Evaluation of Alameda County Behavioral Health Early Childhood Mental Health Consultation Standards of Practice Training and Technical Assistance Pilot

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Background

Early Childhood Mental Health Consultation (ECMHC) is an evidence-informed, preventative service that identifies potential mental health concerns in young children and reduces the risk of school suspensions and expulsions, as well as addresses less severe, yet disruptive behaviors that present challenges within the classroom environment. ECMHC reduces the likelihood that less severe behaviors intensify to a higher level of severity and impairment.

In 2017, the [National] Center of Excellence for Infant and Early Childhood Mental Health Consultation conducted an extensive review of existing IECMHC consultation programs around the country and found that all successful programs require four foundational building blocks: (1) eligibility, (2) service design, (3) workforce, and (4) infrastructure (Center of Excellence for IECMHC, 2017). As this specialty area expands, there is a growing need and desire for a national consensus on ECMHC competencies, and what is required to support and expand an effective ECMHC workforce (COE IECMHC, 2017; Johnston et al., 2013).

Indeed, providing guidance for aligning ECMHC core components, such as organizational infrastructural support, workforce development, and service design across multiple ECMHC grantees were key goals and motivation for the development of the Alameda County ECMHC Standards of Practice. Alameda County community-based mental health organizations, Alameda County Behavioral Health, and First 5 Alameda County have been partnering to provide training and early childhood mental health consultation services (ECMHC) since 2000. Although the services and training continue to grow, the following gaps and barriers preclude a fuller expansion:

- Lack of consistent coordination among agencies in the provision of ECMHC services
- Lack of identifiable, consistent ECMHC Standards of Practice that provide structure and accountability in ECMHC service delivery
- Lack of consistent training on ECMHC services to support ECMHC workforce development
- Lack of consistent technical assistance to support ECMHC workforce development
- Lack of outcomes-based evaluation
- Lack of a consistent funding source that supports the use of ECMHC Standards of Practice, and ECMHC services in general

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ECMHC Standards of Practice Training and Technical Assistance Pilot Intervention

To this end, Alameda County Behavioral Health (ACBH) and First 5 Alameda County partnered to develop proposed ECMHC Standards of Practice to be piloted in 2016-2018. Training and technical assistance (T/TA) was designed and implemented by ACBH. The training and technical assistance for this intervention pilot was delivered by a very seasoned mental health professional who has worked with Alameda County Behavioral Health Services for 19 years. The T/TA coordinator had extensive expertise and background in offering additional professional development and technical assistance to ECMHC grantees throughout Alameda County.

Evaluation Background

The goal for this study was to pilot an evaluation that met several objectives: 1) to determine whether the delivery of training and technical assistance for ACBH's EMCHC Standards of Practice met its stated objectives; 2) to inform Alameda County ACBH's technical assistance and Standards of Practice in terms of ongoing design and implementation; 3) to add to the field of literature on effective strategies for infant and early childhood mental health consultation; and 4) to provide findings that could guide Alameda County and other communities' and states' efforts to build a comprehensive system of ECMHC standards in order to align multiple EMCHC grantees and impact the system in a more coordinated fashion.

EXECUTIVE SUMMARY

Specific research questions were as follows:

1) Was there growth on key outcomes after mental health consultants implemented infrastructure components as detailed in the ECMHC Standards of Practice?

2) How did participants rate and reflect on their experiences with the ECMHC Standards of Practice implementation?

Methods

This evaluation was both a summative outcome evaluation and a process / exploratory evaluation, which included data collected from 2017 through 2019. The main purpose of this evaluation was to explore the impact of ECMHC Infrastructure Components on ECMHC service delivery as measured by outcomes and feedback through multiple informants (e.g., teachers, directors, consultants, ECMHC agency leadership).

Quantitative, standardized data was collected at the program, classroom, teacher and child level across three different time points: baseline, 6 months and 12 months (directors and consultant measures only). Background information and qualitative feedback data was also collected from the JFCS East Bay mental health consultants, JFCS East Bay supervisors, ACBH leadership and participant child care administrators. Quantitative data was collected via a combination of questionnaires, observations, and surveys. Qualitative data was collected via interviews and focus groups. The measurement and design strategy were largely based on the program developers' theory of change and child care research on effective Early Childhood Mental Health Consultation (ECMHC) models.

Results

The data from this evaluation presents compelling evidence the Alameda County ECMHC Standards of Practice Training and Technical Assistance pilot program was a success as measured by statistically significant increases on almost all of the key evaluation outcome measures, and overwhelming positive feedback from teachers, directors, and consultants. Key findings are summarized below.

Increases in Key Outcomes

We found statistically significant growth on most of the key evaluation outcome measures:

- Consultant self-efficacy (improvement over a period of 12 months)
- Consultant hopelessness (decreased over a period of 12 months)
- Director self-efficacy (improvement after 6 months and also after 12 months)
- Classroom emotional climate (improvement over a period of 6 months)
- Children's attachment (improvement over a period of 6 months)
- Children's self-regulation (improvement over a period of 6 months)
- Children's initiative (improvement over a period of 6 months)
- Children's risk of expulsion (decreased over a period of 6 months)

Testing our Hypotheses about the Theory of Change:

Consultants who received more 'dosage' (e.g., more training and technical assistance on the ECMHC Standards of Practice) also rated higher on:

- Consultant self-efficacy
- Fidelity in implementing Standards of Practice
- Director self-efficacy
- Director engagement with ECMHC
- Teacher-consultant relationship

The findings related to Consultant Self-Efficacy seem to shed even more light on an emerging theory of change for this training and technical assistance intervention. We discovered that higher ratings on consultant self-efficacy were positively associated with improvements in child outcomes and improvements in emotional classroom climate.

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Feedback from Participants

Teachers' and directors' feedback on the ECMHC they received from JFCS East Bay was overwhelmingly positive. Average feedback and satisfaction scores averaged 3.65 out of a possible 4.00.

Director qualitative feedback: The top 3 themes from the focus group with directors included:

1. There was positive director buy-in and engagement with ECMHC.
2. Director- consultant relationships were stronger with consultants receiving more T/TA from the intervention.
3. Directors' self-efficacy was positively impacted by their relationship with mental health consultants.

Consultant qualitative feedback: The most salient themes that emerged from consultants' conversations during the focus groups included the following:

1. Consultants hired specifically for the ECMHC SOP T/TA intervention had positive experiences with the T/TA coordinator.
2. Consultants hired specifically for the ECMHC SOP T/TA intervention reported feeling extremely supported by their supervisor and ECMHC program leaders.
3. The larger group of consultants who tended to be more seasoned and didn't receive as much T/TA also had positive experiences, and reported feeling more grounded and efficacious in their work as a result of receiving T/TA during the group sessions.
4. Having a bifurcated system of T/TA support created some negative tension among the consultants.

Future Directions and Recommendations for Next Steps

- **Top Recommendation: Pursue comprehensive funding that will adequately support growth and change in an organization's capacity and infrastructure. This includes offering similar dosage of T/TA to all the mental health consultants in an agency.**

- Continue to refine the T/TA model. For example, provide the same dosage with all consultants in an agency. In addition, explore ramping down dosage intensity toward the end stages of T/TA.
- Continue to articulate and test the theory of change for offering T/TA on the ECMHC Standards of Practice.
- Continue to fund an evaluation that can help test the theory of change and offer insight into the efficacy of the T/TA model.
- Expand the use of ECMHC Standards of Practice tools with additional Alameda County community based mental health agencies.
- Collaborate with partners to integrate ECMHC Standards of Practice in their ECMHC training efforts.
- Continue to explore other system levers in Alameda County for enhancing organizational capacity to support a highly qualified ECMHC workforce, effective ECMHC programming, and a clearly defined model.

INTRODUCTION

"How you are is as important as what you do."
- Jeree Pawl

Over the last several decades, considerable light has been shed on the indelible influence that early childhood experiences have on a child's development and trajectory later in life, which has led researchers and practitioners alike to critically examine the myriad of factors that ultimately shape the outcomes of young children (Brennan, Bradley, Allen & Perry, 2008; Center on the Developing Child, 2009; Gilliam, 2014; McLean et al., 2015; NAEYC). More specifically, as research on early brain development and attachment continues to expand (Bick, Zhu, Stamoulis, Fox, Zeanah & Nelson, 2015; Zeanah et al., 2009), so too has the need to evaluate the contexts in which children are experiencing their first years of life, such as the early care and education (ECE) programs wherein nearly one fourth of children under the age of five in the United States spend the majority of their days (Child Trends, 2016). The literature on the positive influence that quality ECE has on a child's future is vast (Barnett et al., 2005; Duncan & Magnuson, 2013; Mann, Reynolds, Robinson & Temple, 2001; Peisner-Feinberg et al., 1999; Gromley, Phillips & Anderson, 2017; Reynolds, 2018; Shivers, 2015; The Carolina Abecedarian Project, 1999), and reveals that high quality ECE is specifically linked to outcomes such as greater school success, higher graduation rates, decreased need for special education services later on, better math skills, and less difficulties when it comes to children who struggle with emotional regulation (Howes, Calkins, Anastopolous, Keane & Shelton, 2003; Keane & Caulkins, 2004; Yoshikawa, 1995; Zigler, Taussig & Black, 1992). On the contrary, however, there is data that also reveals low quality ECE programs can adversely influence a child's trajectory, especially when it comes to children with challenging behaviors (Boyd, Barnett, & Bodrova 2005).

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Dr. Walter Gilliam, a highly respected researcher on preschool expulsion in the country, revealed in his initial studies that challenging behavior in ECE programs is often alarmingly addressed with punitive measures that result in removal of young children from their natural learning environments (Gilliam, 2005; Gilliam, 2007; Gilliam, 2008). His research on preschool expulsion suggests that preschool children are expelled from ECE programs in the US 3.2 times more often than their K-12 counterparts, and are likely to be at risk for school failure in elementary and secondary education (Gilliam, 2005). Literacy rates and math and reading standardized scores of children in third grade programs are influenced heavily by a child's history within educational settings, and high school drop-out rates are higher for those that experienced negative educational experiences prior (US Department of Education, 2016). In 2013, nearly 8,000 preschoolers were excluded in some form or another from their natural learning environment, and those numbers have unfortunately continued (US Department of Education, 2016). By 2016, that number had doubled, and nearly 17,000 young children under the age of five were expelled or suspended from ECE programs nationally (National Survey of Children's Health, 2016).

Comorbid with this critical issue of preschool expulsion are the racial and gender disparities in discipline practices and outcomes among children in ECE programs (Gilliam, 2005; Gilliam et al., 2016). Specifically, African American preschoolers are 3.6 times more likely to receive one or more suspensions in comparison to their white counterparts, which is especially alarming given that they only make up 19% of the children enrolled in ECE programs yet encompass 47% of suspensions and expulsions (US Department of Education, 2016). Further, boys are three times more likely to experience a punitive measure such as suspension or expulsion than their girl counterparts (US Department of Education, 2016). These startling statistics have sparked a need for change among researchers, practitioners and ECE programs in the recent years, yet only recently have those stakeholders started to examine the preschool expulsion issue through a critical lens (Gilliam et al., 2016).

In order to combat this complex issue, national and state policy makers and institutions have started to reinforce best practices and implement strategies that aim at increasing the social emotional wellness of young children in ECE settings (Dakota, Care & Design, 2008; Hemmeter, Ostrosky & Fox, 2006; Hunter & Hemmeter, 2009; State of New Jersey Department of Education, 2007; Zigler, 2016). Several organizations that focus on enhancing the overall wellness and development of young children have evolved as a byproduct of the increased awareness of both early childhood experiences and the impact of quality ECE programs (e.g., Center for Social and Emotional Foudations of Early Learning (CSEFEL); First 5 California; NAEYC). These programs emphasize the need for young children to develop their social and emotional skills in the context of their early care experiences with caregivers, and consider those realms of development to be just as important as the other developmental domains. Other programs have evolved in order to address the challenging behaviors in ECE classrooms, as it has been revealed in the literature that ECE teachers often feel most unprepared and untrained when it comes to supporting children with these presenting concerns (Connors-Burrow, Patrick, Kyzer, McKelvey, 2016; U.S. Department of Health and Human Services, Administration on Children and Families, Office of Research and Evaluation 2010–2015). Specifically, the Early Childhood Mental Health Consultation specialization (ECMHC), a promising intervention approach tailored to increase teacher capacity in supporting children with behavioral concerns, is at the forefront of the literature and in practice, and has been deemed both efficacious and effective as a mode for preventing expulsion and increasing teacher capacity to support all young children in ECE programs (Hepburn, Perry, Shivers, & Gilliam, 2013; Gilliam, 2007; Shivers, 2015).

Early Childhood Mental Health Consultation

Early Childhood Mental Health Consultation (ECMHC) is an evidence-informed, multi-level intervention that partners mental health professionals with early childhood professionals to promote the social, emotional and behavioral health of young children (Birth to 5) in Early Care & Education (child care) programs (see www.ecmhc.org). ECMHC is a preventative service that identifies potential mental health concerns in young children and reduces the risk of school suspensions and expulsions, as well as addresses less severe, yet disruptive behaviors that present challenges within the classroom environment. ECMHC reduces the likelihood that less severe behaviors intensify to a higher level of severity and impairment.

Early childhood mental health consultation has been evolving over the last thirty years across the nation. In the past 10 years it has been deemed "an evidence-informed, multilevel intervention in which mental health professionals team with people who care for young children (age birth to 6) to promote healthy social emotional development" (Hunter, Davis, Perry & Jones, 2016, p. 6). The collaborative nature of consultation serves as the mechanism that drives meaningful change within ECE settings when it comes to children with challenging behaviors, and can serve as an intervention at three systemic levels: programmatic, classroom, and child (Hepburn et al., 2013; Kaufman, Perry, Hepburn & Hunter, 2013). Mental health consultants provide clinical strategies to ECE providers in countless ways, ranging from providing direct modeling for teachers in their classrooms, to utilizing

reflective tools aimed at examining teacher well-being and capacity, to facilitating family meetings when it comes to a particular child and their needs, to engaging in professional development trainings with entire staff teams focused on several topics that are of importance to the field of early childhood, etc. (Hunter et al., 2016). As more literature evolves on the efficacy and effectiveness of ECMHC, it has become clearer that the role of a consultant is somewhat malleable; scholars have been able to identify some unifying practices of consultants across the nation, yet have also illuminated the fact that the work is very idiosyncratic in nature (Duran et al., 2009; Johnston, Steier, & Heller, 2013; Kaufman et al., 2013).

