Infant-Early Childhood Mental Health Consultation (IECMHC) Formative Evaluation Final Report

Child Care Aware of Washington

October 15, 2021

Prepared by The Athena Group in partnership with the Indigo Cultural Center

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EXECUTIVE SUMMARY

What is Infant-Early Childhood Mental Health Consultation?

Infant and early childhood mental health is sometimes called social and emotional health. IECMH partners mental health professionals with early learning professionals, teachers, and families to enhance their ability to provide care for young children. Key research-supported[1] goals include:

Research shows that IECMHC can

- ✓ **Increase** healthy social and emotional development among young children.
- ✓ **Strengthen** relationships among childcare staff, children, and families.
- ✓ **Improve** pro-social behaviors among children, and reduces child expulsions, particularly among boys of color.
- ✓ **Improve** classroom climate, enabling greater emphasis on quality instruction.
- ✓ **Reduce** teacher stress and decrease staff turnover.

- Strengthen the efforts of families, childcare providers, and early childhood systems to support the healthy social and emotional development of all children.
- Prevent, identify, and reduce the impact of mental health challenges for children and families.
- Improve ability of providers, teachers, and families to manage challenging behaviors, address racial disparity issues, and reduce suspensions and expulsions.

In 2017, under direction of the Washington State Legislature, the Department of Children, Youth, and Families (DCYF) began planning for a statewide expansion of Infant and Early Childhood Mental Health Consultation. In 2019, the legislature funded a new state supported IECMH Consultation services to be implemented by DCYF in partnership with Child Care Aware of Washington (CCA of WA).[2] Six Mental Health Consultants were funded, one for each DCYF region. In April 2021, the Federal Preschool Development Grant funded three additional MHC

Evaluation Scope: The purpose of this formative program evaluation was to assess the design and implementation of the IECMHC program through its first year, inform efforts to build scalable practices as the program expands across the state, and identify early successes that support positive and equitable long-term outcomes for the social-emotional health of children, families, and the child care providers who serve them. The evaluation employed developmental evaluation methods and participatory strategies to engage key stakeholders, closely involve the IECMHC team in interpreting results, and apply an equity lens in data collection and research.

[1] Source: Center of Excellence for Infant and Early Childhood Mental Health Consultation. (2020). The Evidence Base for Infant and Early Childhood Mental Health Consultation (IECMHC). http://www.iecmhc.org/documents/CoE-Evidence-Synthesis.pdf

[2] Senate Bill 5903, Section 7

positions, and in May 2021, the Washington State Fair Start Act for Kids passed, which provided funding for the Program Director, a new Supervisor position to assist with program planning and administration, and six additional MHCs.

What is the need for IECMHC in Child Care Settings?

- Across Washington State, there are approximately 160,000 children enrolled in licensed child care and exempt school-age programs.[3] These children spend a **significant portion of their day in care, where they develop critical developmental social and emotional skills** through age-appropriate play and learning.
- **Families and children who experience a high level of stress and trauma,** as well as those with higher early childhood developmental and learning needs, have few resources to turn to and **rely on child care programs** to support their children.

PROGRAM DEVELOPMENT HIGHLIGHTS

- ✓ Director and a total of 8 MHCs have been hired across 5 regions. The 6th region is contracting with a part-time MHC to provide services until a permanent MHC is hired.
- ✓ 3 new positions funded by the Federal PDG grant have been filled, all with bilingual, multi-cultural consultants.
- ✓ Recruitment is underway for 6 additional MHCs and a statewide supervisor funded by the Fair Start Act.
- ✓ Implementation guidance and protocols for the MHC team are fully developed.
- ✓ Case management and referral systems are operational and undergoing continuing refinement.
- ✓ MHCs are engaged in ongoing professional development training and certifications, both as a group and to meet individual workforce development goals.
- ✓ Collaboration and development of referral practices between MHCs and Coaches continues to develop and expand.

- Evaluation results show high needs among families and children in **foster care** and the **child welfare** system, who lack **access to health insurance**, and live in **remote or economically marginalized** communities.
- Both Providers and Coaches need help to support teachers and children around **challenging behaviors, supporting adult wellbeing and emotional regulation, identifying expulsion risks,** and supporting providers with **more behavioral and developmental screenings**
- Relatively **few providers notify their Coach or ask for help before expelling a child**. A majority of Early Achievers **Coaches indicated they need more training or supports to coach providers** on this topic.

