers are struggling with their own emotional health, as well as that of their staff and the families/children they serve.

**Over 60%** of Providers report needing mental health consultation, inclusion, or social emotional/behavioral supports.

Comments about challenges with emotional well-being included reports of children and families feeling stressed, fearful, afraid, anxious, and worried. Social emotional challenges for school-aged children included missing friends and having trouble with online school. Families

with employment and housing challenges were experiencing higher rates of stress and providers saw the impact on the children in their care. Below are some quotes from the provider survey related to social-emotional health:

- *They are stressed and acting out more frequently. Children are hitting, biting and other inappropriate behavior more often. The older children are saying negative self-talk, such as "I'm stupid".*
- *Our school age children are really suffering as they would much rather be in school with their classmates than at a childcare facility. Our younger children have had some struggles that we don't usually see.*
- *Random big feelings, fear all the time, insecurity at home. 25% of our families have been unemployed sometime this year.*
- *Children who were previously receiving services are no longer getting any assistance and providers are having to manage on their own with no guidance (speech, autism, OT, etc.) Behaviors such as throwing, screaming, hitting, not sleeping.*

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*Children with Challenging Behaviors are not getting the one on one support or in-person they need. The providers are many times having to accommodate for provided services such as distant learning, on-line therapy sessions, etc. for the children in care which takes their time and attention from other children and duties. This can leave the provider with very little or no time for their own care and needs, as well as that of their families.*

Early Achievers Coach

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Some positive comments included reports of the resilience of children, families, and the communities in which child care providers operate. In addition, some positive reports included mentions that young children did not understand the pandemic or stressors. Providers mentioned providing opportunities for children to talk about feelings and concerns as one way to support emotional well-being.

- *The kids are resilient and are thriving in spite of everything!*

Coaches also shared examples of the social-emotional and behavioral needs of the providers and children on their caseloads, including:

- *Staff stress and anxiety, children experiencing changes in familial or child care environments/structure.*
- *Some behavioral challenges with kids, but mostly self-care for providers.*
- *Some students struggling from time to time, teachers not having skills to help during the situations.*
- *Children experiencing anxiety, fatigue, being disengaged, anger and sadness.*

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*Families are under duress at this time. This is manifest[ed] through challenging behaviors in the classroom. Teachers are also under a great deal of their own personal stress and are ill equipped to handle situations with children and families effectively.*

Early Achiever Coach

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## Child Care Workforce Development Needs

Providers also expressed a strong need and desire for professional development training and consultation to support themselves and families around challenging child behaviors, which have increased as a result of the pandemic.

According to CCA of WA's 2019 Child Care Data Report, only 34 percent of licensed Providers report having any training and/or experience in providing emotional and/or behavioral support to children with challenging behaviors. The December 2020 Early Achievers Provider Survey found that "Managing challenging behaviors" was the training topic most frequently desired by Providers (60 percent), followed by closely related "Supporting adult wellbeing and emotional regulation" (45 percent) and "Conducting behavioral or mental health screenings or assessments" (43 percent).

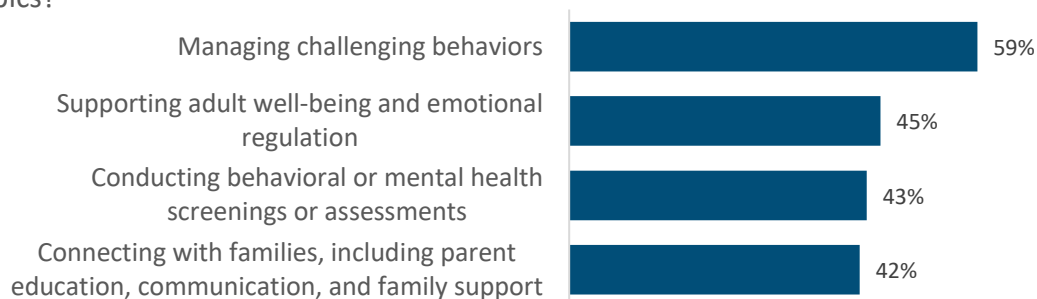
*We support providers use of ASQ, and plans for supporting children's behavioral needs, however providers don't have the basic resources to implement these plans. Providers cannot practice the self-regulation needed to implement successful behavior support with inadequate teacher/child ratios, inadequate health and mental health resources, making an unlivable wage, wearing all the hats.*

Early Achievers Coach

### Exhibit 2

#### Providers seek training on managing challenging behavior and mental health related topics.

Is your program interested in receiving training on any of the following topics?



Source: Early Achievers 2020 Provider Survey, all providers

Related to the need for more supports for mental health consultation and supporting providers and families around challenging behaviors, the 2020 Provider Survey found that relatively few Providers are using child development screening tools on a regular basis and a large proportion need additional support and training. Over 36 percent are not using them at all, and 20 percent

*"I have taken online trainings on how to help children with their emotions and to feel safe despite everything that is happening."*

*"He tomado entrenamientos en línea sobre como poder ayudar a los niños con sus emociones y a sentirse seguros a pesar de todo lo que está pasando por ahora están bien."*

-Spanish-speaking Early Achievers Provider

are using them only when there is a specific concern. This prevents a large proportion of Providers from being able to identify concerns and ask for early intervention assistance from their Coach or other professionals. The survey data showed that Family Child Care programs are less likely to use these tools compared to Child Care Centers, and that practices vary widely between regions.

## MHC-Related Coach Workforce Needs

The survey data indicates that there is a need for additional professional development for Coaches to effectively support the IECMHC program. Coaches would like to receive more information, training, and support to help Providers reduce expulsions, to work with providers and families around challenging behaviors, and they would like more information on how to engage their regional MHC. This presents an opportunity for structural and programmatic changes to create a system where Coaches have the knowledge and skills to coach providers on preventing expulsions, and providers reach out to coaches who can then pull in MHCs when needed.

**The majority of Coaches shared that they do not hear from their providers when there are behavioral challenges in the program or before providers take expulsion or suspension actions.**

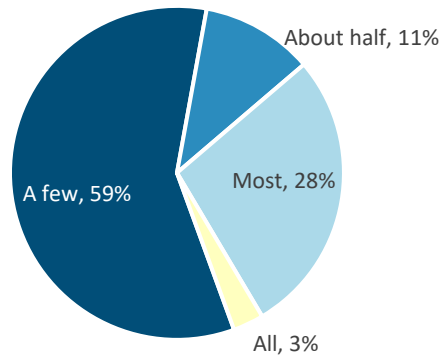
- Over 60 percent of Coaches reported that **only a few** of their Providers inform them when there are difficult behaviors or a risk of expelling a child at a program.
- A similar proportion, 59 percent, report that **only a few** of their Providers ask for assistance before taking action, such as suspending or expelling children.

**Over 60%** of Coaches reported that few providers inform them when there are difficult behaviors or risk of expelling a child.

### Exhibit 3

#### Few providers ask for coaching assistance before suspending or expelling children.

What proportion of providers you work with ask for coaching assistance with difficult problem behaviors before taking action such as suspending or expelling a child?