Effectiveness of Early Childhood Mental Health Consultation

Outcome studies on the effectiveness of the ECMHC model have revealed very promising data across the country and across the three main levels of consultation (Duran et al., 2009; Hepburn, et al., 2013; Hunter, Davis, Perry & Jones, 2016; Kaufman, Perry, Hepburn & Hunter, 2013; Shivers, 2016). In regards to child outcomes, ECE programs that have participated in ECMHC have seen children increase their social emotional competence and decrease engagement in challenging behavior (Hunter et al., 2016; Hepburn et al, 2013; Shivers, 2016). In terms of teacher outcomes, ECMHC has been shown to improve teacher-child relationships, decrease teacher stress, improve classroom climate and enhance teacher capacity to teach social emotional skills in the classroom (Hunter at al., 2016; Hepburn et al., 2013; Shivers, 2016). At the programmatic level, participation in ECMHC has been linked to improved staff interactions, a decrease in staff turnover and, most critically, a decrease in the rates of expulsion and suspension across ECE settings nationally (Hunter et al., 2016). Although these outcomes 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. Therefore, a current focus of ECMHC practice and policy among states throughout the country is aimed at examining how to 'standardize' ECMHC program delivery across ECMHC grantees and ECMHC programs through the implementation of consistent guiding principles and standards of practice (Hunter et al., 2016; Kaufman et al., 2013).

Well Defined Early Childhood Mental Health Consultation Service Delivery Models

Due to the fluid nature of ECMHC and the increased focus on early childhood and its influence on concurrent and future developmental outcomes, research teams across the nation have illuminated the need for more evaluation and research to better inform the field about which key elements of ECMHC are driving the enhanced outcomes we see across the county and across participants (Duran et al., 2009; Hepburn et al., 2013; Hunter et al., 2016; Kaufman et al., 2013). For example, in an evaluation of 21 state ECMHC models (Duran et al., 2009), eleven respondents indicated that there are multiple service delivery models in multiple sites across the states they cover. Duran and colleagues in that same seminal policy brief ('What Works', 2009) that examined several ECMHC models, suggested that "ECMHC program administrators and mental health consultants need a theoretical foundation and a clearly articulated model to guide their work with children, families, providers and programs." (p. 10). Further, the brief, in reflecting on future areas of improvement, proposed that a consensus must be established around the core values and principles of ECMHC, as well as with the competencies and qualifications necessary of mental health consultants. Brennan et al. (2008) and Perry et al. (2009) identified in their literature reviews that there are several gaps in both research and practice are a result of the "lack of consensus about the essential components of effective mental health consultation… and the training, supervision and support needs of consultants." (Duran et al., 2009, p. 16). There is consensus in the field that there is a need to balance the uniqueness of ECMHC programs, with the increasing awareness that programs need some essential ingredients (e.g., tools; infrastructure; internal systems; etc.) to create a foundation for success. For example: The [National] Center of Excellence for Infant and Early Childhood Mental Health Consultation conducted an extensive review of existing IECMHC consultation programs around the country and found that all successful programs require four foundational building blocks: (1) eligibility, (2) service design, (3) workforce, and (4) infrastructure (Center of Excellence for IECMHC, 2017).

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Professional Development for Mental Health Consultants

As the field expands, there is a growing need and desire for a national consensus on ECMHC competencies, and what is required to support and expand an effective ECMHC 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, comportment, and competence in ECMHC 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.

Providing guidance for aligning ECMHC core components, such as organizational infrastructural support, workforce development, and service design across multiple ECMHC grantees were key goals and motivation for the development of the Alameda County ECMHC Standards of Practice.

Background: Alameda County Behavioral Health (ACBH) Early Childhood Mental Health Consultation (ECMHC) Standards of Practice (SOP)

History and Development of ECMHC Standards of Practice in Alameda County

Alameda County community-based mental health organizations, Alameda County Behavioral Health, and First 5 Alameda County have partnered to provide training and early childhood mental health consultation services (ECMHC) since 2000. Although the services and training continue to grow, the following gaps and barriers preclude a fuller expansion:

- Lack of consistent coordination among agencies in the provision of ECMHC services
- Lack of identifiable, consistent ECMHC Standards of Practice that provide structure and accountability in ECMHC service delivery
- Lack of consistent training on ECMHC services to support ECMHC workforce development
- Lack of consistent technical assistance to support ECMHC workforce development
- Lack of outcomes-based evaluation.
- Lack of a consistent funding source that supports the use of ECMHC Standards of Practice, and ECMHC services in general

To this end, Alameda County Behavioral Health and First 5 Alameda County partnered to develop proposed ECMHC Standards of Practice to be piloted in 2016-2018. The pilot included evaluation of the ECMHC Standards of Practice implementation, with a primary focus on the training and technical assistance provided in this implementation.

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Why do we need ECMHC Standards of Practice?

- To provide an infrastructure or framework for community-based mental health agencies that guides the implementation of ECMHC services.
- To maximize consistency and collaboration in culturally and linguistically responsive implementation of early childhood mental health consultation across Alameda County.
- To provide clarity and consistency about the role of an ECMHC provider so that early care and education programs know what to expect from the services.
- To inform ECMHC training curricula that will contribute to ECMHC workforce development/capacity.
- To provide a framework for accountability of ECMHC providers.
- To minimize barriers to successful ECMHC services.
- To maximize successful child-level, classroom-level and program-level outcomes.
- To be able to clearly articulate ECMHC practices and outcomes to potential funders for sustainability purposes.

ECMHC Standards of Practice Include:

1. **Site assessment at all levels of ECE program**
2. **Service agreements – that establish expectations and structure of ECMHC services**
3. **Plan development - Action Plans are co-created with the ECE staff which guides the delivery of ECMHC services**
4. **Organizational structure – regularly scheduled weekly supervision with "reflective" approach**
5. **Clear model design – a practice protocol for ECMHC**
6. **Training – internal agency onboarding process of new consultants that consists of "Core" trainings in ECMHC**
7. **Staffing – documented job description that includes minimum qualifications and competencies of ECMH Consultant**
8. **Evaluation – identify tool or method to evaluate ECMHC services annually**

Description of Training and Technical Assistance on the ECMHC Standards of Practice

Background and Expertise of T/TA Coordinator

The training and technical assistance for this intervention pilot was delivered by a very seasoned mental health professional who has worked with Alameda County Behavioral Health Services for 19 years. The T/TA coordinator also had the following expertise and background in offering additional professional development and technical assistance to ECMHC grantees throughout Alameda County:

- Provides regular onsite ECMHC support to ECE staff and the parent/caregivers of those children receiving care in ECE programs that consists of working in partnership with early childhood professionals to promote the social, emotional and behavioral health of young children.
- Provides administrative and clinical oversight of County operated ECMHC program, Building Hope.
- Developed, coordinated, and facilitated trainings on ECMHC practices and SOP for Alameda County and contracted ECMHC programs. (i.e., Harris Training – ECMHC Component, F5 ECMHC Learning Community, ECMHC & Transformational Coaching Training).
- Coordination and oversight of Alameda County operated and contracted ECMHC programs. Responsibilities include:
    - Assess program readiness and provide technical assistance to Alameda County and contracted ECMHC providers (15 Outpatient Programs) in building capacity of infrastructural components per Standards of Practice (SOP).
    - Monitor contract deliverables of all providers that are implementing ECMHC and SOP. Provide technical assistance towards the completion of contract deliverables.

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Description of T/TA Dosage and Objectives

The Training and Technical Assistance (T/TA) on the ECMHC Standards of Practice (ECMHC SOP) was delivered in varying groups and with varying levels of T/TA for different groups of recipients. The groups were configured as follows. For a fuller description of dosage and objectives for each group, please see Appendix A.

T/TA Configuration	TA Dosage (e.g., amount of time)
Small group training and TA – 3 newly-hired consultants	TA Dosage – 2x /per month for a total of 3 hours
Individual TA with ECMHC Supervisor to the 2 newly-hired ECMHC SOP grant consultants	TA Dosage – 2x /per month for a total of 3 hours
TA with two newly-hired ECMHC consultants – specific requirement of the SOP grant	TA Dosage – 1x /per month for a total of 1 hour and 30 minutes
All ECMHC agency supervisors and ECMHC program director	TA Dosage – 1x /per month for a total of 1 hour and 30 minutes
Large group training and TA – all ECMHC consultants, supervisors and program director	TA Dosage – 1x /per month for a total of 2 hours

Logic Model

The Logic Model displayed below depicts how the ECMHC Standards of Practice are related to the various aspects of the training and technical assistance delivery, grantee activities and evaluation outcomes. The Logic Model as well as the evaluation design and protocol were collaboratively developed by the evaluation principal investigator, Alameda County Behavioral Health Children's Services (ACBH) ECMHC leadership, and leadership from the pilot project grantee organization, **Jewish Family & Community Services East Bay (JFCS East Bay)**.

Logic Model

Objective: To assure consistency and collaboration in culturally and linguistically responsive ECMHC services to strengthen child-level, classroom- level and program-level ECMHC services across Alameda County provider agencies.

Target Audience:

ECMHC service providers.

Grantees of ECMHC funding in Alameda County.

ECMHC Standards of Practice (SOP):

1. Development and implementation of Site Readiness Assessment
2. Development and implementation of ECMHC Service Agreement
3. Development and implementation of classroom-level and child-level (as appropriate) Action Plan with ECE teachers
4. Development and implementation of program-level Action Plan with ECE Program Director
5. 3-6 hours of ECMHC focused reflective supervision per month
6. Identify and articulate clear model design with ECE staff and ECMHC staff
7. Development and implement internal agency process for new ECMHC consultants
8. Articulate clear outcomes, population served, and possible assessment tools to measure outcomes
9. Identify sustainable funding resources for ECMHC services
10. Identify and articulate ongoing ECMHC services evaluation methods to inform and enhance Action Plans

Training and TA Activities:

1. **BHCS to provide SOP training and technical assistance to ECMHC service providers**
2. **Additional TA on various phases of consultation process**
3. **Group TA**
4. **Meetings, phone calls and emails with supervisors**
5. **Provide resources and tools**
6. **Support in manualizing orientation and training for new staff**

ECMHC Direct Service Activities:

<u>Grantee Agency:</u>
Design and implement new procedures, tools, training, and protocols for ECMHC staff

<u>Supervisors:</u>
Provide supervision with consultants around the use of new protocols and tools

Increased hours of supervision focused exclusively on ECMHC

<u>Mental Health Consultants:</u>
Implement consistent use of enhanced protocols and tools with teachers and administrators at ECMHC sites

Short-Term Outcomes:

SOP#1:
Director and Teacher engagement/buy-in
Consultant's self-efficacy

SOP#2:
Director and Teacher engagement/buy-in
Teacher-Consultant relationship
Director-Consultant relationship

SOP #3:
Consultant's self-efficacy
Teacher's self-efficacy
Classroom emotional climate
Child's social and emotional functioning
Child's risk of expulsion

SOP#4:
Director's self-efficacy
Director-Consultant relationship
Changes in ECE policies and procedures

SOP #5:
Consultant's self-efficacy

SOP #6:
Consultant's self-efficacy
Fidelity to ECMHC model

INTRODUCTION

Current Evaluation Study

The goal for this study was to pilot an evaluation that met several objectives: 1) to determine whether the delivery of training and technical assistance for ACBH's EMCHC Standards of Practice met its stated objectives; 2) to inform Alameda County ACBH's technical assistance and Standards of Practice in terms of ongoing design and implementation; 3) to add to the field of literature on effective strategies for infant and early childhood mental health consultation; and 4) to provide findings that could guide Alameda County and other communities' and states' efforts to build a comprehensive system of ECMHC standards in order to align multiple EMCHC grantees and impact the system in a more coordinated fashion.

Specific research questions are as follows:

1) Was there growth on key outcomes[1] after mental health consultants implemented infrastructure components as detailed in the ECMHC Standards of Practice?

2) How did participants rate and reflect on their experiences with the ECMHC Standards of Practice implementation?

Evaluation Partner: Indigo Cultural Center

The Institute of Child Development Research and Social Change at Indigo Cultural Center is a community-based research firm that specializes in action research and evaluation[2] . The Institute is directed by Dr. Eva Marie Shivers. Indigo's mission is to conduct rigorous policy-relevant research on early education and child development by partnering with community agencies and public administrators who are dedicated to improving the lives of children, especially those from low-income and marginalized communities.

Since 2007, Indigo Cultural Center has honed a unique evaluation and research experience for government agencies, community-based organizations and other non-profit agencies seeking a range of professional services such as: basic child development and early education research, focus group facilitation, program evaluation, policy consultation, and training. Indigo Cultural Center has built a strong reputation as a Community Based Participatory Research (CBPR) organization with clients both within and outside of Arizona; whereby evaluation design, implementation and dissemination activities are closely aligned with our partner's ongoing service delivery to establish and maintain continuous quality improvement.

[1]Key outcomes include: classroom emotional climate; self-efficacy (teacher, director and consultant self-efficacy); and children's outcomes: risk of expulsion, attachment, self-regulation, and initiative.

[2]For more information about Indigo Cultural Center, please visit: https://www.IndigoCulturalCenter.org

Evaluation Approach

This evaluation was both a summative outcome evaluation and a process / exploratory evaluation, which include data collected from 2017 through 2019. The main purpose of this evaluation was to explore the impact of ECMHC Infrastructure Components on ECMHC service delivery as measured by outcomes and feedback through multiple informants (e.g., teachers, directors, consultants, ECMHC leadership).

Quantitative, standardized data was collected at the program, classroom, teacher and child level across two different time points: baseline and 6 months. Background information and qualitative feedback data was also collected from the JFCS East Bay mental health consultants, JFCS East Bay supervisors, ACBH leadership and participant child care administrators. Quantitative data was collected via a combination of questionnaires, observations, and surveys. Qualitative data was collected via interviews and focus groups. The measurement and design strategy were largely based on the program developers' theory of change and child care research on effective Early Childhood Mental Health Consultation (ECMHC) models (Duran et al., 2009; FSU, 2006; Green et al., 2006; Gilliam, 2007; Hepburn et al., 2013; Johnston & Brinamen, 2006; Shivers, 2016).

Designing an Evaluation Plan

As a result of relying heavily on Community Based Participatory Research principles, the development and implementation strategy for the Evaluation Plan was worked out in partnership with Alameda County Behavioral Health (ACBH) and JFCS East Bay. Indigo Cultural Center began the process by becoming very familiar with all the work and products completed by Alameda County ECMHC stakeholders (e.g., ECMHC Infrastructure Components and Standards of Practice). This approach aligned well with Indigo's previous ECMHC strategies of largely basing an ECMHC Evaluation Plan on the program developers' theory of change, ECMHC infrastructure components, logic model, standards of practice and national child care research on effective EMHC models.