[3] CCA of WA State Data Sheet)

- Many **Providers feel unprepared to support and engage families** in problem solving around challenging behaviors, which almost always have underlying systemic causes.

Service Delivery Highlights

July 2020 – June 2021

177 Provider Referrals for IECMHC support (individual providers)

105 Child care sites receiving MH Consultation

12,544 Children (licensed capacity) at programs that have received IECMHC services

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

300+ MHC referrals for external community based services for children and families

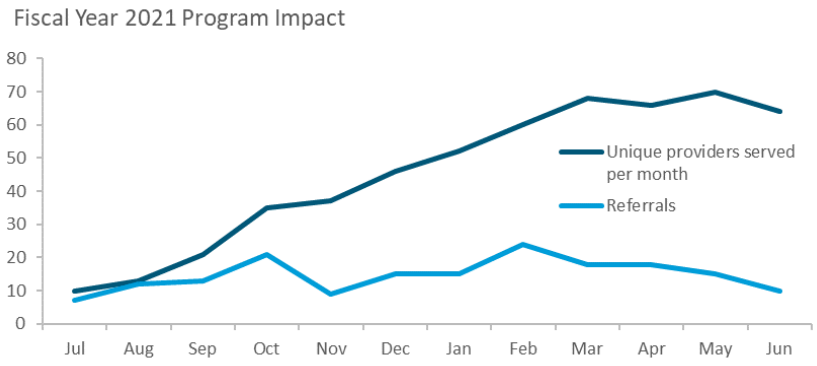
100+ outside referrals for childcare directors/teachers

Source: IECMHC program database.

Early Success and Outcomes

CCA of WA was able to quickly and fully launch the IECMH Consultation Program and begin providing direct services, especially given that the program was initiated just at the onset of the Covid-19 pandemic. The Director's depth and breadth of experience in infant-early childhood mental health consultation enabled development of a clear vision and plan for both program design and operations that enabled the program to hit the ground running. CCA of WA's strong existing relationship and well-established service delivery network with its regional partners facilitated the timely onboarding of qualified Mental Health Consultants (MHCs) in five of the six regions.

IECMHC Referrals have remained steady during the year, while the total number of providers reached continues to climb.



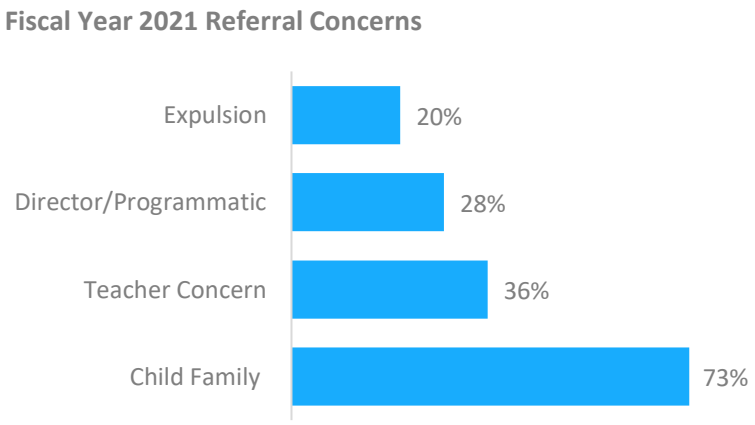
The program quickly grew and by the end of the year responded to referrals from 177 child care providers who serve a total of 12,544 children in their child care programs. Although individual focus children are identified at many programs, the impact of consultation often reaches all children in care, as consultants work at both the programmatic and classroom levels. As new mental health consultants are hired and trained, there is an opportunity for this program to reach even more of Washington State's licensed child care providers and children. Understanding of IECMH Consultation has increased among providers and regional staff, and with additional consultant staff, the program expects to see increased referrals and cases.