Source: Early Achievers 2020 Coach Survey

#### Coaches report low confidence in ability to support behavioral challenges.

- 55 percent of Coaches report low confidence (Somewhat or Not at all confident) in their ability to coach providers around challenging behaviors.
- Over 60 percent of Coaches feel unprepared (Somewhat or Not at all prepared) to help their providers engage families around problem solving/individualized planning related to behavioral challenges.
- 32 percent of Coaches do not use screening or assessment tools with their providers, and 16 percent are using them only when there is a specific concern.

*...I don't feel that I can provide much more than ideas around problem solving behaviors due to not having credentials to diagnose. I feel we need more training around how to support providers regarding this because there are providers who confide in us to help in this area, but we don't always feel equipped. We need more intervention services available in each region to help with the need.*

Early Achievers Coach

## Coaches need more information on several topics to better understand mental health consultation.

- 62 percent report that information or training on **how to identify if there is a risk of suspension or expulsion** with a provider would be helpful.
- 52 percent report that **training on reflective supervision/consultation** would be helpful.
- 48 percent report that information about the **racially disparate impacts of child care expulsions and suspensions** would be helpful.
- 45 percent of Coaches report that **general information about mental health consultation** would be helpful.

*"I was not prepared with the mental health component to help my providers."  
-Early Achievers Coach*

## Finally, Coaches reported high rates of interest in information about how to partner with MHCs to support providers on their caseloads.

- 71 percent of Coaches report information about how to help providers maintain their own emotional well-being would be helpful.
- 65 percent of Coaches report that information on how to support a provider dealing with challenging behaviors in classrooms or with individual children would be helpful.
- 55 percent of Coaches report interest in more information or training on developmental or other screening tools.
- 48 percent of Coaches report that information on how to help children develop social-emotional skills would be helpful.

*As a coach supervisor, I know that coaches are at all different levels of comfort in this area. Some are willing to support but may not have the most knowledge or information on what is best for each individual situation. This is a great area of concern, especially as children are overwhelmed with all that is going on and exhibiting challenging behaviors that may be out of the ordinary, especially with school-age children being in care longer and under many stressors.*

Region Lead

## MHC Workforce Perspective

The Evaluation Team held a number of group and individual conversations with the MHC Director and Consultants to discuss the needs they are experiencing among providers referred to them for consultation. The MHC team is observing many of the same needs and stressors revealed by Coaches and Providers in the surveys and confirms that the pandemic has further heightened the need for IECMH Consultation. Mental Health Consultants have shared that the referrals they are getting from Coaches most often present under the general category of “challenging behaviors,” however, upon engagement they find the issue is usually a symptom of other root causes such as: instability or stress of the adults in a child’s life (families and/or teachers), underlying trauma, and child development issues. Specifically, the MHC team has shared that Providers, teachers, families/children, and Coaches are experiencing compounded stressors around a complexity of issues, all of which are affecting their social emotional well-being. Some examples of these stressors include:

- Personal trauma, grief, and loss related to the pandemic and personal experience.
- Complex adult dynamics among providers and families, which impact care for children.
- Uncertainty and fear around the health and safety of children, staff and families.
- Complex social emotional needs of families related to trauma, family instability, foster care, substance abuse, economic insecurity, mental health, homelessness, etc.
- Supporting children with special needs who are in child care due to school closures.
- Community- and state-wide trauma and loss.
- Provider anxiety around financial sustainability and survival of their businesses.

### Referrals and requests for mental health consultation: What can they tell us about need?

Referrals to the MHC program can provide an indication of the early demand for services, as well as provide some information about the type of services and support needed by providers. Since the program began offering services, the MHC team has received a total of 112 referrals, with referrals increasing most months.

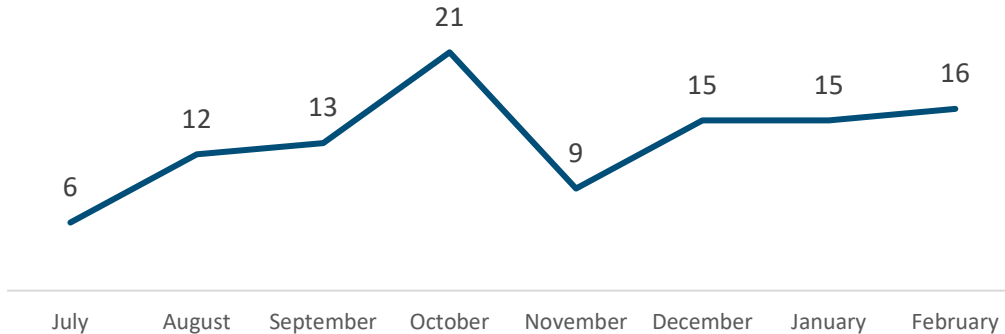
*“I’m seeing a LOT of adult support needed. Referrals come in for children, but we soon realize the concerns are about the adults. They have a yearning for support. Their confidence is shaken, are feeling isolated, concerned about COVID and keeping their doors open, on top of the child behaviors. So much regulation is needed and it’s coming through in their conversations with me. A lot of my work is getting teachers and directors regulated so that they can work with the children.”*

-Regional Mental Health Consultant

#### Exhibit 4

Monthly MHC referrals show an overall upward trend since July 2020.

2020-2021 MHC Referrals



Source: IECMHC Program Data, pulled 2/19/2021

For each referral to the IECMHC program, the team tracks the primary concern that led to the referral. However, there can be multiple initial concerns that lead to a referral and additional concerns can arise once a case is initiated. Understanding the concerns that lead to referrals can help illustrate the reasons Coaches and Providers currently seek consultative support. Cumulatively since July 2020, most referrals for MHC have been initiated with concerns for children or families (79 percent). About one-fifth, 21 percent, have included a concern about **expulsion risk**. Other categories of primary concern for referrals include **teacher concern** (currently 39 percent of referrals have this concern type) and **director or programmatic concern** (20 percent). This data aligns with the experience of MHCs who report that referrals are often initiated as a result of child behavior, and that additional needs for adult social emotional support and training emerge later.

Most referrals (78 percent) have come from Child Care Centers, rather than Family Child Care (FCC) programs. The fact that there are relatively few referrals from FCCs may be something for the Team to attend to in the coming months. As of February 19, 2021, there was one provider waitlisted for services, in the King/Pierce County region.



## SERVICE SUCCESSES AND EARLY OUTCOMES

In addition to the work being done to develop program structure and processes, and despite being in the middle of a pandemic, the MH Consultants began providing consultation services to Providers, families/children and Coaches almost immediately after being hired. This included providing support with pandemic- and non-pandemic related stressors, relationship building, racial equity discussions, and providing information and training about MHC within their organizations.

### MHC Consultation Pivoted from Planned In-person to Virtual

Mental health consultation is relationship-based and is designed to be conducted in-person with childcare Providers, teachers, and children-families. The MHC team adapted their mental health consultation expertise and methods to develop new responsive, flexible methods of supporting children, families, Providers and Early Achievers coaches in a virtual environment. Some of their consultation activities include:

- Consultation on grief and loss, anxiety, homelessness, financial insecurity, fear and trauma related to the pandemic and racial injustice, and support for families of first responders.
- Support to Providers and families with behavior concerns, inclusive classroom practices, children at risk for expulsion, and communicating with children about COVID19, racial injustice, and antibias.
- Supporting Providers who have the additional stressors of caring for school-agers and children with special learning needs who are being served in child care settings because of school closures.
- Developing resources and Tip Sheets for Early Achievers coaches and Providers to support stress management, self-care and resilience; promoting resiliency and trauma-informed approaches. Bringing a mental health lens to book studies and professional development trainings.