Over the course of seven months, the Indigo Cultural Center evaluation team worked very closely with ACBH ECMHC leadership and JFCS East Bay ECMHC leadership to design an Evaluation Plan that was grounded in the nascent theory of change related to the ECMHC Standards of Practice, and grounded by the realities of conducting an evaluation in a context where the mental health consultants themselves were the primary data collectors and already had demanding case-loads and schedules.

METHODS

Evaluation Procedures

Training JFCS East Bay staff: Appendix B contains a copy of the 'Evaluation Protocol' document that was created by Indigo's evaluation team but based on the seven months of collaborative discussion with Alameda County Behavioral Health (ACBH) and JFCS East Bay leadership. Dr. Shivers conducted an on-site training in Berkeley with all consultants and supervisors and reviewed the procedures outlined in this document. Indigo's evaluation project manager provided oversight, coordination and support throughout the entire evaluation implementation period.

The design of this evaluation involved collecting data from early care and education teachers, their administrators and the mental health consultants. Qualitative data was also collected from ECE directors, ECMHC consultants, ECMHC supervisors, ECMHC agency leadership (JFCS East Bay), and TA provider leadership (ACBH).

Baseline data collection
(Time 1)

At the beginning of their work with consultants, participating teachers completed a background questionnaire and several self-assessments. Child care administrators and directors were also asked to complete a background questionnaire and several self-assessments. In addition, consultants completed a classroom observation with participating teachers. This observation spanned two visits. The observational tool they used focused on several different dimensions of classroom environments that are important for children's social and emotional well-being (Gilliam, 2008). These baseline data were collected within six (6) weeks of teachers' agreement to work with a JFCS East Bay mental health consultant.

Follow-up data collection
(Time 2: 6 months)

Six months later, teachers and administrators were asked to complete the same set of questionnaires and satisfaction feedback surveys. Classroom observations were also conducted again.

Consultants also completed background questionnaires, self-assessments and provided ratings and written feedback on their experiences with individual teachers and child care programs at baseline, and the six-month time-points. They were also asked to complete a checklist that tracked which specific elements of the Standards of Practice were implemented with specific sites.

Final data collection
(Time 3: 12 months)

After 12 months in the pilot project, administrators were asked to complete the same set of questionnaires and satisfaction feedback surveys. Consultants were also asked to complete the same self-assessments and checklists they completed at Time 1 and Time 2.

In order to gather more context for how the Standards of Practice were implemented, JFCS East Bay agency supervisors and the agency director were interviewed. ACBH leaders (including the SOP TA Provider) were also interviewed. Focus groups were conducted with mental health consultants and early care and education administrators who participated in the project.

Information collected from all participants is kept confidential and is only shared with members of the evaluation team. Participants' supervisors and co-workers do not have access to completed questionnaires and surveys. ID numbers are assigned by the evaluation team. A document that links names with ID numbers was created and is safely stored (password protected file) in a file that is separate from the data. All responses and results from this evaluation will be aggregated. Patterns of effectiveness (or non-effectiveness) will not be associated with any specific evaluation participant.

Obtaining Consent

IRB approval was granted prior to any data collection. Prior to the implementation of evaluation activities with teachers and administrators, the Indigo evaluation team facilitated a meeting that introduced them to the evaluation (e.g., purpose, objectives, design, and tools). The evaluation team carefully reviewed the consent form with the group of Mental Health Consultants – emphasizing the voluntary and confidential nature of this evaluation. Throughout the consenting period (about 5 months) the Indigo Cultural Center evaluation team was able to answer questions and address concerns about recruiting participants for the evaluation and obtaining consent.

Data Collection and instrumentation

Data were collected through questionnaires, observations, and surveys. A summary of the instruments used and the information collected is included in the following charts.

Procedures and Instruments

TEACHER INSTRUMENTS

Baseline = T1; 6 months = T2; 12 months = T3

	Surveys	Origin of the Measure	Timepoint	Time Commitment	Total Time
1	Teacher Background Information	Shivers	T1	Number of items: 19 Estimated Time Budget: 5-7 minutes	T1: 20-44 min T2: 20-47 mins Combined: 40-91 mins (0.66-1.51hrs)
2	Teacher Self-Efficacy	Teacher Opinion Survey (Gellar & Lynch, 1999)	T1, T2	Number of items: 12 Estimated Time Budget: 5-7 minutes	
3	Attachment, Regulation, Initiative	DECA-C	T1, T2	Number of items: 37 Estimated Time Budget: 5-15 minutes per focus child	
4	Risk of Expulsion	Preschool Expulsion Risk Measure (Gilliam)	T1, T2	Number of items: 14 Estimated Time Budget: 5-15 minutes per focus child	
5	Satisfaction	Feedback Survey	T2	Number of items: 11 Estimated Time Budget: 5-10 minutes	

CONSULTANT INSTRUMENTS

Baseline = T1; 6 months = T2; 12 months = T3

	Surveys	Origin of the Measure	Timepoint	Time Commitment	Total Time
1	Consultant Background Questionnaire	Shivers	T1	Number of items: 32 Estimated Time Budget: 10-15 minutes	T1: 13-20 min T2: 21-25 min T3: 21-25 min + Focus Group 60-120 mins Combined: 94-165 mins (1.56-2.75hrs)
2	Consultant Self-Efficacy	Adapted from TOS	T1, T2, T3	Number of items: 12 Estimated Time Budget: 3-5 minutes	
3	Consultant Feedback and Professional Comfort Scale	Shivers *Survey completed in retrospect	T2, T3	Number of items: 12 Estimated Time Budget: 3-5 minutes	
4	Focus Group	Focus Group: Questions determined by Indigo; i.e., What contributed to increased self-efficacy?	T3	Number of items: TBD Estimated Time Budget: 60-120 mins	
5	Service Delivery	Fidelity checklist	T2, T3	Number of items: TBD Estimated Time Budget: TBD, Goal <15 minutes	

	Surveys	Origin of the Measure	Timepoint 1/2	Time Commitment	Total Time
1	Emotional Climate	Preschool Mental Health Climate Scale: PMHCS (Gilliam)	T1, T2	Number of items: 59 Estimated Time Budget: 60-120 mins	60-120 minutes x amount of participating Classrooms

DIRECTOR INSTRUMENTS

Baseline = T1; 6 months = T2; 12 months = T3

	Surveys	Origin of the Measure	Timepoint	Time Commitment	Total Time
1	Provider Background Information	Shivers	T1	Number of items: 25 Estimated Time Budget: 10-15 minutes	T1: 17-25 min T2: 10-17 mins T3: 10-17 mins + Focus Group 60-120 mins Combined: 87-162 mins (1.45-2.7hrs)
2	Director Background Information	Shivers	T1	Number of items: 7 Estimated Time Budget: 2-3 mins	
3	Director Self-Efficacy	Adapted questions from: Teacher Opinion Survey (Gellar & Lynch, 1999)	T1, T2, T3	Number of items: 12 Estimated Time Budget: 5-7 minutes	
4	Satisfaction	Feedback Survey	T2, T3	Number of items: 11 Estimated Time Budget: 5-10 minutes	
5	Focus Group	Focus Group: Questions determined by Indigo; i.e., What contributed to increased self-efficacy?	T3	Number of items: TBD Estimated Time Budget: 60-120 mins	

Sampling Strategy

We conducted a power analysis to determine whether our sample sizes would be large enough to conduct a meaningful analysis. The table below summarizes sample sizes at each time point for each level of participant.

SAMPLE SIZES			
	Baseline T1	6 months T2	12 months T3
Consultants	10	8	8
Teachers	47	44	n/a
Directors	15	15	7

Process Exploratory Evaluation Design

The purpose of utilizing a qualitative approach in this evaluation design is to gather exploratory data about the process of implementing the ECMHC Standards of Practice. Gathering information about the process of implementing the SOP from multiple perspectives will not only help fill out the background context of our quantitative measures, but more importantly, it will help ACBH in determining next steps in bringing the SOP and complementary TA to scale with the rest of Alameda County ECMHC grantees.

Perspectives Captured	Methodology
JFCS East Bay Mental Health 'Seasoned' Consultants	1 Focus Group
JFCS East Bay Mental Health Consultants (hired specifically for this grant)	Joint Interview
JFCS East Bay Supervisors	Joint Interview
JFCS East Bay Director	Interview
ACBH Early Childhood Division Director	Interview
ACBH ECMHC SOP Trainer	Interview
Child Care Directors/Administrators	Focus Group

RESULTS

Analysis

Items in the data sets were examined descriptively for accuracy and any discrepancies were resolved by comparing the electronic files to the raw data. Next, scale scores for all measures were created. Data analysis included t-tests to ascertain change in subscale means between time-points. Change scores were also calculated to represent change between time points and correlations between key outcomes variables and change scores were computed. And finally, correlational analyses were conducted to test for associations among certain variables and key outcomes.

Description of Participants in Evaluation

CONSULTANTS

n = 10

Age:

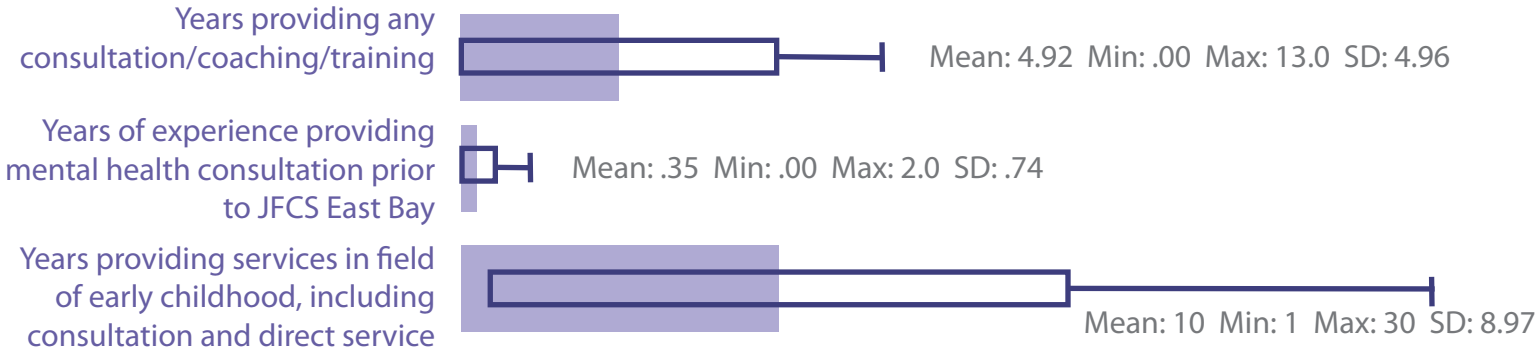
Gender: 90% Female, 10% Male

Race/Ethnicity: 10% Black/African American
50% White/Caucasion
30% Latinx
10% South Asian

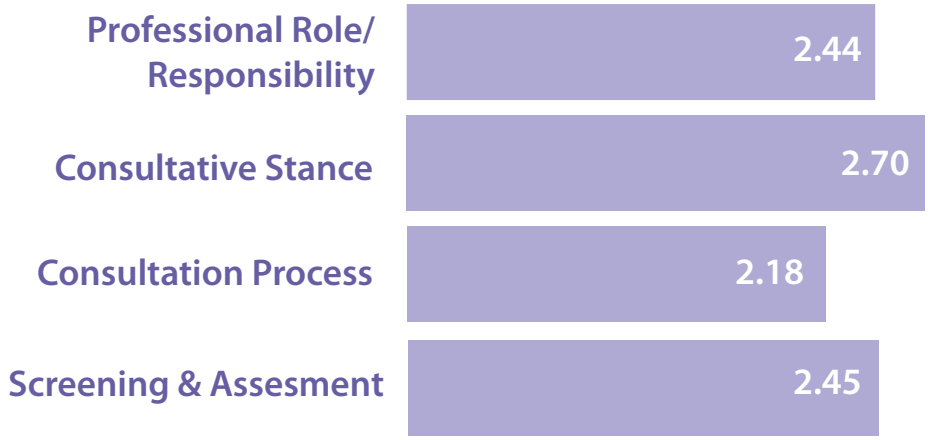
100%
Have Master's Degree

Type of Graduate Degree:
10% Psychotheraphy
10% Counseling Psychology
10% Applied Psychology
10% Education
20% MSW
10% Infant Mental Health
30% No Response

Consultants' Experience



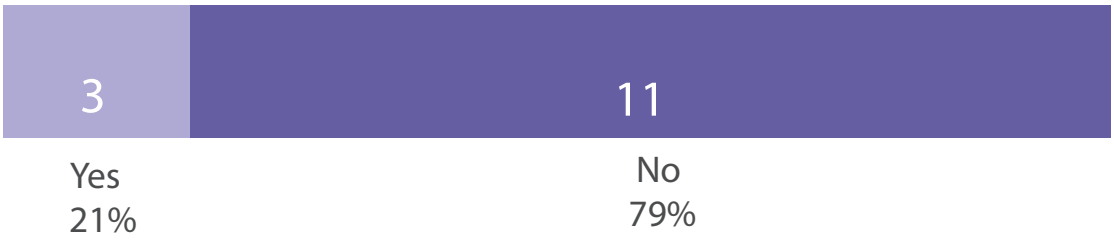
Consultant Self-Assessment Scores: Areas of Expertise



RESULTS

EARLY CHILDHOOD PROGRAMS

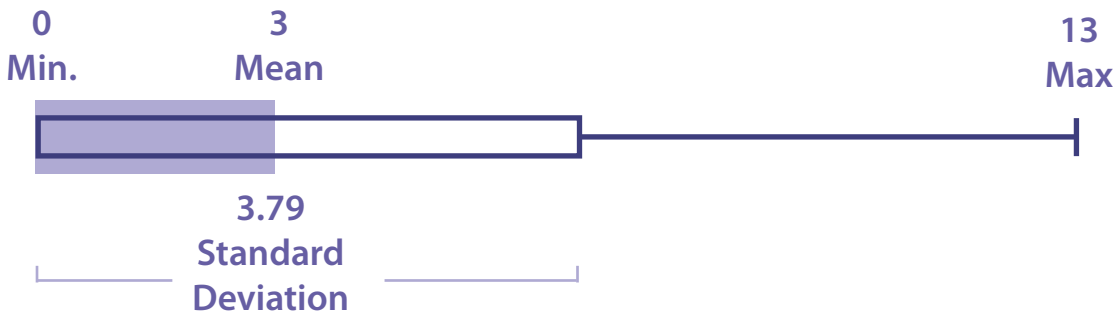
Program part of a school district?