> **"There are tons of strengths to this program! Our MHC has been a tremendous asset and has been an important connector between programs, families, Coach, and external specialists."**
>
> – Regional Coordinator

MH Consultation is addressing concerns at program, teacher, and family/child levels

Over the full 2021 fiscal year, 20 percent of providers indicated that expulsion was a risk at the time of referral, which is consistent with feedback shared by the MHCs and in the regional interviews. According to the MHC team, expulsion is a risk in even more cases, even when providers don't indicate that at the time of referral.

Referrals can include multiple underlying concerns



Enhanced workforce development, staffing, and infrastructure. An important success this year was the funding to hire nine additional MHCs as well as a new Supervisor to support the work of the Director. The staffing increases will help address infrastructure-related concerns identified in the evaluation around the capacity of the IECMHC to achieve its intended impact, and the initial limited amount of funding provided for program supervisions and indirect supports. The new staff included three bilingual/multicultural positions, one to serve Spanish-speaking providers statewide and two multilingual MHCs for the King-Pierce region, helping to meet the IECMHC program goal to develop a culturally diverse workforce that matches the communities served.

> **"Within 2 months, there are hardly any concerning behaviors…and the conversations with the family are more about support sustaining their own stress level in order to be present for the child. Due to the child's progress, the stress and concern around the child needing additional outside services has decreased at this time."**
>
> – Mental Health Consultant, Olympic Peninsula

Family Success Story

"My husband and I have been working with a mental health consultant from the holding hope program for nearly a year. We have been so thankful for this program! It has been incredibly helpful in developing intervention plans for our child's withholding challenges at preschool and any other behavioral questions we have. All of the strategies have helped us feel more successful as parents in helping our child to overcome his fears and the behavioral challenges that come with his tummy hurting at preschool. Her suggestions have also helped his daycare provider to understand his struggles and strategies to try. This is a wonderful program for families!!"

There are emerging and compelling IECMHC research and evaluation findings that demonstrate the impact of IECMHC on closing racialized gaps and promoting greater cultural responsiveness with Black, Indigenous, and children of color.[4] Continuing to center a racial equity orientation to Washington State's IECMHC infrastructure and model delivery, as the program is now doing, can help disrupt bias and perhaps even prevent young Black, Indigenous, and other children of color from entering into the preschool to prison' pipeline (Meek & Gilliam, 2016). One highly recommended strategy is to drastically increase the diversity of the IECMHC workforce – including supervisors and leadership.

Positive Regional Response. Evaluator engagement with regional leaders and staff showed a high level of satisfaction with the IECMHC services provided. MHC support of child care programs, and especially their ability to connect teachers, families, and children, is starting to fill a crucial gap. MHCs have also been a valuable consultative resource for Coaches who are unsure what to do, what a provider/teacher's needs are, and if a referral is warranted. Regional leaders say that many more MHCs are needed to meet the needs of providers and families.

Early Achievers Coaches highly value the expertise of MHCs, especially the focus of the IECMHC program on The Teaching Pyramid model, which some see as the foundation of quality improvement work and reducing expulsion. Many also appreciate the Beyond Behaviors book studies with their MHCs, as well as the clarity of the strategies of the Conscious Discipline training they have received.

Challenges and Opportunities

Recruitment Challenges. The Central Region continues to experience barriers to hiring a permanent MHC who meets the professional requirements as well as the racial, cultural, and linguistic requirements (Spanish fluency) needed for this position to be accessible and effective. The region has contracted with a LCSW part-time to temporarily provide MHC services until a permanent MHC is hired, however, only a few referrals have been submitted. The Region's child care providers remain largely

[4] (Albritton, Mathews, & Anhalt, 2019; Davis, Shivers, & Perry, 2018; Shivers, Farago & Gal-Szabo, 2021; Silverman & Hutchinson, 2019).

without IECMHC services, which is inequitable, given that the other regions have been serving their providers for over a year. Providers in the Central region are unique in terms of its high Hispanic/Latino(a) population and percentage of FCC providers (approximately 80 percent), which raises additional concerns around the racial and cultural equity of IECMHC services in the region. A newly hired statewide Spanish speaking MHC is focusing outreach efforts in the Central region to try to fill the gap in the interim as recruitment continues.