### MHC Regional Outreach and Engagement

CCA WA and the IECHMC Program Director have been developing outreach materials to inform regional staff about the availability of the MHC program, what mental health consultation is how it can strengthen the social emotional wellbeing of providers, families and children. Results of the December 2020 Coach surveys indicated a desire for more information on MHC and how to access these services for providers on their caseloads, so these new informational tools are clearly needed. Some of the program materials recently completed include:

#### Service Delivery Highlights

##### July 2020 – February 2021

**107** Referrals for IECMHC support (providers and individual children)

**61** Child care sites receiving MH Consultation

**700+** Coaches and community partners receiving MH consultation, support or training

**100+** MHC referrals for external community based services for children and families

**25+** outside referrals for childcare directors/teachers

Source: IECMHC program database.

- Brochure (in English, Spanish, and Somali) describing the state's IECMH Consultation program
- *When to Reach Out to your Regional MHC*, a document for Coaches providing guidance and examples of providers circumstances when it could be helpful to reach out to their MHC.

Consultants are adjusting to their new positions within their organizations, fostering relationships with Coaches, and developing provider referral processes. More specifically Consultants have been:

- Joining meetings of coaches and providers to provide orientation to IECMHC and identify providers who could benefit from further consultation.
- Creating internal agency procedures for prioritizing and referring providers for consultation.
- Collaborating with B3QI Coaches, Early Achievers Coaches, leadership and others to streamline referral processes and coordinate services.
- Facilitating book studies with Coaches and or groups of Providers on books such as *Beyond Behaviors: Using Brain Science and Compassion to Understand and Solve Children's Behavioral Challenges*, *Managing Emotional Mayhem* and *White Fragility*.
- Offering agency-wide training on the Impact of Implicit Bias and Racism in Expulsion and Suspension practices
- Joining in regional and Tribal Professional Learning Communities
- Participating in deep content review of Trauma Informed Care training curriculum under development at Cultivate Learning
- Participating in regional school-age child care support planning
- Offering regional agency-wide support for grief and loss
- Compiling and procuring resources to support regional IECMHC work
- Engaging in Early Achievers revisioning conversations

## Consultation to Providers

The MHC program team continues to develop and implement a comprehensive data system, capable of tracking traditional direct consultation as well as consultation for coaches, training, and virtual consultation during the pandemic. Data reports are provided at least monthly by the CCA of WA Data Team and are shared with the MHC program team and evaluators.

Child Care Centers are more commonly served by MHCs than Family Child Cares, with more referrals coming from Child Care Centers and more Centers served than FCCs as sites and through action plans. Ensuring adequate outreach to FCCs may be important for the team to consider in the coming months. MHC specific Action Plans are most commonly child-focused, though every site collaborates with the MHC to identify overall goals and action steps at the time of enrollment.

## Exhibit 5

### Cumulative MHC Program Activity, July 2020 through February 2021

	MHC Activity	Total
Outreach and Initial Consultation for Providers	Referrals for MHC	107
	MHC Consultation Total Sites Served	61
	<i>Child Care Centers Served</i>	<i>48</i>
	<i>Family Child Care Served</i>	<i>13</i>
	MHC Waitlist	1
Action Plans	Total Action Plans	45
	<i>Child-focused</i>	<i>28</i>
	<i>Teacher/classroom focused</i>	<i>12</i>
	<i>Program focused</i>	<i>5</i>
	<i>Child Care Centers</i>	<i>33</i>
Additional Provider Supports	External Referrals Made	106
	Trainings	11+
Coach Consultation	Coach Contacts (duplicated count)	2,584
	Coach Consultation Hours	408.83

Source: IECMHC Program Data, pulled 2/19/2021

### **Regional Systems Building Efforts**

MHCs in all regions have engaged in intentional relationship building efforts both within their agencies and among Early Achievers staff, but also in their communities as they identify partners and additional resources to support children, families and Providers. Other regional systems building work has included compiling and procuring resources to support regional IECMHC work, creating a regional “services map” to identify resources and gaps, and creating internal agency procedures for prioritizing and referring Providers for consultation.

The MHCs have also focused on **racial equity** work in several ways during this early period of program development. Consultants address implicit bias and racial equity in their individual reflective supervision as well as through individual learning and study. In addition, the Consultants have engaged in regional racial equity efforts as participants and leaders. Finally, the Consultants have incorporated racial equity practices and concepts in trainings for providers and coaches. Additional future focus will include disaggregating service data by race/ethnicity and developing eligibility and priority criteria using a racial equity lens.

### **Early Outcomes and Successes**

During the first months of the program the MHCs began providing consultation services to providers and families, in addition to providing supports and training to Early Achievers coaches and regional staff. Caseloads for each consultant have filled out and the MHC Team is working to

learn and develop benchmarks and guidelines for what constitutes a “full” caseload, especially given current virtual service delivery, and varying regional needs for systems-level supports. Since July 2020 the program has provided consultation to 61 child care sites, with 45 individual cases/action plans.

### *Provider Consultation Early Successes*

Initial results show important early breakthroughs with providers and children, and positive feedback from Coaches. MHCs have shared that the majority of case referrals coming to them fall under the general category of “challenging behavior,” but when they engage with the provider, they find there are actually more specific underlying causes.

Some specific examples of recent mental health consultation experiences and successes include:

- A referral was made for significant child behaviors, distress, and reenacting trauma during play time, for a child whose family was in crisis. The MHC met with the director, coach, teachers and parent, to reinforce strengths, provide trauma-informed strategies, as well as tips to support grief and loss. The consultant also provided specific language to use to support child when re-enacting trauma, and ideas to support regulation for teachers and child. As a result, the teachers and director are calmer and more confident in their ability to support the child and parent, and strategies in the classroom resulted in decreased aggressive behavior and increased regulation for child.
- A provider learned from the MHC that a child’s aggressive behavior was related to underlying sensory sensitivities. The MHC worked with provider and mother to understand the reasons for the behaviors and use tools and positive solutions which tremendously calmed the child’s aggressive and noncompliant behaviors. The teacher and mother are more regulated, empowered, and less reactive, and engaging in more positive interactions with the child.
- A referral came in for a child who was having “challenging classroom behavior.” The MHC and program Director determined that the teaching team needed support with their stress, frustration, and burnout, as well as strategies to meet the child’s needs in the classroom. Additional consultation revealed the child was behind in several developmental areas. The MHC

*“The [teachers] have started to take initiative and... ownership in understanding, meeting, and supporting this child’s behavior.”*

**-Regional Mental Health Consultant**

was able to support the teachers’ mental health, work with staff to understand the reasons for the child behavior, involve the family, and bring in external speech and behavioral specialists. The teachers' have more understanding and empathy about the behaviors, and they are also ready with the strategies in supporting these behaviors.