Type of care provided

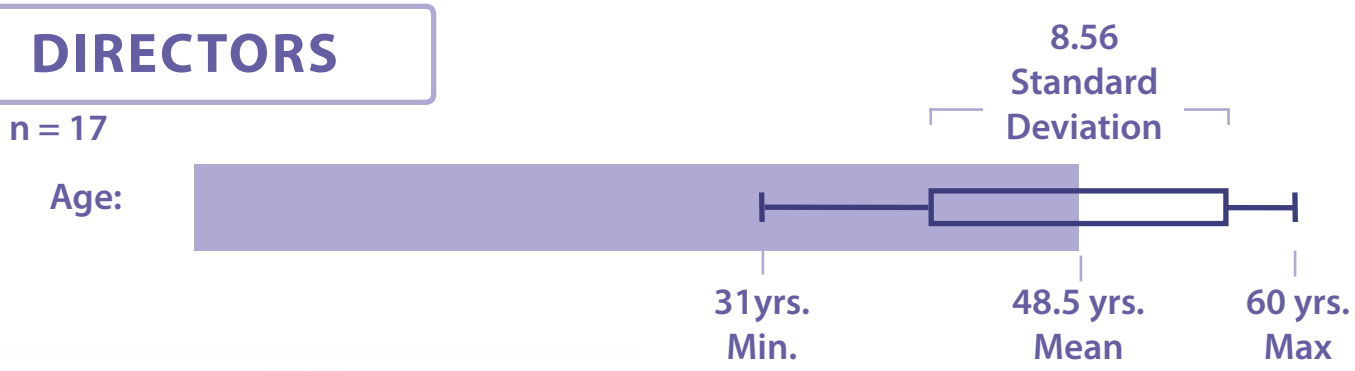
Currently accredited by a national professional organization?

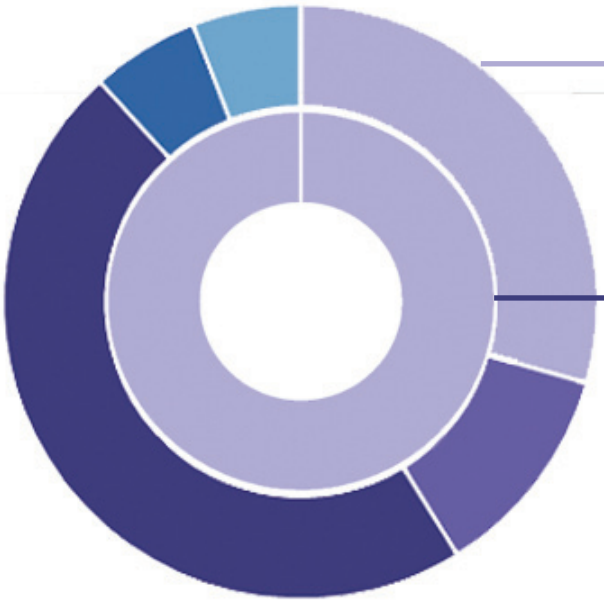
Children with special needs - IEP or IFSP



DIRECTORS

n = 17

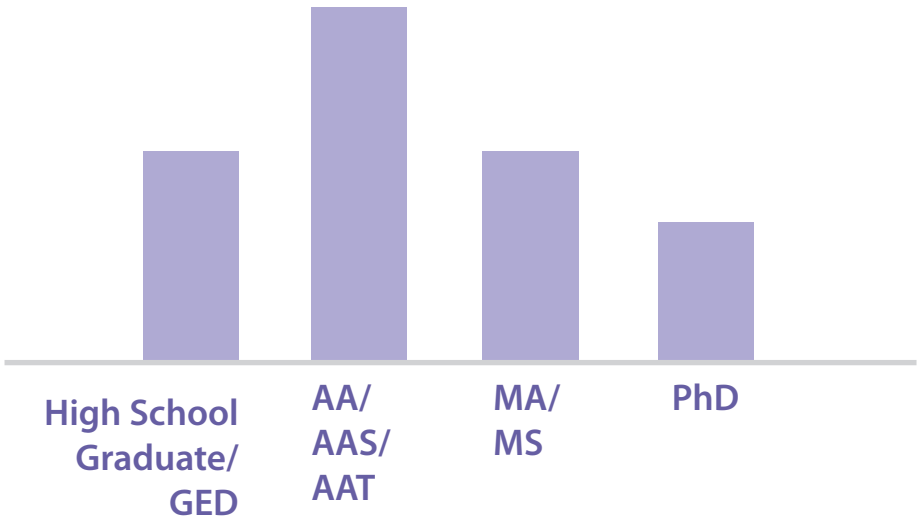




Race/Ethnicity: 29% Black/African America
12% White/Caucasion
47% Latinx
6% Indian
6% Native American

Gender: 100% Female

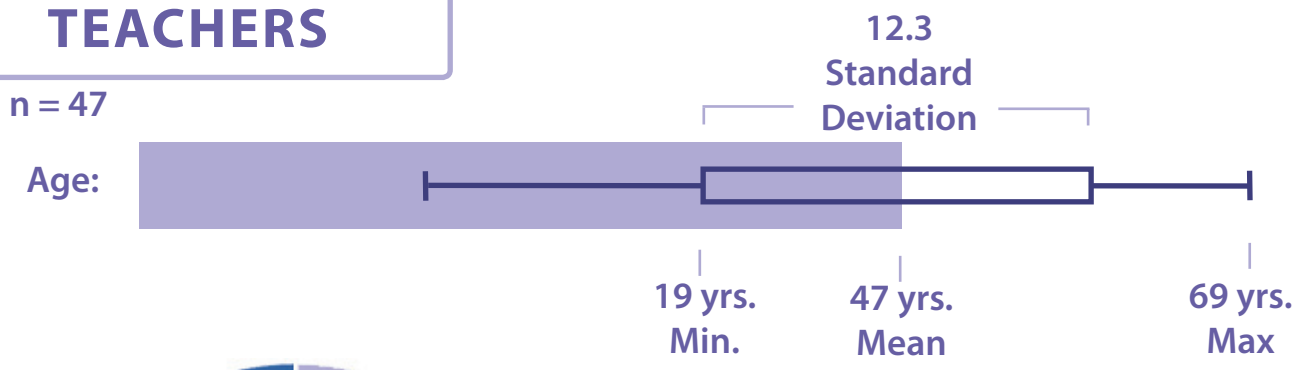
Highest Level of Education Completed

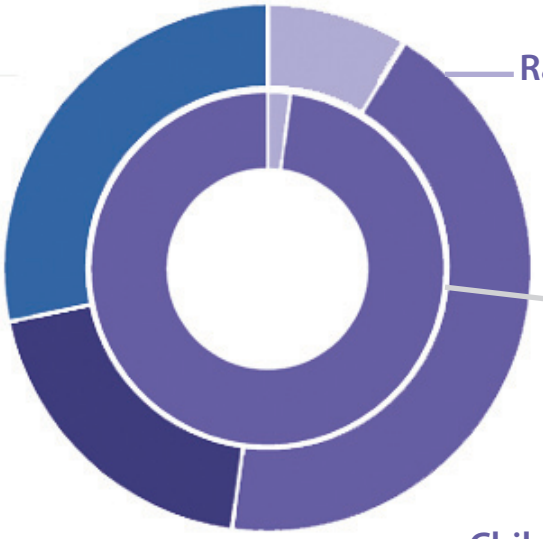


RESULTS

TEACHERS

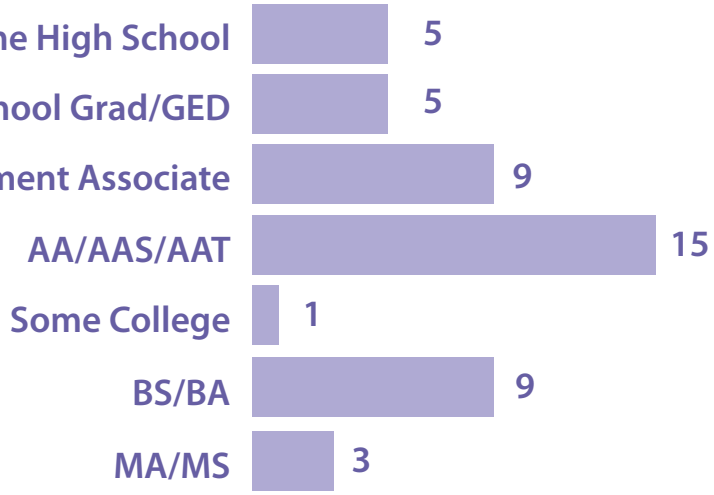
n = 47



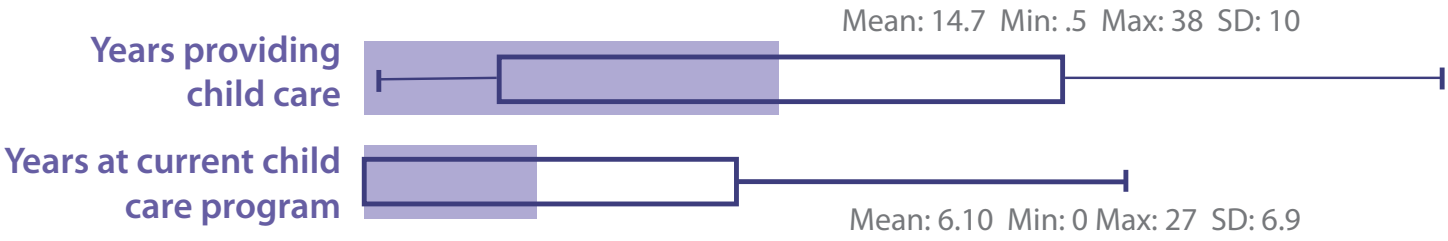


Race/Ethnicity: 9% White
43% Latinx
20% Black/African American
28% Asian

Gender: 98% Female, 2% Male



Teacher's Highest Level of Education Completed



FOCUS CHILDREN

n = 21

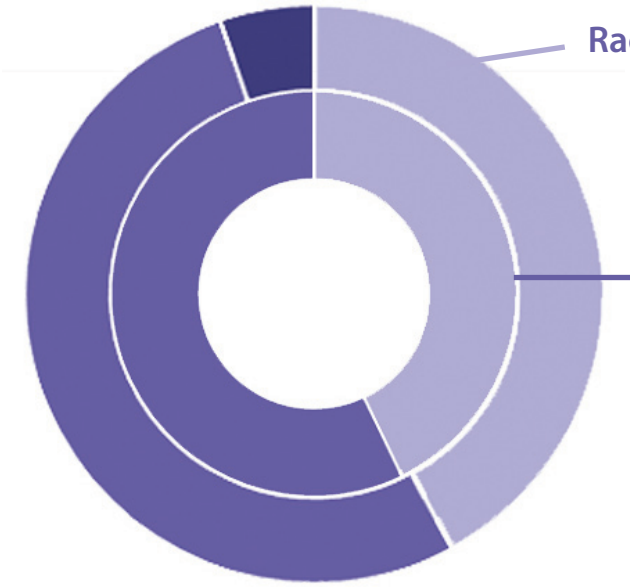
Age (in months):

1.12 Standard Deviation

12 months Min.

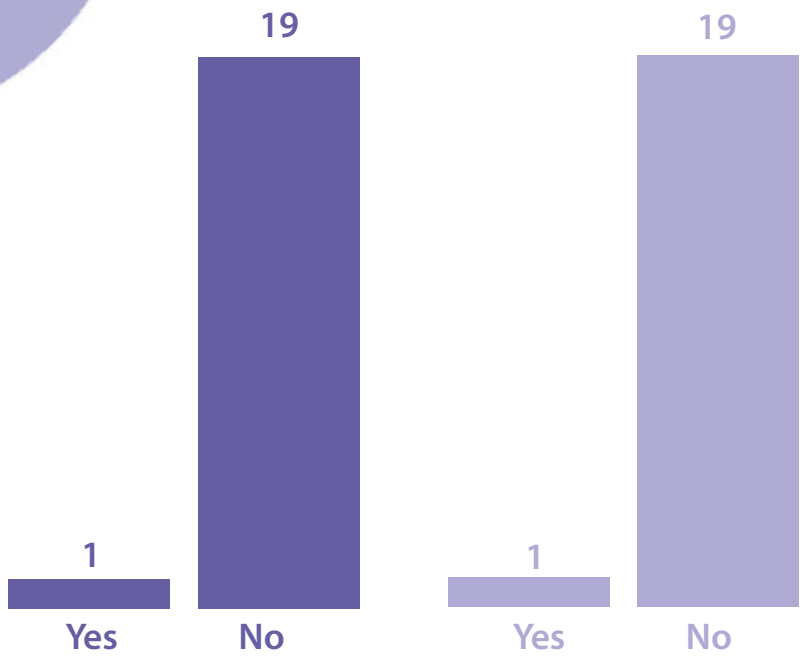
37 months Mean

60 months Max



Race/Ethnicity: 42% Latinx
53% Black/African American
5% Multi-Racial/Ethnic

Gender: 43% Female, 57% Male



RESULTS

Research Question #1: Were there increases on key program outcomes?

We examined whether there were changes in key outcomes of interest between time-points. To examine potential change, we conducted paired sample t-test analyses to determine whether there was changes in outcomes from baseline (Time 1) to 6 months (Time 2), and where applicable from 6 months (Time 2) to 12 months (Time 3), and baseline (Time 1) to 12 months (Time 3). Statistical hypothesis testing was used to determine whether these changes in key outcomes over time are statistically significant. This test provides a p-value, representing the probability that random chance could explain the result. In general, a p-value of 5% or lower (e.g., $p < .05$; $p < .01$) is considered to be statistically significant or highly statistically significant (e.g., $p < .001$). Because of the small sample sizes in these data, we looked for meaningful trends in the data, so we also reported when an outcome was 'approaching statistical significance' ($p < .10$). P-values are indicated by asterisks next to each score, and a key (legend) appears below each table.

Teacher-Level		
	Baseline (T1) mean score	**6-months (T2) mean score**
Teacher self-efficacy	3.97	4.06
Teacher self-efficacy: HOPELESSNESS	2.60	2.47
Classroom Emotional Climate (Preschool Mental Health Climate Scale)		
Transitions	3.23	3.72*
Directions & Rules Subscale	3.07	3.42**
Staff Awareness Subscale	3.11	3.86***
Staff Affect Subscale	3.42	3.77*
Staff Cooperation Subscale	3.17	3.69**
Staff-Child Interactions Subscale	3.31	3.93***
Teaching Feelings & Problem-solving Subscale	2.26	3.00***
Individualized & Developmentally Appropriate Pedagogy Subscale	3.07	3.80***
Child Interactions Subscale	3.42	3.96***
Negative Indicators Subscale	2.07	1.61*
Total Sum Score (no negative indicators)	169.2	193.9***

Child-Level		
	Baseline (T1) mean score	**6-months (T2) mean score**
Self-control	2.61	3.26*
Initiative	2.89	3.46*
Attachment	3.30	3.71*
Risk of expulsion	2.83	2.50*
Director-Level		
	Baseline (T1) mean score	**6-months (T2) mean score**
Director self-efficacy	3.89	4.13*
Director self-efficacy: HOPELESSNESS	2.30	2.23
Consultant-Level		
	Baseline (T1) mean score	**6-months (T2) mean score**
Consultant self-efficacy:	3.42	4.05*
Consultant self-efficacy: HOPELESSNESS	2.60	2.00*
Consultant fidelity checklist: Establishing ECE and ECMH partnership	8.20	15.90*
Consultant fidelity checklist: Organizational structure	12.10	22.10*
Consultant fidelity checklist: Total score	20.40	38.00*

Child-Level Outcomes

Walter Gilliam's seminal research study in 2005 demonstrated that behavior problems in very young children can be severe enough to warrant removal from their preschool programs (Gilliam, 2005). The experience of being expelled or even suspended from a child care program can instigate an onslaught of other negative experiences for children and families. Mental health consultation is designed to address and remedy the growing concern of child care expulsions (Duran et al., 2009). We used the Preschool Expulsion Risk Measure (PERM) to assess a teacher's perception of the likelihood that the focus child would be expelled from their current program.