Capacity to meet needs. The additional MHC staffing will increase the capacity of the program to serve providers; however, given that an MHC conducting on-site consultation will typically carry a caseload of about 10 cases at a time, the need still far outstrips the demand. Significant additional MHC funding and resources are needed if the program is to grow to meet recommended ratios and caseloads, and if it is to equitably reach providers with higher needs in marginalized communities.

Additionally, the ongoing pandemic is hampering the ability of MHCs to provide consultation as effectively as possible. Relying on provider descriptions of behavior and situations limits the ability to understand situations, as complex dynamics often cannot be understood virtually. Coaches, as the key source of referrals, also are less able to determine if referrals are needed. Offering on-site observations with Coaches and MHCs as soon as possible will help more effectively identify and respond to provider needs.

"Such an incredible program! (MHC) has been an answer to our dreams!"

– Center Director, Olympic Region

"…most importantly, (MHC) acknowledged me and helped me to realize if I'm not "healthy" my program won't be. That my feelings matter."

– Family Child Care Provider Olympic Region

Program Priorities and Referral Systems. Early Achievers Coaches are the primary source of referrals at this time, and as the program rolled out, the primary goal was to build knowledge of IECMHC, information on when to refer, and develop the referrals system software infrastructure. Because caseloads were initially low and all consultation has been virtual (until recently), the referrals are generally accepted by MHCs as they come in on a first-come, first-served basis, without prioritization. Also, in most regions, certain Coaches are working closely with MHCs, while other Coaches are not yet referring providers. Our interviews revealed that some Coaches may not understand what IECMHC services can offer, how to submit referrals, how collaboration between Coaches-MHCs should work, or how their skills differ from MHCs'. The result is that actively-involved Coaches (and the providers they serve) are receiving more direct access to the IECMHC program than other providers. This uneven distribution of referral sources raises the risk of creating an inequitable referral system and highlights the need for the IECMHC team to continue engaging the Regions and Coach workforce on IECMHC services, and how MHC-Coach Collaboration can work. It also highlights the need for CCA of WA to develop program priorities and strategies to guide how referrals and cases are accepted. Work has already begun on this task through evaluation research and analysis to better define community-based regional needs, and conversation with the IECMHC program director around defining program priorities.

> **"We need to build opportunity for providers to access the program and be equitable. What is the process to ensure we're reaching high needs' programs? For B3QI we used to get a list of risk factors. At least it was a starting point."**
>
> – Eastern Region Supervisor

Developing an integrated system of MHC-Coach collaboration. Evaluation research and analysis identified a need to more clearly define how to integrate MHC with Coaching practice, determine where the two intersect, and how the two roles can best work together to support the IECMHC program, providers, and children in their care. One of the ideas raised by the Regions, Mental Health Consultants, and members of the Evaluation Advisory Group included working with DCYF-Early Achievers, CCA of WA and the Regions to develop tiers or levels of supports for providers on social-emotional health, behaviors, racial equity, and family engagement. This would include:

- Foundational training and skill development for all Early Achievers providers;
- Coaching services for providers around the foundational training and skills, as well as specific assistance implementing preventive tools such as behavioral health screening tools and others recommended by MHCs;
- Referrals to MHCs for more advanced needs that are "higher on the Pyramid" and/or require Consultation around the full

> **"This is the real change we're looking for!"**
>
> – Early Achievers Coach, Eastern Region

IECMHC model (Director/Program, Teacher/Classroom, and Child/Family); and

- Leverage coach support for longer-term implementation of skills, classroom changes, and/or training after MHC engagement.

Child care workforce. Additionally, the economic stressors experienced by the child care workforce, already high before the COVID-19 pandemic, are even higher now. MHCs and Coaches report that Providers are struggling with basic needs. This level of stress can have a significant and negative impact on all aspects of early childhood mental health, including child behavior, provider/family relationships, emotional dysregulation, reduced resiliency, and increased expulsions. Significant investments are needed at the state level to enhance workforce stability and financial security for these vital professionals. This is necessary to support the ability of all child care providers to provide quality care and to support the social emotional health of all children.