- Consultation for a particular child had evolved as his behavioral problems escalated. At the IEMHC’s recommendation and ongoing guidance the site director set up a multi-disciplinary team meeting with stakeholders in the child’s caregiving system (family, mother’s rehab counselor, site Director and program manager, child’s social worker, and CPS caseworker). During the meeting, attendees reached a consensus

regarding the child's behavioral challenges, needs and family dynamics, and the IECMHC recommended therapeutic actions to be taken on behalf of the child, family and other attendees. One of the key outcomes of this specific case, beyond supporting the family, was that the site director and program manager learned from their role as active participants in the process and developed skills to help them manage a multi-disciplinary team to support improved outcomes for at-risk children at the site.

- The IECMHC received a referral for a program-level consultation to support a new Director with reducing stress and improving morale among her staff. The MHC learned from the Early Achievers Coach that the provider team had been experiencing an ongoing struggle to work well together, and that the site had a long history of high staff turnover, high levels of staff anxiety and reactivity, low communication between director and staff, and low job satisfaction amongst the staff. The MHC conducted weekly consultations with the Director to develop ways to support staff and leadership with strategies to co-create a positive culture and climate, and to hold a positive strengths-based all-staff meeting. The MHC also communicated with the staff to help them with stress management and increase their ability to feel more helpful and successful in their work with each other, children and families. Weekly consultation continues in order to help manage Director/Staff stress and explore effective communication strategies to support morale and improve the Director's relationships with the staff, families, and children that the site serves.

### *Successful MHC Consultation and Case Collaboration with Coaches*

MHCs in all regions are engaging in intentional relationship building efforts within their agencies and among Early Achievers staff to develop referral processes and identify providers who could benefit from further consultation. Through the Early Achievers Coach survey and a few individual conversations, the Evaluation Team has been able to gather information and feedback from Coaches who have engaged with their regional MHC. We have also held multiple discussions and interviews with MHCs, who have shared how valuable it has been to have Coaches as resources and thought partners when working with Providers. During the Early Achievers evaluation focus groups, several Coaches mentioned how beneficial it has been to have their new regional MHC onboard, including comments such as "They came at precisely the right time!" and "We have needed someone to help us and providers with challenging behaviors for a long time."

*We have been hearing of these [behavioral and social-emotional] needs since the beginning of Early Achievers. I am so thankful for the investment in mental health coordinators for our regions! PLEASE add Conscious Discipline!*

Early Achievers Coach

Below is a small selection of the comments from the Coach survey about their regional MHCs:

- *It has been wonderful to have our IECMHC and the B3QI and Infant mental health Consultant as resources in our Region. I support providers as challenging behavior comes up in our discussions - sometimes that means I will reach out to a colleague for support.*

- *Our mental health consultant is gifted at listening and reflecting in ways that allow me, and others to more fully participate in the problem solving process. I appreciate the ease of the referrals in Impact and I really enjoy time spent doing work with our mental health consultant. I feel better at my job and being a better human after our time together.*
- *When providers share their concerns, I used to spend a great deal of time in a classroom with the teachers observing behaviors and talking through a plan with them. ...our ESD has not had a mental health consultant for a few years, so that was not available to us. Now that each region has a MHC, I would possibly bring the MHC into the discussion. Observations have been impossible during COVID and virtual coaching.*

## MHC Book Study for Coaches and Providers

*Our team did a book study [with our Mental Health Consultant and other Early Achievers leaders] on Conscious Discipline – the Managing Emotional Mayhem book. We shared a series on it for providers, too. In my opinion, all parents should have that book! As Coaches, just dealing with our emotions and the trauma of this situation, we've heavily relied on it. It's been helpful for our coaching. [We have] used it to help providers through emotional overwhelming times.*

Early Achievers Coach

Quotes related to specific areas MHCs have helped with include:

- *Absolutely helpful. There is actually someone knowledgeable about the issues AND how to appropriately address those issues with providers and FAMILIES. I am so, so grateful for this, and our MHC is fantastic!*
- *Our MHC's support in book study is valuable and her presence in our PLC has been requested and invitation accepted. We look forward to positive outcomes.*
- *LOTS of great research and information to inform on mental health topics.*
- *I have basic knowledge of the social-emotional and mental health of young children and teachers, but not extensive. Our MHC's wheelhouse of information on trauma and developing brain really brings a focus on the science and nature of the behaviors. He is a specialist...and has resources he can give to us and teachers right away.*
- *[Our MHC has helped with] Planning meetings to create a support pathway for Coaches to collaborate with the mental health Consultant to provide a scaffolding level of support for teachers and children through a relationship-based approach.*
- *That they take each referral seriously and act with a sense of urgency. Also, I receive regular reports on sites progress and challenges so I can support providers by following up and providing resources.*

- *It is very hard to support in this area when you can't be there in person to see what is really going on. Most providers are not trained to use ASQ and do not understand how to use it. I have had success referring them for mental health consultation.*
- *Willingness of providers to engage in mental health referrals for consultation...It's so good, I wish everyone could just know how helpful the meetings could be for them.*

## Challenges and Opportunities

### *Referral System*

CCA WA, the IECMHC Director, and MHC Consultants have been working to spread the word about the new MHC program and to successfully integrate the new program within their regional organizations. However, referrals from Coaches have been slower to come in than initially expected, especially in some regions. Consultant caseloads have been growing slowly and have gradually reached capacity.

There are several factors that might explain why referrals have been lower than expected given the level of need that exists. Evaluator discussions with the MHC Program Director and Consultants, and the Early Achievers surveys and focus groups with regional staff and Providers, all reveal that Providers are extremely stressed and have very limited time or capacity to engage in activities other than keeping their businesses open and operating. The evaluation team has also heard from the MHCs that many Coaches do not understand what mental health consultation is or can offer, and the Coach surveys revealed a high level of interest in, and need for, additional information on MHC. As discussed earlier, there is a real opportunity to develop a system where the Coaches receive training and professional development so that they can proactively coach and engage with their Providers to support challenging behaviors and bring in their regional MHCs when warranted.

*Coaches should be empowered to ask how providers are doing, how close they are to expelling a child, how serious the problems are? Getting Coaches set up to talk to providers about engaging families, how to help providers talk to families. I really want to increase coach capacity for engagement with Providers. If I could have a team of Coaches who are aligned and ready to lean in we could do a lot more.*

Regional Mental Health Consultant

### *Virtual Consultation and Coaching*

Additionally, because of the pandemic Coaches have not been onsite with their providers since March 2020, and MHCs have never met them in person. They have therefore not been able to speak directly with directors and teachers or observe classrooms and child behaviors, which is necessary in order to fully understand the environment and culture of a program, and identify

*During the pandemic, it has become more difficult to coach providers in responding to challenging behavior when I do not see the learning environment and teacher-child interactions.*

Early Achievers Coach

social-emotional, behavioral or development concerns. MHC team members shared that the implications for not being able to visit providers and observe teachers, classrooms and children in-person is very concerning. MHCs (and Coaches) are having to overly rely on adult reports of the problems rather than being able to observe behaviors and teacher-child interactions first-hand, which increases

the likelihood that they are not addressing the underlying concerns.

### *Infrastructure Resources*

One of the challenges currently facing the MHC program is limited support for core elements of its infrastructure. Providing enough resources for program infrastructure, including staffing for reflective supervision and administration, are crucial to the foundation of a strong IECMHC program.<sup>4</sup>

The program Director position is currently funded only through private external funds without state support. Additionally, there is currently no funding support for the internal structures and systems needed to support the program. For example, CCA of WA has devoted extensive in-kind time and resources to developing and administering the MHC database needed to support case management and ongoing reporting. Additionally, CCA WA is doing its best to provide the administrative support needed by the Director, however, this is creating some stress and resource strain because CCA WA does not have the necessary administrative resources.