RESULTS

The PERM is a measure developed by Walter Gilliam and has been used in several different states' ECMHC evaluations to establish this instrument's validity. Preliminary validation findings with the PERM indicate that it is a good predictor of child expulsions, it is associated with teacher depression, and it is sensitive to mental health consultation intervention (Gilliam, 2010; Hepburn, Perry, Shivers, & Gilliam, 2013).

The scale includes 12 items in a 5-point Likert format. Providers rated the extent to which they agreed or disagreed with the 12 statements (1 = strongly disagree; 5 = strongly agree).

	Mean Score Baseline (T1)	Mean Score 6 months (T2)
Preschool Expulsion Risk Measure	2.83	2.50*

Note: The level of significance of the difference between means at each time-point is indicated by the following symbols: *p<.05; **p<.01; ***p<.001

We also used the Devereux Early Childhood Assessment (DECA), first Edition (1998) to measure changes in children's self-regulation, attachment and initiative. The DECA is a behavior rating scale that is completed by teachers and provides an assessment of within-child protective factors central to social and emotional health and resilience, as well as a screener for behavioral concerns in young children. The scale used in the present study includes 27 items that reflect three separate subscales: Self-Regulation, Attachment/Relationships, and Initiative.

The DECA manual defines Self-Control as the child's ability to express emotions and manage behaviors in healthy ways. Attachment/Relationships is defined as the mutual, strong, and long-lasting relationships between a child and significant adults such as parents, family members, and teachers. Finally, Initiative refers to the child's ability to use independent thought and action to meet his or her needs. Teachers were asked to rate the focus children on each of the 27 items using a scale of 0 through 4 (0 = never; 4 = very frequently).

	Mean Score Baseline (T1)	Mean Score 6 months (T2)
DECA Self-Control Subscale	2.61	3.26***
DECA Initiative Subscale	2.89	3.46***
DECA - Attachment Subscale	3.30	3.71*

Note: The level of significance of the difference between means at each time-point is indicated by the following symbols: *p<.05; **p<.01; ***p<.001

Teacher-Level Outcomes (Self-Efficacy)

We used the Teacher Opinion Survey (Geller & Lynch, 1999) to measure teacher's self-efficacy. Bandura defines self-efficacy as "beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments" (1977, p.3). There is a rich literature on K-12 teacher self-efficacy, which demonstrates that efficacious teachers bring about more positive change in their teaching practices and students' outcomes (Armor et al., 1976; Berman et al., 1977). Furthermore, teacher self-efficacy is reported to be malleable as a result of professional development interventions (Mullholland & Wallace, 2001). Although there is less literature about self-efficacy with early care and education professionals, there are some findings that indicate that teachers with higher efficacy levels are more likely to construct positive relationships with children (Johns, 2003; NICHD ECCRN, 2005a). We hypothesized that as a result of receiving mental health consultation from consultants who in turn were receiving varying levels of training and technical assistance, teachers would begin to shift their feelings and beliefs about how effective they are at managing children's challenging behavior.

The scale we used included 12 items in a 5-point Likert format. Child care teachers rated the extent to which they agreed or disagreed with the 12 statements (1 = strongly disagree; 5 = strongly agree. This scale is comprised of two subscales: Personal Self-Efficacy and the Hopelessness/Overwhelmed scales. We conducted a series of paired sample t-test analyses to determine whether there were increases in personal self-efficacy and decreases in hopelessness from baseline (Time 1) to 6 months (Time 2). There were no statistically significant increases for Teacher Self-Efficacy.

	Mean Score Baseline (T1)	Mean Score 6 months (T2)
Personal Self-Efficacy Subscale	3.97	4.06
Hopeless/Overwhelmed Subscale	2.60	2.47

Note: The level of significance of the difference between means at each time-point is indicated by the following symbols: *p<.05; **p<.01; ***p<.001

RESULTS

Teacher-Consultant Relationship

After 6 months of providing mental health consultation (Time 2), and after 12 months of providing mental health consultation (Time 3), consultants were asked to report on their relationship with the lead teacher in the classroom. This scale was comprised of three items which assessed positive aspects of the relationship on a scale of 1 to 10 (1=low quality; 10= high quality).

	Mean Score 6 months (T2)	Mean Score 12 months (T3)
Teacher-Consultant Relationship	6.38	7.41*

Note: The level of significance of the difference between means at each time-point is indicated by the following symbols: *p<.05; **p<.01; ***p<.001

Teacher Classroom Practices: Emotional / Mental Health Climate

We used a classroom observation measure by Walter Gilliam (2008) that attempts to target those aspects of classroom functioning that are most relevant to the day-to-day work of mental health consultants. The Preschool Mental Health Climate Scale (PMHC; Gilliam, 2008) focuses on aspects of the overall classroom emotional environment (mostly interactions and the flow of activities) that may be related to children's mental health and social emotional functioning. Validation findings indicate that scores on this measure predict child behavior scores and teacher mental health (Gilliam, 2008), and this measure has been widely used in ECMHC programs around the country (Hepburn et al., 2013). There are ten (10) subscales contained on this instrument. Observers spend two days observing the classroom, and then rate indicators on each of the subscale dimensions on a scale of 1 – 5 (low to high). Optimally, scores should increase as a result of receiving mental health consultation (Gilliam, 2008). We conducted a series of paired sample t-test analyses to determine whether there were increases in optimal mental health classroom environments from Time 1 to Time 2. There were statistically significant increases on the total score as well as on all mean scores over time.

PMHC Total Score	169.2	193.9***
PMHC Subscale Scores		
	Mean Score Baseline (T1)	Mean Score 6 months (T2)
Transitions	3.23	3.72***
Directions & Rules	3.07	3.42**
Staff Awareness	3.11	3.86***
Staff Affect	3.42	3.77*
Staff Cooperation	3.17	3.69**
Staff-Child Interactions	3.31	3.93***
Teaching Feelings & Problem Solving	2.26	3.00***
Individualized & Developmentally Appropriate Pedagogy	3.07	3.80***
Child Interactions	3.42	3.96***
Negative Indicators (high score not optimal)	2.07	1.61*

Note: The level of significance of the difference between means at each time-point is indicated by the following symbols: *p<.05; **p<.01; ***p<.001

RESULTS

Director-Level Outcomes

Director Self-Efficacy

The scale we used was adapted from the Teacher Self-Efficacy measure described above and included 12 items in a 5-point Likert format. Early care and education directors / administrators rated the extent to which they agreed or disagreed with the 12 statements (1 = strongly disagree; 5 = strongly agree. This scale is comprised of two subscales: Personal Self-Efficacy and Hopelessness/Overwhelmed. We conducted a series of paired sample t-test analyses to determine whether there were increases in personal self-efficacy and decreases in hopelessness from baseline (Time 1) to 6 months (Time 2), from 6 months (Time 2) to 12 months (Time 3), and from baseline (Time 1) to 12 months (Time 3).

	Mean T1	Mean T2	Mean T3
Personal Self-Efficacy Subscale	3.89^{B}	4.13^{A}	4.49^{AB}
Hopeless/Overwhelmed Subscale	2.30	2.23	1.93

Note: Means with the same superscript differ from each other at $p < .05$ significance.

Consultant-Level Outcomes

Consultant Self-Efficacy

The scale that mental health consultants completed was adapted from the Teacher Self-Efficacy measure described above and included 12 items in a 5-point Likert format. Mental health consultants rated the extent to which they agreed or disagreed with the 12 statements (1 = strongly disagree; 5 = strongly agree. This scale is comprised of two subscales: Personal Self-Efficacy and Hopelessness/Overwhelmed. We conducted a series of paired sample t-test analyses to determine whether there were increases in personal self-efficacy and decreases in hopelessness from baseline (Time 1) to 12 months (Time 3).

	Mean T1	Mean T3
Personal Self-Efficacy Subscale	3.42	4.05^{**}
Hopeless/Overwhelmed Subscale	2.60	2.00^{+}

+p<.10; *p<.05; **p<.01; ***p<.001

Fidelity Checklist

Researchers have increasingly found that fidelity of program implementation, or whether the program is delivered as the program developers intended (Dusenbury, Brannigan, Falco, & Hansen, 2003), is importantly related to program outcomes in both family-based and school-based prevention programs (see Durlak & Dupree, 2008, for a review). Given the importance of fidelity for program outcomes, it is critical to develop systems to continuously evaluate fidelity of implementation.

In the present evaluation, we monitored consultant fidelity by working with our partners (ACBH and JFCS East Bay) to create a 'Fidelity Checklist' that listed all the components involved with implementing various aspects of the Standards of Practice. The 'Fidelity Checklist' consisted of 5 different sections: 1) Establishing ECE and ECMHC Partnerships; 2) Organizational Structure; 3) ECMHC Staffing/Training; 4) Outcomes/Evaluation; and 5) Model Design. Consultants were asked to complete the measure by indicating to what extent they have addressed a particular item (e.g., 'I completed the ECE Program Action Plan in collaboration with ECE program leadership'). The first two sections were most relevant to the training and technical assistance on the Standards of Practice received by consultants, so we focused our analyses on these two subscales as well as the total score. 'The Fidelity Checklist' included a total of 30 items and a 4-point Likert scale (0= 'have not started'; 4='totally completed').

	Mean T1	Mean T2	Mean T3
Establishing ECE and ECMH Partnership Subscale	8.20^{A}	15.90^{A}	16.90
Organizational Structure Subscale	12.10^{A}	22.10^{AB}	11.38^{B}
Fidelity Checklist Total	20.40^{A}	38.00^{A}	28.30

Note: Means with the same superscript differ from each other at $p < .05$ significance level.

RESULTS

Research Question #2:
Are background variables associated with significant improvement in key outcomes?

Although this was a pilot project with a relatively small sample, we still thought it was important to explore whether there were patterns of association between constructs related to the ECMHC Standards of Practice intervention (i.e., intervention dosage and less time as a mental health consultant) and improvements in some of the key outcomes. For this analysis we only selected key outcome variables that we hypothesized were more amenable to change as a result of the consultants receiving ongoing training and technical assistance on the ECMHC Standards of Practice. Those variables were increases in: teacher self-efficacy (also decreases in teacher hopelessness); teacher-consultant relationship; consultant self-efficacy; director engagement; director self-efficacy.

In order to explore these patterns of association, we first calculated a change score on each of the key outcomes that we hypothesized were more likely to improve as an immediate result of the Standards of Practice intervention with consultants, and then conducted Pearson bi-variate correlational analyses with background variables related to receiving training and technical assistance (e.g., T/TA dosage; consultant self-efficacy) and selected outcome change scores. The results are displayed below. The number reported next to each variable indicates the correlation coefficient 'r score.' In statistics, the correlation coefficient r score measures the strength and direction of a linear relationship between two variables on a scatterplot. The value of r is always between +1 and –1. In other words, the closer the coefficient r score is to either +1 or -1, the stronger the linear association there is between the two variables.

Intervention dosage (e.g., the total amount of training and technical assistance mental health consultants received on the ECMHC Standards of Practice) was associated with the following improvements in key outcomes:

Consultant self-efficacy

- There were positive patterns of association between intervention dosage and consultant self-efficacy after 6 months of receiving training and technical assistance on the ECMHC Standards of Practice (r=.71, p=.05). In other words, mental health consultants who received a higher dosage of training and technical assistance (T/TA) on the ECMHC Standards of Practice had higher ratings of self-efficacy after receiving 6 months of T/TA.

Fidelity in implementing the Standards of Practice

- There were very strong positive associations between the amount of intervention dosage and scores on the first 2 sections of the 'Fidelity Checklist' (1. Establishing ECE and ECMHC Partnerships; and 2. Organizational Structure) (r=.90, p=.002). In other words, those mental health consultants who received more training and technical assistance on the ECMHC Standards of Practice in the first 6 months of the pilot intervention were further along in implementing the Standards of Practice.

Promising trends (approaching statistical significance):

Director self-efficacy

- There were positive trends of association (e.g., approaching statistical significance) between intervention dosage and director self-efficacy after 6 months of receiving ECMHC with the new Standards of Practice (r = .52, p = .07). In other words, mental health consultants who received a higher dosage of training and technical assistance (T/TA) on the ECMHC Standards of Practice were working with directors who reported higher ratings of self-efficacy after receiving 6 months of consultation.

Director engagement with consultation

- Similarly, there were positive trends of association (e.g., approaching statistical significance) between intervention dosage and director engagement with mental health consultation after 12 months (T3) of receiving ECMHC with the new Standards of Practice (r = .48, p = .10). In other words, mental health consultants who received a higher dosage of training and technical assistance (T/TA) on the ECMHC Standards of Practice were working with directors who were rated as having higher engagement with consultation after 12 months.

RESULTS

Teacher-consultant relationship

- There were positive trends of association (e.g., approaching statistical significance) between intervention dosage and the teacher-consultant relationship after 12 months (T3) of receiving ECMHC with the new Standards of Practice ($r = .45$, $p = .07$). In other words, mental health consultants who received a higher dosage of training and technical assistance (T/TA) on the ECMHC Standards of Practice reported more optimal teacher-consultant relationships (i.e., 'Consultative Alliance' – Davis, 2018) after 12 months.

Less time in the field (i.e., the newly-hired mental health consultants received more T/TA in this pilot) was associated with the following improvements in key outcomes:

- Decreases over time in TEACHER Hopelessness over time (subscale of self-efficacy scale) ($r=.26$, $p=.10$).

- Decreases in CONSULTANT Hopelessness over time ($r=.7$, $p=.05$).

In other words, the newer consultants – who were also the recipients of more training and technical assistance (T/TA) on the ECMHC Standards of Practice – demonstrated a statistically significant decrease in HOPELESSNESS over time, and these same consultants also worked with teachers who demonstrated a statistically significant decrease in HOPELESSNESS over the first 6 months they worked together.