> **"Having a statewide cohort of Mental Health Consultants was brilliant. Behavioral health was not my background, and this gives me and our Consultant important support."**
>
> – Regional Coordinator

Conclusions and Recommendations

CCA of WA and the IECMHC program team successfully developed, staffed, and rolled out the program in five regions across the state, despite the immense amount of pivoting that had to occur due to the pandemic. They have thoughtfully and effectively created and established foundational design and operational elements that are crucial to the development of a sound program and thoroughly aligned with recommended professional practices. Feedback about IECMHC services from CCA of WA's regional partners and participating child care providers is highly positive and promising. It is clear that the additional MHC staff funded and hired this year are much needed and will likely generate similar results and successes across the state.

This evaluation makes recommendations to CCA of WA and its partners in the following areas.

- **Develop priorities and strategies for delivering IECMHC services**
- Continue to refine **Coach and provider referral systems.**
- Further **clarify MHC-Coach collaboration practices** and develop an integrated system of supports for providers.
- Continue to provide leadership and support around **integrating an equity lens i**nto MHC staff professional development and provision of IECMHC services to providers and families.

INTRODUCTION

Background

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

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

- Improves teacher-child interactions and the overall quality of the classroom climate for all children.
- Results in the reduction of teacher-reported behavioral problems.
- Improves pro-social behaviors among children, and reduces child expulsions, particularly among boys of color.
- Decreases teacher stress, lowers rates of teacher turnover, and reduces the time families miss work.[5]

In 2017, under direction of the Washington State Legislature, the Department of Children, Youth, and Families (DCYF) began planning for a statewide expansion of Infant and Early Childhood Mental Health Consultation. In 2019, the legislature provided funding for new state supported IECMH Consultation services to be implemented by DCYF in partnership with Child Care Aware of Washington (CCA of WA).[6] Funding was made available for six Mental Health Consultants, one for each DCYF region. Because funding was not provided for a Program Director, the Perigee Fund provided one year of financial support for this position (as well as funding for this formative program evaluation). Funds were also not available for infrastructure and program administration development, and CCA of WA absorbed these costs. In April 2021, DCYF and CCA of WA received funding for three additional MHC positions through the Federal Preschool Development Grant. Additionally, in May 2021, the Washington State Fair Start Act for Kids passed, which provided

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

[6] Senate Bill 5903, Section 7

funding for the Program Director, a new Supervisor position to assist with program planning and administration, and six additional MHCs. In February 2021, the program was officially named Holding Hope.

Evaluation Scope and Methodology

This formative evaluation was intended to support and inform development of the IECMHC program through its first year by providing evaluative information on program design and implementation. The goal of the evaluation was to help point the way towards building a sound program foundation, systems that are scalable as the program grows, and practices to support achievement of program goals and long term outcomes for the social-emotional health of children, families, and the child care providers who serve them.

Additionally, the results of this evaluation are intended to inform the efforts of CCA of WA, the Washington State Department of Children, Youth, and Families, and community partners to effectively develop and scale high quality IECMH Consultation for child care providers across Washington State.

The evaluators were asked to address a number of questions related to program development, rollout and early implementation, and initial results, including the following:

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

To provide a framework for the research, the evaluation team applied the Four Essential Building Blocks for designing an IECMHC program that were developed by the Center of Excellence for IECMHC at Georgetown University.[7] Sound development of these four foundational program components will help ensure the program's purpose, target population, and services are well defined, and that the structures, systems, personnel, and funding necessary to support effective program operations are identified.

[7] Designing an IECMHC Program: Four Essential Building Blocks

Eligibility describes the population the program serves, and is determined by defining the target population, geographic reach, and service delivery setting.

Service Design describes how the program delivers IECMHC services; it includes service dose, consultant capacity, and service access.

Workforce describes the preparation and support required to be a consultant, including training, qualifications, and reflective supervision.

Infrastructure describes the support mechanisms that must be in place to implement an IECMHC program, including a theory of change, a logic model, a service organization, policies and procedures, and a manual.

The evaluation employed developmental evaluation methods and participatory strategies to ensure that the information and research generated was iteratively shared with and used by CCA of WA and the MHC team, stakeholders were included, and that an equity lens was closely integrated with the data collection and research. In addition to formative program elements, the evaluation supported capacity building within the IECMHC program to monitor and report on participant impacts and outcomes.