As the number of MHCs in the program grows from six to nine (and potentially more) in the coming months, the MHC Director will need an administrative assistant, additional resources and funding to fully support the requisite professional supervision responsibilities of the program, its administrative needs, and the full cost of operations. The regional community-based partners will also need funding to cover not only the personnel cost of the new MHC positions but also the overhead and supervision costs that come with these positions.

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<sup>4</sup> <https://www.iecmhc.org/documents/iecmhc-buildingblocksguide.pdf>



## Potential for impact with continuing implementation and expansion

### *Literature Review Results*

As part of this interim report the Evaluation Team conducted a literature review on what research shows about the effectiveness of IECMHC. The emerging evidence for the effectiveness in promoting positive social and emotional outcomes for young children and in reducing the risk of negative outcomes has been the impetus for many states (including Washington) to invest in IECMHC programs and systems. The body of evidence to date suggests that IECMHC has a positive impact on a number of program, staff, and child outcomes. There are several comprehensive literature reviews that provide great detail about the many outcomes states and communities have explored with IECMHC (e.g., Brennen et al., 2008; Center of Excellence for IECMHC, 2020; Hepburn et al., 2013; Perry et al., 2010). These and others are cited with the full literature review in Appendix D of this report.

To date, the strongest domains of outcomes in IECMHC are 1) **children's social and emotional well-being** and 2) **teachers' social-emotional support for young children** (Center of Excellence for IECMHC, 2020). However, there are other emerging research and evaluation themes that are drawing attention as well. Examples include: **programmatic and classroom outcomes** (Brennan et al., 2008; Connors-Burrow et al., 2013; Heller et al., 2012) ; the **impact of IECMHC on home visiting services** and other professionals working with teachers of young children (e.g., quality coaches) (Lambarth & Green, 2019; Ruch, Luna, & Antonio, 2016); exploring the mechanisms (or processes) of IECMHC that contribute to positive outcomes (Allen & Green, 2012; Davis, 2018; Davis, Perry & Rabinovitz, 2019; Davis, Shivers, & Perry, 2018; Green et al., 2006; Kniegge-Tucker et al., 2020) and finally, the **impact of IECMHC on closing racialized gaps and promoting greater cultural responsiveness** with Black, Indigenous and children of color (Albritton, Mathews, & Anhalt, 2019; Davis, Shivers, & Perry, 2018; Shivers, Farago & Gal-Szabo, in press; Silverman & Hutchinson, 2019).

*“Within 2 months, there are hardly any concerning behaviors...and the conversations with the family are more about supporting and sustaining their own stress level in order to be present for the child. Due to the child's progress, the stress and concern around the child needing additional outside services has decreased at this time.”*

- Mental Health Consultant

## *Key Takeaways from the Literature Review*

These examples of emerging areas of research exploration are aligned with Washington's IECMHC delivery model and theory of change; and therefore continuing to implement IECMHC in Washington along with a robust evaluation agenda will not only serve to deliver a program to Washington's early care and education community that will have a strong impact on young children, but also advance the general knowledge throughout the country. Specifically centering a racial equity orientation to the evaluation and model delivery in Washington's model can help ensure that we are making every attempt to disrupt bias and perhaps even prevent young Black, Indigenous, and other children of color from being caught in the 'preschool to prison' pipeline (Meek & Gilliam, 2016).

The examples of successes shared in this report are early indicators that the program is already working as intended to strengthen **children's social and emotional wellbeing, build the capacity and self-efficacy of child care professionals** to support the social emotional needs of young children, and reduce expulsions.

Additionally, there are some parallels between Washington's MHC model, which is integrated with the Early Achievers Coaches, and other states' MHC delivery models in which MHCs work with home visitors or other professionals who work with teachers of young children. The emerging evidence base on these latter program models suggests promise that Washington's integration of MHCs and Coaches may also have positive effects on social-emotional wellbeing of teachers and children. Our conversations with Mental Health Consultants, and anecdotal evidence from Coaches, show that collaborative efforts and positive results are already occurring between the MHCs and their Coaches. This evaluation's Needs Assessment shows that a clear opportunity exists to more proactively assess and screen provider and family/child needs for MHC services, provide behavioral and early intervention supports to teachers, families and children, and identify expulsion risks sooner rather than later. Discussions with the MHC Consultants indicate that they are already partnering effectively with some Coaches, and that further development of Coach capacity and collaboration with the MHCs would further enhance MHC service delivery and outcomes.

It is imperative that evaluation partners continue to work together to expand and deepen the collective research agenda for IECMHC. Together, we can more effectively define and align IECMHC core components, such as organizational infrastructural support, workforce development, and service design in the service of closing racialized gaps and promoting school readiness and healthy development for young children.

### **Implicit Bias and Preventing Expulsions**

*I think there needs to be more guidelines that highlight this as a critical part of best practice and quality care so that the work on implicit bias that coaches are doing is backed by the state and programs see this as something that **MUST** be happening to support the learning and healthy development of the communities they serve.*

Early Achievers Coach

## UPCOMING STEPS FOR THE EVALUATION

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The Evaluation Team will be building on the results and early learnings of the first phase of the evaluation and collaborating with the MHC team and the Evaluation Advisory Group to shape the evaluation work for the next six months. Evaluation activities are likely to include program development support and assessment in the following key areas identified in the Needs Assessment and this interim report:

- **Internal program structures and systems** to support MHC program management, supervision, case management, reporting, and the data system process and infrastructure needed to ensure collection of essential case activities and participant characteristics (such as race/ethnicity of focus participants).
- **Framework and systems for Referrals and MHC-Coach collaboration** such as building Coach understanding of IECMHC and effective referral processes, and engagement between MHCs and Coaches.
- **Efforts to ensure program is reaching the target population**, such as building Coach and Provider capacity to identify need for MHC, using an equity lens to help providers support challenging behaviors and reduce expulsion risks, and connecting children to external specialist supports.
- **MHC Team consideration of how best to return to on-site service delivery**, and which aspects of virtual consultation have been successful and could be effectively incorporated into service delivery in the future.
- **Development and initial testing of measurement tools** to assess the experiences of those interacting with the MHC program (providers/teachers, coaches, and regional leadership), to track early successes and longer term results, and lay the groundwork for a future outcome evaluation.

The goal of the evaluation is to help point the way towards building a sound program foundation, systems that are scalable as the program grows, and practices to support achievement of program goals and long term outcomes for the social-emotional health of children, families, and the child care providers who serve them.

## APPENDIX A: EVALUATION SCOPE AND OBJECTIVES

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The evaluation objectives are to answer the following questions:

- What is working well and what is not working as well for those impacted by the IECMH consultation pilot (e.g., families, child care providers, and Early Achievers Coaches)?
- What is working well and what is not working as well for those implementing the IECMH consultation pilot (e.g., the IECMH consultants, the CCA of WA system, and DCYF)?
- What is the impact of the IECMH consultation pilot to date? What is the potential for impact should implementation continue?
- What are we learning about what we need to continue, stop, change, or grow in order to have a strong IECMH consultation system in Washington state, which meets the needs of families, providers, and communities? (Learnings might be in the realms of policy, financing, program design, consultant activities, qualifications, or training, etc.)
- Given what we are learning in this pilot, how might IECMH consultation in Washington state continue to grow?