RESULTS

Beginning to test our Theory of Change: Since we hypothesized that greater 'intervention dosage' would be associated with increases in CONSULTANT Self-Efficacy, and this hypothesis was confirmed in our analyses, we thought it would be important to explore whether these increases in CONSULTANT Self-Efficacy were in turn associated with other key outcomes. We found the following statistically significant patterns of association.

Greater increases in CONSULTANT Self-Efficacy were associated with the following improvement in key outcomes:

Child level outcomes:

- Greater increases in child self-control (DECA) (r=.56, p=.003)
- Greater increases in child initiative (DECA) (r=.63, p<.001)

Teacher level outcomes:

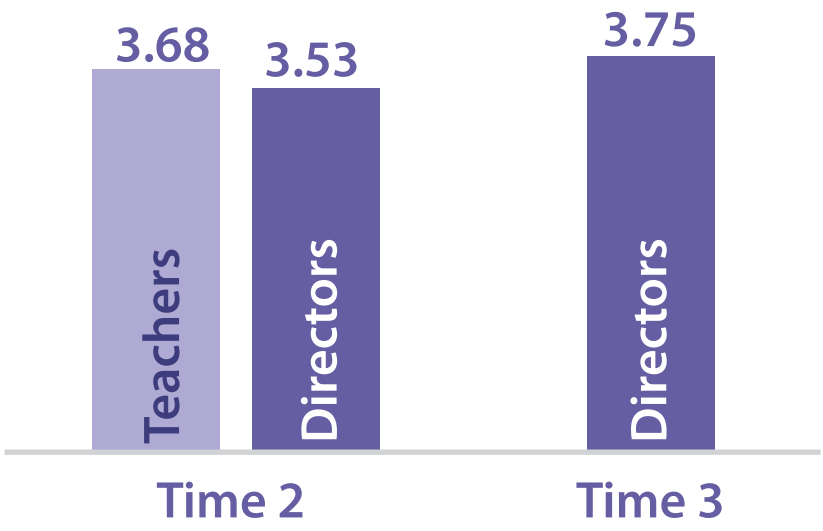
- Greater increases on the Preschool Mental Health Climate Scale total score (PMHCS) (r=.28, p=.06)
- Greater increases on teacher PMHCS 'Awareness' subscale (r=.30, p=.05)
- Greater increases on the PMHCS 'Feelings' subscale (r=.40, p=.007)
- Greater increases on PMHCS 'Individualized Pedagogy' subscale (r=.54, p<.001).
- Greater increases on PMHCS 'Child Interactions' Subscale (r=.30, p=.05)
- Decreases in TEACHER HOPELESSNESS (Self-Efficacy subscale) (-.42, p=.007)

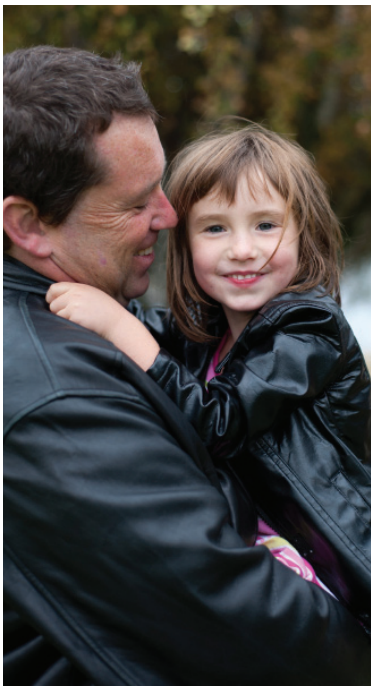
Research Question #3:
How did participants rate and reflect on their experiences with the ECMHC Standards of Practice implementation?

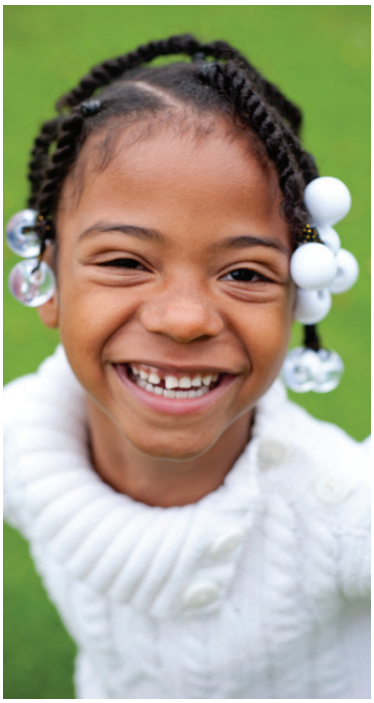
Teacher and Director Feedback

After six months of working with their early childhood mental health consultant, participants (teachers and directors) were asked to complete a Feedback Survey (adapted from Green, Everhart, Gordon, & Garcia-Gettman, 2006). The same feedback survey was completed again at 12 months, but only with directors. The Feedback Survey contained nine items that were rated on a scale of 1 (strongly disagree) to 4 (strongly agree). There were also two open-ended items (salient themes presented below). Examples of the close-ended items included: "I have a good relationship with the mental health consultant"; "Our mental health consultation services help children with challenging behaviors." Wording on the Director Feedback Survey was slightly changed. In order to reduce response bias upon completion of feedback surveys, participants placed their surveys in a sealed envelope, so their consultants could not view them.

Feedback Survey Mean Scores







Themes from Focus Groups

We chose this methodology because we were interested in participants' perspectives and reflections on their various experiences with the training and technical assistance pilot intervention. Focus group interviews have proven to be an effective methodology for this purpose as they are best used in situations where the research topic is relatively less known, and the evaluation is expected to gain much from involvement of the interested community (Edmunds, 1999). Results from focus groups can also produce new data and insights that might not occur through individual interviews alone, and result in research findings that can stand alone or be combined with other sources of data as part of a comprehensive evaluation (Morgan, 1998).

The director focus group included five directors who were all receiving ECMHC from the grantee agency, JFCS East Bay. There were two focus groups with mental health consultants – one focus group included the newly-hired ECMHC SOP grant consultants, and the other focus group included the other mental health consultants who did not receive the same intensity of T/TA dosage.

Each of the three focus groups were audio recorded and transcribed. Using open coding, we conducted a constant comparative analysis of the content of the participants' responses (Strauss & Corbin, 1998). By and large, the focus group transcripts revealed many positive statements about participants' experiences with the training and technical assistance intervention pilot. It should be noted that for purposes of this report, we only present the most salient condensed themes that emerged during our analysis. We offer these insights as a way to understand the data trends uncovered through the quantitative findings reported in earlier sections of this report and as a way to keep moving the conversation forward in terms of how we can improve programs and systems for ECMHC in Alameda County.

Director Feedback

The most salient themes that emerged from directors' conversations during the focus group included the following:

1. There was positive director buy-in and engagement with ECMHC.

"What has kept me engaged is the knowledge and belief that gaining a better perspective on how the environment and one's experiences directly impacts behavior."

"We meet for an hour and I use every bit of my hour every week, every bit. She meets with me twice a week, twice a month and she meets with the teachers twice and she's very involved. We talk about many children. The parents are excited, um, you know, because they're concerned about children and she's right there with them."

"I think what keeps me engaged is again, my weekly meetings with [my consultant]. As a director, I do know it can be lonely, you know, especially if you haven't developed that colleague group that you can call and say, "Hey, what do you think about this?" Because a lot of decisions are on you."

"The barriers that make it difficult to be engaged are mainly centered around agency structure and not related to the consultant at all."

2. Director- consultant RELATIONSHIPS WERE STRONGER with consultants receiving more T/TA from the intervention.

"I feel I have a very good relationship with [my consultant], in the short time I have known her I have come to really value her opinion, and advice. I am able to be totally transparent with her which adds to the value of our relationship. What built trust and willingness for me was her reciprocating that same transparency I have shown."

"My journey with mental health, my initial thought is life is a box of chocolates. You never know what you're going to get because in the past I've had some mental health consultants, where I'm like, "Do you have any experience with early childhood education?" It's different animal, you know, and they have not been very helpful at all. Um, actually I really enjoyed the standards of practice that they have set. I see a difference even between, um, the model that [my former consultant] delivered compared to what [my current consultant] is delivering. And I do see more effectiveness in this new model."

"I really got a connection now that I'm meeting with [my consultant] more often. I feel like I can talk to her about many things happened to me in my personal level and my job level. And also talk about the teachers and the kids and their families. Because it is hard to compartmentalize ourselves because the truth is there's stuff that's going on at home or in our own families – well we're human! We bring it to work with us and as part of our mental wellbeing. And if we're off, it's harder to be available to staff and families."

3. Directors' SELF-EFFICACY WAS POSITIVELY IMPACTED by their relationship with mental health consultants.

"[My consultant's] willingness to listen and provide an outlet for me to work out any challenges I have had to face and still face within the program has added to my feeling like I am making a positive difference in the program."

"[Our consultant] has been able to witness and remind me of all the positive changes I have made thus far. This is very valuable to me especially in times when I am frustrated or anxious about all the work that still needs to be done."

"So, when I've had to dismiss staff or discipline staff, you know, it's good to have a sounding board to say "You're doing the good work. I know you made an uncomfortable decision, but in the end, you know, you're doing the right thing, you're going down the right road."

"And you know, I've been in this field for well over 20 years. I started right out of high school and it can be just emotionally draining where sometimes it's like, "Do I want to get up and do it?" But it's like I need to do it. And so I just feel this [new consultation] model has just helped us become more healthy so that we can serve the children and meet their needs and, you know, do all those things that we're trained to do. This model, um, it makes it easier to do that."

4. Directors had suggestions for how Alameda County can IMPROVE SERVICES

"From what I know and have experienced through the program I would think continuing with their current process of soliciting the opinions and views of those they are serving will continue to aid Early childhood educators in developmentally appropriate practices."

"I would love to see some form of workshops offered specifically to administrators that builds on children's emotional wellbeing."

Consultants' Feedback

The most salient themes that emerged from consultants' conversations during the focus groups included the following:

1. Consultants hired specifically for the ECMHC SOP T/TA intervention had POSITIVE EXPERIENCES WITH THE T/TA COORDINATOR.

"I love how [the T/TA Coordinator] always encouraged me to reflect. It was the way I learn best. I like not having all the answers, she always encouraged me to bring my agenda. What are my questions and my challenges?

"And I love she shared her experience as a mental health consultant. And I learned, I learned from that. I think that's one of the best things, cause I like hearing how she a has been working as a consultant over the years."

"[The T/TA Coordinator] is embracing or kind of embodying the Consultative Stance that we worked from."

"Yeah. I think because the [Consultative] Stance is like what we know. Sure. We know that. But like [the T/TA Coordinator] was always trying to connect everything back to that. And I find myself doing that too now. I find that I enjoy my work more when I'm really grounded in, why I care about this work because this [Consultative Stance] is important."

"I really felt that [the T/TA Coordinator] was really understanding our industry because she was, she did [mental health consultation] and she still is doing it. For me it was great that she knew everything. How everything works in the county and her knowledge of all our sites."

"Our [T/TA Coordinator] has done a lot of work with Kadija [Johnston]. Having that deep knowledge of the Consultative Stance. Yes, that was the best part for me."

2. Consultants hired specifically for the ECMHC SOP T/TA intervention REPORTED FEELING EXTREMELY SUPPORTED by their supervisor and ECMHC program leaders.

"I felt really supported by [my supervisor and the ECMHC program director] Like the agency could help me with anything that I needed. They were really open, more trainings, more shadowing. I think that they offered whatever I needed to grow as a new consultant."

"I felt really supported. I feel for my personality, whatever reasons, I really liked to just do my own thing and they allowed me to do that. And because of the structure of this program, this project, I'm pretty sure they wouldn't have like just let any new person do that. Um, and so it felt you had a lot of autonomy to kind of do things in the way that in a way that felt good for you...Yeah. They supported me by allowing me to like take in the material as I understand it and implement it as I see the work."

3. The larger group of consultants who tended to be more seasoned and didn't receive as much T/TA also had positive experiences, and reported FEELING MORE GROUNDED AND EFFICACIOUS in their work as a result of receiving T/TA during the group sessions.

"I think that having some tools as opposed to going in informally was really good. Having a little bit of structure was good, which at first I resisted because I didn't think [my sites] would buy into it. Um, the tools helped teachers and the director understand more about what I was doing."

"At first I kind of resisted because going in I said, "I've been doing this for a long time and you know, this is all relationship based. You know, I have a different rapport with every teacher." Um, but having some structure gave me more comfort that maybe they have another way of learning about how I do what I do."

"At multiple times over the course of the project I feel like the structure that it provided to our program gave me a greater sense of hope and optimism, um, towards the work. Cause I, I feel like as a program we hadn't, we didn't have a lot of um, structure, um, kind of before this in terms of like, this is the way we do consultation. It was very kind of, uh, there were definitely some, you know, principles and expectations and guidelines. But in terms of like the, the processes, it was very um, it was, it was very, not very clearly defined."

"And so in that sense, there were things about the project which felt, you know, kind of a constrictive and limiting. Um, but on the other hand, the way that we've been doing it before, it felt very much kind of at the mercy of the conditions on the ground. Like whatever worked well, it was great, but then when it didn't work well, there wasn't anything to sort of like fall back on".

"Yeah, I think a lot of us, sort of earlier generation consultants, um, mostly learned by getting thrown in to a site and being told this is like an idealized picture of like what it's supposed to look like, knowing that like no one here had ever really experienced that."

4. Having a bifurcated system of T/TA support created some NEGATIVE TENSION among the consultants.

"So there's a part of me that was like, um, maybe whoa, that was like jealous when they were like these new consultants and they were getting all this training and attention."

"But then like I was supposed to also be doing this new model, but I wasn't getting that all the support, um, that same training and support. Um, yeah. And so I don't know if that created like a weird dynamic within the team."

"I think that, you know, being one of the folks that had less training, I kind of felt like I was behind the eight-ball in a lot of ways. Like the folks that had the training, they were well versed in it, to talk about it. Um, and I, I kind of felt like I should know this cause I've been doing this for a while. But I feel slightly incompetent because I don't have the level of comfort as a result of all the training. So it's easy for [the new consultants] to *have a 360 view of what this is going to look like and mine is sort of singly dimensional. Um, so I can't see it."*

"So it just felt like, not a rivalry, but it just kind of felt like it wasn't as fun talking about this exciting work that we're doing in the larger group. And then we're having to like kind of backtrack to talking about Action Plans with the large group when we've been doing that for awhile."