The evaluation design is framed around the Georgetown University Center for Child and Human Development's *Four Essential Building Blocks* of a successful IECMHC program.<sup>5</sup> Sound development of these four foundational program components will help ensure the program's purpose, target population, and services are well defined, and that the structures, systems, personnel and funding necessary to support effective program operations are identified.

1. Eligibility: Who receives services?
2. Service Delivery: Focus on development foundational tools and processes for outcomes tracking.
3. Workforce Development
4. Infrastructure: Program design, systems, and supports: logic model, policies and procedures (implementation guide) and Program structures – Staffing, supervision, database, professional development

The evaluation is applying a mixed-methods approach to evaluate development of the new IECMHC program, using developmental evaluation participatory techniques to inform and support formative development of the program. Methods include ongoing facilitated discussions with the MHC program team, surveys, focus groups, and interviews with key informants and stakeholders.

## APPENDIX B: IECMH CONSULTATION LOGIC MODEL

*Note: GREEN items and some others are limited or not possible due to COVID-19.*

All activities are grounded in the Guiding Principles for IECMHC and the Consultative Stance:  
*Relationship building, reflection, holding hope, cultural responsiveness, and equity.*

Consultation Activities	Theory of Change	Short Term Outcomes	Long Term Outcomes
<b>Child/Family-focused:</b> Support providers with specific child/family needs.	MH Consultants provide support for teachers and directors in responding to child/family-specific needs, to build capacity of teachers, providers, and families.	<ul style="list-style-type: none"> <li>Children with identified concerns receive increased referrals.</li> <li>Children improve social skills and emotional competency.</li> <li>Families experience improved communication with staff and improved ability to support child.</li> </ul>	<ul style="list-style-type: none"> <li>Decrease in parenting stress for families and children have increased access to and availability of community resources.</li> </ul>
<b>Teacher/Classroom:</b> Support providers with stress management, regulation, training on social emotional development. Help teachers explore, understand, and shift biases about children.	MH Consultants address adult self-regulation and provide reflective support and professional development to improve practice. Teachers shift their understanding of the meaning of child behavior and treat children more equitably.	<ul style="list-style-type: none"> <li>Teachers feel less stress and understand impact of their state on children.</li> <li>Teachers know more about social emotional development and improve relationships with children and families</li> <li>Classroom environment is more positive.</li> </ul>	<ul style="list-style-type: none"> <li>Teachers have reduced burnout and improved job satisfaction.</li> </ul>
<b>Program/Provider:</b> Support providers with stress management, guide program planning, staff training and improvement efforts.	MH Consultants support organizations to plan for and integrate principles of social emotional development and equity into program practices.	<ul style="list-style-type: none"> <li>Improved provider-staff communication and teamwork.</li> <li>Providers more confidently apply social-emotional practices.</li> <li>Increased awareness and attention to preventing suspensions, expulsions, and exclusionary practices.</li> </ul>	<ul style="list-style-type: none"> <li>Decreased staff turnover, child suspension and expulsion, improved program quality.</li> <li>Increased program attendance, reduced parent stress and loss of work.</li> </ul>

<p><b>Early Achievers Coaches:</b> Provide reflective practice, group meetings, and training on social-emotional and trauma-informed practices.</p>	<p>MH Consultants support Coaches with secondary trauma and provide expertise and resources to integrate social-emotional informed practices into quality improvement coaching.</p>	<ul style="list-style-type: none"> <li>• Relationships and trust built between MHCs and Coaches. Immediate needs for reflection and support are met.</li> <li>• Coaches learn when to engage MHCs for help with providers.</li> <li>• Coaches better equipped to help regulate and support provider needs.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced coach stress, increased knowledge of resources. Coaching on quality childcare integrates social-emotionally-informed practices.</li> <li>• Consultants &amp; Coaches work as partners to support MH needs of providers, children &amp; families.</li> </ul>
<p><b>Systems Level Work:</b> Support regional organizations, develop resource libraries, training, and other tools.</p>	<p>MH Consultants address pandemic, racial equity, and operation needs with a social emotional lens, increasing capacity of the EA system and partners.</p>	<ul style="list-style-type: none"> <li>• Coaches and regional partners effectively respond to key needs in the field.</li> <li>• Relationships, trust, and shared knowledge built.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased coordination and capacity to provide equitable social emotional services and resources.</li> </ul>

## APPENDIX C: ADDITIONAL SURVEY DATA/CHARTS

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### Early Achievers 2020 Provider Survey Data

What proportion of your children present behaviors that you or your staff struggle with?

**By Region**

	King/Pierce County		Central Washington		Northwest Washington		Eastern Washington		Olympic Peninsula		Southwest Washington	
All	1%	3	7%	11	0%	0	5%	6	2%	1	0%	0
Most	5%	18	10%	15	7%	10	11%	13	2%	1	7%	5
About half	12%	46	13%	20	13%	18	9%	11	15%	9	16%	11
A few	82%	303	70%	108	80%	110	75%	91	82%	49	76%	51
Total		370		154		138		121		60		67

**By Provider Type**

	Family Child Care		Child Care Center		School Age Only Program	
All	4%	21	0%	0	0%	0
Most	7%	42	6%	19	8%	2
About half	11%	62	15%	50	29%	7
A few	78%	443	80%	269	63%	15
Total		568		338		24

**Do you and your staff feel confident in your ability to handle children's behavioral challenges?**

**By Region**

	King/Pierce County		Central Washington		Northwest Washington		Eastern Washington		Olympic Peninsula		Southwest Washington	
Very confident	64%	255	70%	119	64%	98	63%	82	59%	36	62%	44
Somewhat confident	33%	131	28%	48	34%	53	37%	49	39%	24	35%	25
Not confident at all	3%	12	2%	4	2%	3	0%	0	2%	1	3%	2
Total		398		171		154		131		61		71

**By Provider Type**

	Family Child Care			School Age Child Care Center Only Program		
Very confident	71%	455	51%	176	54%	13
Somewhat confident	27%	174	45%	156	46%	11
Not confident at all	2%	10	3%	12	0%	0
Total		639		344		24

**Do you feel prepared to engage families around problem solving (and planning) related to behavioral challenges of their children?**

**By Region**

	King/Pierce County		Central Washington		Northwest Washington		Eastern Washington		Olympic Peninsula		Southwest Washington	
Not prepared at all	2%	8	2%	4	3%	5	0%	0	0%	0	1%	1
Somewhat prepared	38%	152	40%	69	39%	60	45%	59	42%	26	36%	25
Very prepared	60%	240	58%	99	58%	90	55%	71	58%	36	63%	44
Total		400		172		155		130		62		70

**By Provider Type**



	Family Child Care			School Age Only Program		
Very prepared	63%	405	51%	175	50%	12
Somewhat prepared	36%	231	46%	157	50%	12
Not prepared at all	1%	6	3%	12	0%	0
Total		642		344		24

**Do you use developmental screening tools in your program, such as the Ages and Stages Questionnaire (ASQ) or Ages and Stages Questionnaire-Social Emotional (ASQ-SE)?**

	By Region											
	King/Pierce County		Central Washington		Northwest Washington		Eastern Washington		Olympic Peninsula		Southwest Washington	
Yes, we screen all of our children	43%	165	39%	66	43%	64	48%	60	40%	24	57%	39
No, we need more training or information	23%	87	20%	33	24%	36	17%	21	37%	22	18%	12
Yes, we screen when we have a concern	18%	69	24%	41	21%	31	23%	29	13%	8	19%	13
We've been trained, but haven't used these tools yet	16%	60	17%	29	13%	19	12%	15	10%	6	6%	4
Total		381		169		150		125		60		68

	By Provider Type					
	Family Child Care		School Age Only Program			
Yes, we screen all of our children	37%	229	58%	194	13%	3

Yes, we screen when we have a concern	21%	128	17%	58	26%	6
We've been trained, but haven't used these tools yet	17%	104	9%	30	17%	4
No, we need more training or information	26%	159	15%	50	43%	10
Total		620		332		23

**Do you currently have sufficient access to a nurse consultant, child care health consultant, or mental health consultant to support children's health, development, or behavior concerns?**

**By Region**

	King/Pierce County		Central Washington		Northwest Washington		Eastern Washington		Olympic Peninsula		Southwest Washington	
No	55%	214	65%	112	56%	85	59%	76	47%	28	41%	28
Yes	45%	178	35%	61	44%	66	41%	53	53%	32	59%	41
Total		392		173		151		129		60		69

**By Provider Type**

**Family Child Care      School Age  
Child Care Center      Only Program**

Yes	34%	212	63%	214	52%	12
No	66%	419	37%	128	48%	11
Total		631		342		23

**Does your program have a need for any of the following services? Please check all that apply.**

**By Region**

	<b>King/Pierce County</b>		<b>Central Washington</b>		<b>Northwest Washington</b>		<b>Eastern Washington</b>		<b>Olympic Peninsula</b>		<b>Southwest Washington</b>	
Dual language learner supports	39%	64	44%	48	21%	14	32%	18	4%	1	22%	7
Special education or early intervention resources	56%	93	56%	61	59%	39	61%	34	60%	15	50%	16
Resources for tribal or migrant early learning programs	14%	24	45%	49	18%	12	20%	11	12%	3	28%	9
Mental health consultation, inclusion, or social emotional/behavioral supports	58%	97	63%	68	56%	37	59%	33	64%	16	56%	18
Total		166		108		66		56		25		32

**By Provider Type**

	<b>Family Child Care</b>		<b>Child Care Center</b>		<b>School Age Only Program</b>	
Dual language learner supports	22%	118	11%	34	6%	1
Special education or early intervention resources	26%	140	38%	115	41%	7
Resources for tribal or migrant early learning programs	18%	94	5%	15	0%	0
Mental health consultation, inclusion, or social emotional/behavioral supports	27%	142	42%	127	47%	8
Total		534		301		17

# APPENDIX D: LITERATURE REVIEW

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## Background

More than two decades of research has established a compelling link between children's social and emotional development and their readiness to succeed in school (e.g., Mashburn et al., 2008). Unfortunately, when young children experience mental health problems and/or challenging behaviors, they are likely to miss out on important learning opportunities. Many children are expelled from early care and education settings as a result of their perceived behavior problems (Gilliam, 2005; Perry et al., 2008). The first national data on rates of expulsion from preschool underscored the widespread nature of this trend: on average, young children were being expelled from state funded preschool programs at three times the rate of their peers in K-12 settings (Gilliam, 2005). These expulsions disproportionately impacted Latinx and African American boys who were being expelled at higher rates than their white and Asian peers (Gilliam, 2005). Racial disparities in preschool discipline continue today; for instance, Black boys are over three times more likely to be suspended than white preschoolers (U.S. Department of Education Office for Civil Rights, 2016).

## What is Infant and Early Childhood Mental Health Consultation (IECMHC)?

Infant and Early Childhood Mental Health Consultation (IECMHC) has gained prominence as an effective, efficient, and evidence-based strategy for promoting children's social and emotional competence and mental health, addressing challenging child behavior and enhancing the quality of care in early childhood settings (e.g., Brennan et al., 2008; Hepburn et al., 2013).

IECMHC is an intervention that teams mental health professionals with early childhood education (ECE) professionals to improve the social, emotional and behavioral health of children in child care and early education programs. Through the development of partnerships among ECE directors, teachers, and parents, IECMHC builds their collective and individual capacity to understand the powerful influence of their relationships and interactions on young children's development. Children's well-being is improved, and mental health problems are prevented as a result of the consultants' work with teachers, directors, and parents through skilled observations, individualized strategies, and early identification of children with challenging behaviors which place children at risk for expulsion and suspensions (Center of Excellence for IECMHC, 2020). IECMHC involves the collaborative relationship between a professional consultant who has mental health expertise and an early education professional. By its very definition, IECMHC is a non-therapeutic service provided to the child care teacher/provider – not a therapeutic service delivered directly to the child or family (Brennan et al., 2008). Consultation can focus on the emotional and behavioral struggles of an individual child (child-focused consultation), the conditions and functioning of a classroom as they affect all of the children in that environment (classroom-focused consultation), and/or work on a program's leadership to improve the overall quality of the early childhood program (program-focused consultation) (Center of Excellence for IECMHC, 2020).

## Outcomes

The body of evidence to date suggests that IECMHC has a positive impact on a number of program, staff, and child outcomes (e.g., Brennen et al., 2008; Center of Excellence for IECMHC, 2020; Hepburn et al., 2013). To date, the strongest domains of outcomes in IEMCHC are 1) children’s social and emotional well-being and 2) teachers’ social-emotional support for young children (Center of Excellence for IECMHC, 2020). First, many evaluations of statewide IECMHC programs have found increases in children’s emotional competency (e.g., self-regulation; social skills; adaptive behaviors; and other protective factors) and a reduction in children’s challenging behaviors (e.g., hyperactivity, defiance, aggression) (Brennan et al., 2008; Conners-Burrow et al., 2012; Crusto et al., 2013; Hepburn et al., 2013; Gilliam et al., 2016; Perry et al., 2008; Shivers 2015; Van Egeren et al., 2011; Williford et al., 2008). A handful of studies also demonstrate that after exposure to IECMHC, children are less likely to be expelled (Brennan et al., 2008; Davis & Perry, 2016; Gilliam et al., 2016; Perry et al., 2011; Van Egeren, 2011). The second major domain of IECMHC findings with teachers includes increased outcomes such as self-efficacy in managing challenging behavior; increased sensitivity and responsiveness to children; and increased knowledge about children’s social and emotional development (Beardslee et al., 2010; Crusto et al., 2013; Davis & Perry, 2015; Shamblyn et al., 2016; Shivers et al., 2019). Additionally, a teacher’s observed classroom emotional climate has been shown to increase after receiving IECMHC (Beardslee et al., 2010; Hepburn et al., 2013; Shivers, 2015; Raver et al., 2008).

The federal government and national policy leaders have issued several policy briefs highlighting IECMHC as an effective strategy for reducing child expulsion in general, and expulsion for boys of color specifically (e.g., Children’s Equity Project, 2020; U.S. Department of Education, 2014). The emerging evidence for the effectiveness of IECMHC in promoting positive social and emotional outcomes for young children and in reducing the risk of negative outcomes has been the impetus for many states to invest in IECMHC programs and systems.