DISCUSSION

Early Childhood Mental Health Consultation (ECMHC) is an evidence-informed, multi-level intervention that partners mental health professionals with early childhood professionals to promote the social, emotional and behavioral health of young children (birth to 5) in early care and education programs. (See www.ecmhc.org) ECMHC is a preventative service that identifies potential mental health concerns in young children and reduces the risk of school suspensions and expulsions, as well as addresses less severe, yet disruptive behaviors that present challenges within the classroom environment. ECMHC reduces the likelihood that less severe behaviors intensify to a higher level of severity and impairment.

In 2017, the [National] Center of Excellence for Infant and Early Childhood Mental Health Consultation conducted an extensive review of existing IECMHC consultation programs around the country and found that all successful programs require four foundational building blocks: (1) eligibility, (2) service design, (3) workforce, and (4) infrastructure (Center of Excellence for IECMHC, 2017). As this specialty area expands, there is a growing need and desire for a national consensus on ECMHC competencies, and what is required to support and expand an effective ECMHC workforce (COE IECMHC, 2017; Johnston et al., 2013).

Indeed, providing guidance for aligning ECMHC core components, such as organizational infrastructural support, workforce development, and service design across multiple ECMHC grantees were key goals and motivation for the development

DISCUSSION

of the Alameda County ECMHC Standards of Practice. Alameda County community-based mental health organizations, Alameda County Behavioral Health, and First 5 Alameda County have been partnering to provide training and early childhood mental health consultation services (ECMHC) since 2000. Although the services and training continue to grow, the following gaps and barriers preclude a fuller expansion:

- Lack of consistent coordination among agencies in the provision of ECMHC services
- Lack of identifiable, consistent ECMHC Standards of Practice that provide structure and accountability in ECMHC service delivery
- Lack of consistent training on ECMHC services to support ECMHC workforce development
- Lack of consistent technical assistance to support ECMHC workforce development
- Lack of outcomes-based evaluation
- Lack of a consistent funding source that supports the use of ECMHC Standards of Practice, and ECMHC services in general

To this end, Alameda County Behavioral Health (ACBH) and First 5 Alameda County partnered to develop proposed ECMHC Standards of Practice to be piloted in 2016-2018. Training and technical assistance was designed and implemented by ACBH. The training and technical assistance for this intervention pilot was delivered by a very seasoned mental health professional who has worked with Alameda County Behavioral Health Services for 19 years. The T/TA coordinator had extensive expertise and background in offering additional professional development and technical assistance to ECMHC grantees throughout Alameda County.

The goal for this study was to pilot an evaluation that met several objectives: 1) to determine whether the delivery of training and technical assistance for ACBH's EMCHC Standards of Practice met its stated objectives; 2) to inform Alameda County ACBH's technical assistance and Standards of Practice in terms of ongoing design and implementation; 3) to add to the field of literature on effective strategies for infant and early childhood mental health consultation; and 4) to provide findings that could guide Alameda County and other communities' and states' efforts to build a comprehensive system of ECMHC standards in order to align multiple EMCHC grantees and impact the system in a more coordinated fashion.

Specific research questions were as follows:

1) Was there growth on key outcomes after mental health consultants implemented infrastructure components as detailed in the ECMHC Standards of Practice?

2) How did participants rate and reflect on their experiences with the ECMHC Standards of Practice implementation?

The data from this evaluation presents compelling evidence the Alameda County ECMHC Standards of Practice Training and Technical Assistance pilot program was a success as measured by statistically significant increases on almost all of the key evaluation outcome measures, and overwhelming positive feedback from teachers, directors, and consultants. Key findings are summarized below.

Summary of Findings

Increases in Key Outcomes

We found statistically significant growth on most of the key evaluation outcome measures:

- Consultant self-efficacy (improvement over a period of 12 months)
- Consultant hopelessness (decreased over a period of 12 months)
- Director self-efficacy (improvement after 6 months and also after 12 months)
- Classroom emotional climate (improvement over a period of 6 months)
- Children's attachment (improvement over a period of 6 months)
- Children's self-regulation (improvement over a period of 6 months)
- Children's initiative (improvement over a period of 6 months)
- Children's risk of expulsion (decreased over a period of 6 months)

We also hypothesized that there would be an improvement with teacher self-efficacy, but there was no statistically significant change over time. From a statistical point of view, the Indigo evaluation team discovered during the analysis phase that the internal consistency of the items on the Teacher Self-Efficacy Scale did not group together in a way that gave us much confidence

about the measure itself. In statistics and research, internal consistency measures how closely related a set of items are as a group. It is considered to be a measure of scale reliability. Internal consistency (indicated by a Cronbach's alpha score) measures whether several items that propose to measure the same general construct (e.g., self-efficacy) produce similar scores. The alpha score for teacher self-efficacy in this sample at time 2 (6 months) was well below the standard level (e.g., .70+ is considered 'good') and reduced our confidence that this particular measure was truly tapping into self-efficacy for this particular sample of teachers at time 2 (Time 1 alpha = .72; Time 2 alpha = .34). An alternative explanation based on discussion and feedback from our evaluation partners (ACBH and JFCS East Bay), hypothesizes that the limited growth on teacher self-efficacy might have been due to restrictions and systemic conditions in some (not all) of their programs that made it very challenging to meet with consultants and implement strategies and suggestions; thereby, impacting their sense of self-efficacy in the classroom.

Notwithstanding the limitations on the teacher self-efficacy data, there were promising gains on the other key outcome measures.

Testing our Hypotheses about the Theory of Change:

Although this was a pilot project with a relatively small sample, we thought it was important to explore whether there were patterns of association between constructs related to the ECMHC Standards of Practice intervention (i.e., intervention dosage) and improvements in some of the key outcomes. For this analysis we only selected key outcome variables that we hypothesized were more amenable to change as a result of the consultants receiving ongoing training and technical assistance on the ECMHC Standards of Practice.

Consultants who received more 'dosage' (e.g., more training and technical assistance on the ECMHC Standards of Practice) also rated higher on:

- Consultant self-efficacy
- Fidelity in implementing Standards of Practice
- Director self-efficacy
- Director engagement with ECMHC
- Teacher-consultant relationship

This evaluation piloted the assessment of two new constructs in the landscape of ECMHC evaluation – Consultant Self-Efficacy and Director Self-Efficacy. These two constructs were hypothesized to be related to growth and change among consultants and directors. We wanted to highlight and explore the growth and change that we believed would be most malleable to change as a result of receiving training and technical assistance and implementing the strategies from the ECMHC Standards of Practice. The qualitative data

findings on director self-efficacy also help inform our emerging theory of change and underscore the positive outcomes from the statistical findings.

The findings related to consultant self-efficacy seem to shed even more light on an emerging theory of change for this training and technical assistance intervention. We discovered that higher ratings on consultant self-efficacy were positively associated with improvements in child outcomes and improvements in emotional classroom climate. We did not statistically test a causal relationship, but these positive patterns of association demonstrate that as consultants experience a cognitive and emotional shift in the way they see and feel about their work (as a result of the training and technical assistance), this shift might be translating to positive improvements in classrooms and with individual children.

Feedback from Participants

Teachers' and directors' feedback on the ECMHC they received from JFCS East Bay was overwhelmingly positive. Average feedback and satisfaction scores averaged 3.65 out of a possible 4.00. Director feedback continued to improve over the course of the 12-month pilot. These positive scores were reflected in the positive change in key outcomes as well as directors' feedback during the focus group.

Director Qualitative Feedback: The top 3 themes from the focus group with directors included:

1. There was positive director buy-in and engagement with ECMHC.
2. Director- consultant relationships were stronger with consultants receiving more T/TA from the intervention.
3. Directors' self-efficacy was positively impacted by their relationship with mental health consultants.

DISCUSSION

Consultant Qualitative Feedback: The most salient themes that emerged from consultants' conversations during the focus groups included the following:

1. Consultants hired specifically for the ECMHC SOP T/TA intervention had positive experiences with the T/TA coordinator.
2. Consultants hired specifically for the ECMHC SOP T/TA intervention reported feeling extremely supported by their supervisor and ECMHC program leaders.
3. The larger group of consultants who tended to be more seasoned and didn't receive as much T/TA also had positive experiences and reported feeling more grounded and efficacious in their work as a result of receiving T/TA during the group sessions.
4. Having a bifurcated system of T/TA support created some negative tension among the consultants.

Implications

Practice

Perhaps the most important take away from this evaluation report is that the training and technical assistance on the ECMHC Standards of Practice demonstrated the promise of positive effect on consultants, directors, teachers and children. But what must be underscored is that the training and technical assistance really emphasized organizational, infrastructural support for the grantee agency, JFCS East Bay. The findings from the focus group with the consultants and interviews with JFCS East Bay supervisors and leadership truly reflected the importance of a strong organizational infrastructure in supporting best practices and the implementation of new strategies by mental health consultants. For example, an essential component of the Standards of Practices emphasized the organization's ability to create systems, tools and other documents to help guide and monitor the work of mental health consultants.

Another key finding that has implications for ECMHC practice was the growing awareness among consultants that as a result of receiving the training and technical assistance, they were able to integrate the use of tools (e.g., Action Plans; MOU) with the Consultative Stance (Johnston & Brinamen, 2006) – it did not have to be 'either – or.' There is consensus in the field that there is a need to balance the adaptive nature of how mental health consultants embody the Consultative Stance in ECMHC unique early education programs with the increasing awareness

that programs need some essential ingredients (e.g., tools; infrastructure; internal systems; etc.) to create a foundation for success (Center of Excellence for IECMHC, 2017).

Policy / Recommendations

There was extremely positive feedback from the mental health consultants who received the training and technical assistance (T/TA) on the ECMHC Standards of Practice regarding the skill, experience, disposition of the T/TA Coordinator. There is no doubt that the success of this pilot intervention was in large part due to the highly qualified and invested T/TA Coordinator. As this pilot goes to scale, it is essential that a professional with a similar disposition and background be hired and/or trained to deliver effective T/TA to agencies, consultants, and early care and education programs.

A major implication for policy is in regard to securing enough funding to offer support to organizations – not just the mental health consultants who work within. For example, an important finding from the focus groups with the mental health consultants was that all mental health consultants should ideally receive the same dosage of T/TA. In this pilot intervention there was a very small group that received intense T/TA. The larger group of consultants received only monthly sessions. This dynamic created some negative tension among consultants and supervisors. A strong recommendation is to offer the same level of T/TA support to all the consultants in an agency.

The other major implication for policy and future funding relates to the focus on organizational capacity in the ECMHC Standards of Practice. Fortunately, JFCS East Bay had many of the Standards of Practice in place. For example, they already were implementing 2 monthly 2-hour meeting times for all consultants and supervisors, which made the provision of time for T/TA sessions much easier. This existing capacity brings up the notion of 'readiness' of an agency to receive T/TA. How will future grantees demonstrate or even work up to being 'ready' to implement T/TA on the ECMHC Standards of Practice?

However, even though JFCS East Bay already had strong organization capacity and infrastructure, there was still room for improvement at the organizational level. For example, the T/TA helped get more organized requiring action plans which were already in place but not uniformly enforced. The T/TA also helped JFCS East Bay be more strategic in writing MOUs with early education programs and articulating what needs to be in place for successful services. Findings from interviews with supervisors and agency leadership indicated that the funding from the pilot intervention paid for time to do the following:

- Meet as a leadership team to plan meetings; discuss issues consultants were having at sites; agree upon which standards would be implementing department-wide.
- Meet for 2 hours/week with the new consultants on the project
- Create a system to track progress notes and action plans
- Create a training protocol (reading material, shadowing, etc.) for newly hired consultants
- Create a "Consultant Expectations" document that detailed all the new departmental expectations (e.g., progress notes, action plans, meetings w/ teachers, etc.)
- Secure time to review consultants' documentation
- Meet with early education site directors to introduce ECMHC (one meeting), introduce the consultant (another meeting), review and sign initial MOU (a third meeting), and to meet at least annually to renew the MOUs/service agreements (at least a fourth meeting).

As this intervention scales up, it is paramount to consider and plan for enough funding to cover the time needed for agency leadership (including supervisors) to attend to the development of infrastructure, systems, and tools.

Research Implications

Implications for research include the need to continue to explore new constructs for evaluation. The new constructs we tested and measured in this evaluation – Consultant Self-Efficacy and Director Self-Efficacy help the field in general move to a deeper and more meaningful articulation of our general, national theory of change about ECMHC.

Additionally, more evaluation research is needed on how to effectively support not only our ECMHC workforce of mental health consultants, but also how to effectively support supervisors and strengthen organizational capacity.

Limitations

There were several notable limitations in this pilot project and its evaluation. First, the relatively small sample size made it challenging to analyze and interpret results. Second the larger group of mental health consultants started receiving T/TA much later than the newly-hired consultants who were the main focus of this intervention. Based on the very positive feedback from this larger group of consultants, if they had participated in more sessions with the T/TA Coordinator, they might have been able to implement more of the Standards of Practice, and we might have observed more wide-spread improvements among directors, teachers, classrooms and focus children.

Another limitation that was the topic of discussion throughout the pilot project was the confound between T/TA and the reality of 'conditions on the ground' for several sites that participated in this evaluation. Some child care program sites' organizational structure made it extremely difficult for the more seasoned consultants to implement some of the core components of the Standards of Practice. This included a site's ability to commit to meetings with their mental health consultant. There were settings where the consultants simply can not insist on meetings because of the teacher unions and this did not change with this T/TA intervention. So, in regards to being able to test our theory of change and our hypotheses in this evaluation, we could not completely tease out whether the shifts and growth we saw in Consultant Self-Efficacy was a result of receiving the T/TA or whether it was because the grant required that JFCS East Bay select new early education sites that agreed to meet regularly and really wanted consultation as designed.

Future Directions and Next Steps

Recommendations for next steps include the following:

- Continue to refine the T/TA model. For example, provide the same dosage with all consultants in an agency. In addition explore ramping down dosage intensity toward the end stages of T/TA.
- Continue to articulate and test the theory of change for offering T/TA on the ECMHC Standards of Practice. Continue to fund an evaluation that can help test the theory of change and offer insight into the T/TA model.
- **Pursue comprehensive funding that will adequately support growth and change in an organization's capacity and infrastructure.**
- Expand the use of ECMHC Standards of Practice tools with additional Alameda County community based mental health agencies.
- Collaborate with partners to integrate ECMHC Standards of Practice in their ECMHC training efforts.
- Continue to explore other system levers in Alameda County for enhancing organizational capacity to support a highly qualified ECMHC workforce, effective ECMHC programming, and a clearly defined model.

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APPENDICES

Appendix A

Description of T/TA Dosage and Objectives

Small group training and TA – 3 newly-hired consultants

- TA Dosage – 2xs/per month for a total of 3 hours.
- Small group training and TA was intended to provide intensive training and support to strengthen a consultant's foundational knowledge base in Early Childhood Mental Health Consultation (ECMHC) in regards to the theoretical framework (i.e., Consultative Stance: Johnston & Brinamen), key principles of ECMHC, three types of ECMHC, and ECMHC SOP practices.

  Consultants will demonstrate competency in skill abilities as evidenced by:

  a) Have clarity in their role as a "consultant."

  b) Approach classroom and child focused observations with intentionality.

  c) Application of the tenets in the "Consultative Stance" – consultant is able to identify how the tenets are operating in their ECMHC work.

  d) Engage the ECMHC SOP practices to support those various phases in the ECMHC work.

  e) Increased ability on how to respond to challenges in the work by utilizing the Consultative Stance and ECMHC SOP practices as a guide.

Individual TA with ECMHC Supervisor to the 2 newly-hired ECMHC SOP grant consultants:

- TA Dosage – 2xs/per month for a total of 3 hours.
- The focus of the TA support for ECMHC Supervisor was to build capacity in the following areas:

  a) Support development in leadership role of interface with ECE programs as it relates to the implementation and/or compliance with ECMHC SOP.

  - Conducting Site Readiness Assessment process with leadership from ECE programs.
  - Conducting annual meetings with ECE Directors to renew Service Agreements.

  b) Developing skill abilities in administrative oversight of ECMHC consultation with ECE management teams.

c) Provide support and guidance in the monitoring of supervisees implementation and utilization of ECMHC SOP practices in the work.

d) Address challenges in balancing responsibilities in overseeing clinical and administrative issues with supervisees.

<u>TA with two newly-hired ECMHC consultants – specific requirement of the SOP grant:</u>

- TA Dosage – 1x/per month for a total of 1 hour and 30 minutes.
- For the newly-hired ECMHC SOP grant consultants, the focus of TA consisted of:

a) Deepen knowledge of application of the tenets in the "Consultative Stance" – consultant is able to identify how the tenets are operating in their ECMHC work and guide next steps.

b) Guide consultants to explore how they will engage the ECMHC SOP practices to support their ECMHC work.

c) Support consultants in the conceptualization of themes occurring in their ECMHC work with teachers, ECE directors, and classroom needs.

<u>All ECMHC agency supervisors and ECMHC program director:</u>

- TA Dosage – 1x/per month for a total of 1 hour and 30 minutes.
- The focus of the TA support for this small group of ECMHC program leadership was to build capacity in the following areas:

a) Establish their identity and roles as an ECMHC supervisory group.

b) Make determination and agreements regarding extent of the implementation of ECMHC SOP practices agency-wide.

c) Provide reflective space for this team to consider and address the needs of the larger ECMHC staff.

d) Support ECMHC Program Director in providing clarity of expectations and prioritizing which ECMHC SOP practices to implement agency-wide.

APPENDICES

TA with all agency consultants, supervisors and program director:

- TA Dosage – 1x/per month for a total of 2 hours.
- TA support for JFCS EAST BAY consultation team, supervisors, and program director included:

  a) Support supervisory team with organizing agenda and planning focused topics for larger ECMHC team meetings.

  b) Provide training to larger ECMHC team in the development and completion of child level, classroom level and program level Action Plans.

  c) Support ECMHC program director to think through what messages from her role of leadership needs to be articulated to the larger ECMHC staff regarding expectations of agency-wide ECMHC SOP practices – such as consistently documenting via progress notes, completion of Action Plans, clarification and discussion regarding the practices.

Appendix B

Early Childhood Mental Health Consultation Evaluation Protocol

-BASELINE-

APPENDICES

➢ STEP#1

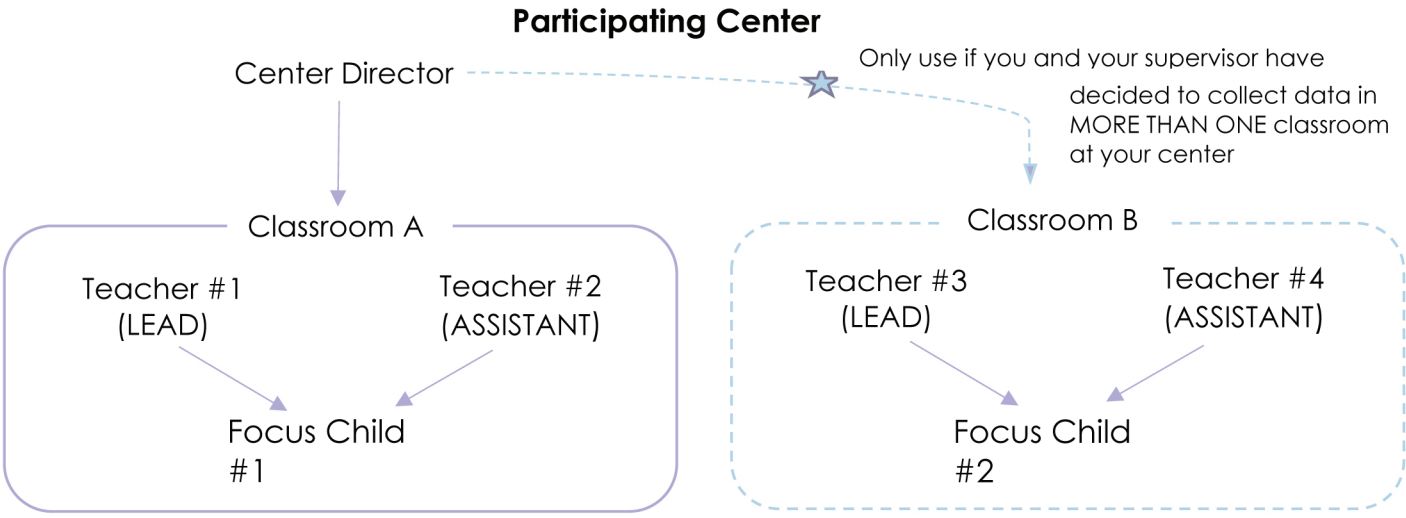
Identify Focus Teachers and Set Due Dates

Together with your supervisor, you will identify which Directors, Teachers, and Children you will ask to participate in the Evaluation. To assist you with this process, you and your supervisor will complete a "EVALUATION PARTICIPATION WORKSHEET" for each participating center.

The EVALUATION PARTICIPATION WORKSHEET is intended to help you determine:

1) **Who** will participate
   a. Consultants who have ESTABLISHED relationships with teachers, you and your supervisor will pick TWO classrooms where you will collect data. The following people will be asked to participate in the evaluation:
      - 2 Centers, 1 classroom in each
      - 2 Directors, 1 from each center
      - 2 Lead and 2 Assistant Teachers (1 Lead/1 Assistant per chosen classroom)
      - 2 Focus Children (1 per chosen classroom)
   b. Consultants who have NEW relationships with teachers, you will be asked to complete the evaluation with ALL eligible participants:
      - EVERY CENTER
      - EVERY Director
      - EVERY Lead Teacher
      - Many Assistant Teachers (ONE per Lead Teacher classroom)
      - Many Focus Children (ONE per classroom)

The following image is intended to be a "visual map" that identifies the participants required for each chosen center. Most chosen centers will only have one participating classroom, but for those who have unique scenarios where there is more than one participating classroom per center, please see the ★ for more guidance.



2) **What** documents need to be completed for participation?

Director

- ☐ Director Consent Form
- ☐ Program Background Information
- ☐ Director Background Information
- ☐ Director Self-Efficacy

Lead/Assistant

- ☐ Teacher Consent Form
- ☐ Teacher Background Information
- ☐ Teacher Self-Efficacy
- ☐ DECA
- ☐ Challenging Behavior Survey

Consultant

- ☐ PMHCS (1 per participating classroom)

Focus Child/Parent

- ☐ Child Consent Form (1 per focus child)

3) **When** the documents need to be completed by

TWO WEEKS post initiating conversation with Directors and Teachers

Collecting baseline data in a timely manner is critical to the integrity and sensitivity of our evaluation. For the purposes of this evaluation, we have determined that the evaluation measurements will be due TWO WEEKS after you have an initial conversation with Directors and Teachers about the evaluation. Example:

You tell the ***Director*** about the evaluation and ask for their participation on **9/1/17** → The *Director Evaluation Measurements* will be due on or before this date to achieve the most optimal baseline data **9/14/17**

You tell the ***Lead/Assistant Teachers*** about the evaluation and ask for their participation on **9/7/17** → The *Lead/Assistant Teacher Evaluation Measurements* will be due on or before this date to achieve the most optimal baseline data **9/21/17**

APPENDICES

➢ STEP#2

Schedule out your evaluation tasks and due dates

Once you complete your EVALUATION PARTICIPATION WORKSHEET, mark your calendars so you remember when you need to complete your evaluation tasks, and make plans for how you will complete the evaluation measures with your Directors and Teachers.

An important strategy for success: PRIORITIZING THE CHILD CONSENT FORMS

You won't be able to complete many of the teacher instruments without achieving a signed consent form for the focus child in each participating classroom. Teachers and Directors often have questions about how to approach parents about this form, and if not coached throughout the process, you can experience big delays here. If you need additional support in how to do this, please reach out to your supervisor and/or Sandie as soon as you encounter issues in this area.

Another important strategy for success: STAFF UNDERSTANDS THE TIME COMMITMENT

During the process of explaining the Director Consent and Teacher Consent, it's important to offer emphasize the time commitment involved in this evaluation. Especially Directors will need to be "on-board" for the idea that their staff will need separate and focused time away with you to complete the evaluation instruments.

We always do our best to make the time burden as low as possible, but it's important to know EACH teacher will take anywhere from 30-60 minutes to complete all of their baseline instruments, and this same time commitment/process will be repeated again in 6-months time. That's 1-2 hours of evaluation time, per classroom (since two teachers will be participating). Please be mindful of this when scheduling out your time to complete the evaluation.

➢ STEP#3

Collect the data

Once you become familiar with all of the evaluation instruments, this is the easy part! You will be responsible for explaining each evaluation measure and supporting the Directors and Teachers through the process of answering their questions as honestly and accurately as possible.

"PRE-CLEANING" THE DATA

A very common (and somewhat annoying) issue is when data questions are missed or overlooked and left blank. Because every little bit of data is critical to our evaluation, when that happens, you have to go back and contact the Director or Teacher to ask them for the answer. The best way around this is to double-check their surveys while you are with them, so you won't have to bother them (or yourself) about it later.

MANAGING DATA "SNAGS"

In a perfect world, every Director, Teacher, and Focus Child would stay present and available for the entirety of the evaluation process. Since we don't live in a perfect world, we must plan for the reality that people *will* leave and sometimes it will happen very unexpectedly. When this occurs, please **CONTACT SANDIE ASAP**. She will help develop a plan for how we keep the evaluation process intact! It will likely be different for every scenario (since every situation will have its own unique challenges and characteristics). The important thing to know now, is just to let Sandie know about a departure as soon as you know!

➢ STEP#4

Turning in the data

After you complete your evaluation packets, please store them in a secure environment— ideally, somewhere with a lock (or less ideally, somewhere as secure and as confidential as possible until you can secure it with a lock back at your office.)

During supervision, bring your evaluation packets to review with your supervisor to ensure that the data is "CLEAN" (meaning, all questions are sufficiently complete).

These data packets will then be passed along to Sandie for final review.

When challenges arise…

Challenges will inevitably arise when attempting to meet this important deadline (e.g., teacher absences, planned vacations, unexpected critical issue, etc.). Please alert Sandie and your supervisor as soon as you encounter a challenge preventing you from meeting a deadline. This way, a plan can be developed for how the most optimal baseline data can still be achieved.

➢ STEP#5

Prepare for 6-month follow-up data collection

This Evaluation Protocol addressed only baseline data collection (Time Point 1), but *most* of this data will need to be collected again at Time Point 2. You don't need to worry about this now. As the 6-month Time Point approaches, Sandie will reach out to you and your supervisor to advise you what to do next. The process will feel very familiar, but with the addition of a few Satisfaction Surveys and without Background/Demographic Data.

A few final thoughts before you get started collecting data…

It will feel like you're collecting a lot of data up front… because you will be! Unfortunately, there's no way around that. The good news is, once the initial data is collected with each of your participating teachers, you will have a 6-month period before you will need to collect data again with that teacher. To sum up, you'll have a lot of evaluation things to do now, and then again in 6 months.

You will need to get comfortable explaining the evaluation to others and asking for their buy-in. If the evaluation feels foreign to you, imagine how it must feel for center

directors, teachers, and parents! To get help with this, please speak with your supervisor, Sandie, and reference the "Talking Points" Document in Dropbox.

If you've been doing consultation for a while (or even if you're new), integrating the evaluation into your service delivery might feel uncomfortable at first. Consultants are always juggling a multitude of competing priorities, and it will be tempting to feel like the evaluation is "just one more thing you need to do". The good news is, your leadership team, in partnership with Indigo Cultural Center, has very thoughtfully crafted an evaluation that is ultimately intended to add a lot of value to your time with teachers and administrators, not detract from your end goal.

EVALUATION TIMELINE SUMMARY

During meetings 1-2 with your Director/Administrator:	
DISCUSS	…The purpose and process of the Evaluation …The time commitment required …The consent forms (Director, Teacher, and Parent)
IDENTIFY	✓ Focus Teachers (who will participate in evaluation) ✓ Focus Children* (who will be the subject of discussion for the evaluation; *ONE per classroom)
DETERMINE	➢ A plan for gaining teacher buy-in along with scheduling focused time to complete evaluation measures ➢ A plan for explaining the evaluation to parents of focus child(ren), and asking for their signed consent
COMPLETE	☐ Director Consent Form ☐ Program Background Information ☐ Director Background Information ☐ Director Self-Efficacy

During meetings 1-2 with EACH of your Teachers:	
DISCUSS	…The purpose and process of the Evaluation …The time commitment required …The consent forms (Director, Teacher, and Parent)
IDENTIFY	✓ Focus Children (who will be the subject of discussion for the evaluation; *ONE per classroom)

DETERMINE	➢ A mutually convenient time to complete evaluation measures and PMHCS ➢ A plan for explaining the evaluation to parents of focus child and asking for their signed consent (If not already determined)
COMPLETE	☐ Teacher Consent Form ☐ Teacher Background Information ☐ Teacher Self-Efficacy ☐ Parent Consent Form * ☐ DECA (Devereux Early Childhood Assessment) * ☐ Challenging Behavior Survey * **if needed, these documents can be completed in visits 2-4*

YOUR EVALUATION TEAM

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We are here to help you! Evaluations can be intimidating, especially to those newer to data collection, but we want you to know that you are not alone in this process. You have the support of our team as well as your program's leadership. We are here to guide you and answer all the questions that come up during this evaluation process. In this document, we have outlined our objectives and the steps you will need to complete to collect the data we need.