## Gaps in the Literature Base / Emerging Evidence

The evidence base for IECMHC continues to develop. As states and communities continue to refine their understanding of the mechanisms that promote greater impact, new areas of focus for evaluators and researchers are beginning to emerge. We highlight several areas below.

### Race and Infant and Early Childhood Mental Health Consultation

Recently, there has been increased attention to the role that implicit racial bias plays in educational and discipline disparities (e.g., Kirwan, 2014, 2017; Kunesh & Noltemeyer, 2019) and in the evaluation of children of color including children in ECE settings (Children’s Equity Project, 2020). A recent study by Gilliam and colleagues (2016) demonstrated that implicit racial bias may play a role in early childhood discipline disparities because teachers more closely scrutinize the behaviors of Black children. The implicit association between race and perceived threat of aggression has been shown with Black children as young as 5 years-of-age (Thiem et al., 2019; Todd et al., 2016). A major predictor of a teacher’s plans to expel a preschooler is the degree to which that teacher feels the child may pose a danger to other children (Gilliam et al., 2016). Therefore, the degree to

which Black children are perceived as more culpable or older or threatening may have significant implications for race disparities in expulsion and suspension rates (Gilliam et al., 2016).

Though increasing numbers of IECMHC models around the country have been evaluated with each demonstrating positive associations on children's outcomes (Hepburn et al., 2013; Perry et al., 2010; Shivers, 2016), according to a recent systematic review (Albritton et al., 2018) only three out of 13 studies addressed discipline issues in preschool. Thus, there is a significant need to understand how mental health consultation can address disproportionate discipline practices affecting children of color (Albritton et al., 2018). Very little research has followed up on the national preschool expulsion findings to determine whether IECMHC is particularly effective for young Black, Indigenous, and Latinx preschoolers, and whether the benefits of IECMHC extended to other outcomes for preschoolers of color. There are several new studies which help shed light on this urgent question.

First, a secondary analysis of IECMHC evaluation data from Arizona (Davis, Shivers, & Perry, 2018) reveals that the 'consultative alliance' (also see: Davis 2018) that mental health consultants co-created with consultees (i.e., child care teachers) played a larger role in predicting positive impacts on children – and in particular, children of color, when one of three conditions existed: 1) the focus child for consultation was either a Latino or African American boy; 2) the consultant had self-reported expertise and confidence relating equity concepts in her work; and/or 3) the consultant and child care teacher were ethnically/racially matched. The results of this study enhance our understanding of how ECMHC works and for whom.

Next, another recent study by Shivers, Farago and Gal-Szabo (in press) examined whether child race and gender could predict 1) child outcomes at the beginning of IECMHC services and 2) to what extent child outcomes changed over a period of 12 months. The findings demonstrated that at baseline, Black children, compared to their white peers, and Black boys, compared to white boys, had higher teacher-child conflict scores at the beginning of consultation services. Conflict scores decreased more strongly over the course of IECMHC such that Black children's outcomes surpassed those of their white peers by the end of consultation (e.g., after 12 months of consultation). A trend was also seen for the reduction of Black boys' preschool expulsion risk, although this trend was only marginally significant (Shivers et al., in press).

Finally, an article by Davis, Perry, and Rabinovitz (2019) reflects on the parallels between IECMHC and other interventions designed to reduce implicit bias. Based on interviews with leaders in IECMHC practice, implementation, and evaluation, the authors created a theoretical framework that articulates how IECMHC is hypothesized to affect expulsion by first reducing the influence of implicit bias on disciplinary decisions – especially for Black, Indigenous and other children of color (Davis et al., 2019).

## **Evaluating Workforce Development: Dosage, Processes and Equity**

As the IECMHC field expands, there is a growing need and desire for a national consensus on IECMHC competencies, and what is required to support and expand an effective IECMHC workforce (COE IECMHC, 2017; Johnston et al., 2013). There have been efforts over the last decade to

streamline best practices through the lenses of guiding principles such as the ten elements of the Consultative Stance (Johnston & Brinamen, 2006) as well as the infant mental health (IMH) competencies – which are competency systems outlined and endorsed by certain states in the U.S. (Korfmacher, 2014). However, challenges continue to arise as practitioners try to increase the effectiveness in consultation. Johnston and colleagues (2013) discuss in their article on training, compartment, and competence in IECMHC that challenges range from limited academic training offered on early childhood mental health, to limited coursework designed specifically for consultation specialization, and even to the lack of funding that exists for intensive professional development for the role.

Having a skilled workforce is one of the essential components of an effective IECMHC program (Duran et al., 2009). As a result, a large portion of many of the budgets for IECMHC initiatives is invested in workforce development. However, we know very little about what is considered effective in terms of professional development dosage, content and processes for supporting mental health consultants and their supervisors. This is especially true when we consider what our IECMHC workforce needs in order to impact outcomes that have implications for racial equity. States like Washington, South Carolina and New York have currently integrated workforce development into their logic models and theories of change in order to pave the way for evaluation partners to explore and articulate how professional development, supervision and other forms of support contribute to the effectiveness of IECMHC.

## Organizational Capacity

Related to workforce development, more evaluation research is needed on how to effectively support not only our IECMHC workforce of mental health consultants, but also how to effectively support supervisors and strengthen organizational capacity. Findings from an IECMHC evaluation conducted in Alameda County, CA (e.g., Berkeley and Oakland) examined the impact of a county-funded initiative in specifically supporting organizational infrastructure and capacity at a community mental health grantee agency that has been providing IECMHC to the bay area for over 15 years. The findings from this study (Shivers, Gal, & Meaney, 2019) reflected the importance of a strong organizational infrastructure in supporting best practices in IECMHC and the implementation of new strategies by mental health consultants. For example, an essential component of the technical assistance offered to the IECMHC grantee agency emphasized the organization's ability to create systems, tools and other documents to help guide and monitor the work of mental health consultants. Currently there is little to no documented guidance, research, or evaluation findings focused specifically on the conditions, practices, policies, etc. on the organizational infrastructure of grantee agencies needed to support a highly skilled IECMHC workforce.

## Conclusion

As more literature evolves on the efficacy and effectiveness of IECMHC, it is clear that the role of a mental health consultant is somewhat malleable; however, evaluation partners working hand-in-hand with IECMHC program directors are beginning to articulate some unifying tenets, constructs and conditions of effective IECMHC programs, while continuing to highlight and underscore the fact

that the work of mental health consultation continues to be tailored, flexible and responsive (Duran et al., 2009; Johnston, Steier, & Heller, 2013; Kaufman et al., 2013). Although the studies reviewed in this document suggest that consultation is effective in supporting ECE programs, the fluid and adaptable manner in which consultation is provided in these settings leaves researchers, funders, policy makers and program directors seeking to better understand exactly “how” or “why” it works. Thus, it is imperative that evaluation partners continue to work together to expand and deepen the collective research agenda for IECMHC. Together, we can more effectively define and align IECMHC core components, such as organizational infrastructural support, workforce development, and service design in the service of closing racialized gaps and promoting school readiness and healthy development for young children.

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