These methods included:

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

Key Learnings from the mid-year Interim Report

An Interim Evaluation Report was completed on March 1, 2021 that assessed program development activities from May 2020 through February 2021. The purpose of the report was to provide an update on program implementation including information on program development, share the results of a needs assessment for IECMH consultation services, and report on services

delivered and early program outcomes. Also included in the report were the results of a literature review on IECMH Consultation evaluation practices and outcomes.

The evaluation team analyzed the data collected from the needs assessment, and MHC interviews and conversations and concluded that the following program development efforts would benefit from additional focus and ongoing evaluation: Internal program structures and systems for supervision; case management and data collection; framework for referrals and MHC-Coach collaboration; efforts to ensure program is effectively and equitably reaching the target population; MHC team consideration of how to return to onsite consultation following the pandemic; and development and initial testing of outcome assessment tools.

Key learnings and conclusions from the report and subsequent conversations with the MHC Program Team and Evaluation Advisory Group included:

- Providers and Coaches need help to more effectively support classrooms and children around **challenging behaviors, support adult wellbeing and emotional regulation, identify when there is a risk of expulsion, and support providers to conduct behavioral and developmental screenings.**
- **MH Consultants**: "**Challenging child behaviors**" almost always have underlying systemic causes – trauma, stress, or developmental concerns – or indicate more support is needed for the teacher.
- High number of Coaches report that **few providers notify their Coach or ask for help before expelling a child.**
- Many **providers feel unprepared to support and engage families** in problem solving around challenging behaviors, and a majority of **Coaches indicated they need additional training or supports in order to coach providers** on this topic.
- Some excellent collaboration and **teaming are occurring between Consultants and Coaches**. MH Consultants believe **partnering with Coaches has the potential to strengthen** MH Consultation and reach more providers/children in-need.
- Advisory Group suggested that more work could be done to **clarify and strengthen** the Coach & MHC **partnership** and roles.

Coach-MHC Collaboration

It's important to note that the Washington IECMHC program model is unique from other IECMHC models across the country, in that Early Achievers Coaches are an intentional component of program delivery. At this time, Coaches are the primary individuals responsible for determining when providers on their caseloads would benefit from mental health consultation and are the primary source of referrals. MHCs are engaging with Coaches and Coaches are collaborating to help support MH consultation efforts. Because there are no program models around the country that are directly comparable, CCA of WA, the IECMHC program Director, MHC Consultants, and regional program partners are in the process of developing and refining this model as the program

is implemented. To provide an initial foundation for this work, the evaluation team used Logic-Modeling and Theory of Change workshops during the first half of the year to develop clarity around:

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

The Interim Report also found that additional clarity is needed for Consultants and Coaches around Coach-MHC referrals and ongoing collaboration, and the role that coaching is intended to play in the program Theory of Change.

Evaluation Focus for second half of evaluation

The evaluators worked with the MHC director to identify the most pressing program development matters and determined that evaluation efforts during the second half of the year would focus on the following four areas:

1. Developing additional clarity around the roles of MHCs and Coaches, researching successful collaboration practices, and identifying opportunities to strengthen Consultant-Coach referral and collaboration practices.
2. Assessing referral and Coach collaboration practices to help ensure the program is reaching higher needs providers, support providers around social-emotional health, and help prevent expulsions and disproportionality.
3. Engaging the Regions to develop a clearer understanding of IECMHC needs across the state.
4. Development of outcome assessment tools to assess the experiences of those interacting with the MHC program (providers/teachers, coaches, and regional leadership), to track early successes and longer-term results, and lay the groundwork for a future outcomes evaluation.

PROGRAM DEVELOPMENT PROGRESS AND RESULTS

Staffing and Hiring

CCA of WA was able to fully launch the IECMH Consultation Program and begin providing direct services within a short period of time, especially given that the program was initiated at the onset of the COVID-19 pandemic. CCA of WA hired the IECMHC program Director in March 2020. The Director's depth and breadth of experience in infant-early childhood mental health consultation enabled development of a clear vision and plan for both program design and operations that enabled the program to hit the ground running. Additionally, CCA of WA's strong existing relationships and well-established service delivery network with its regional partners facilitated the timely onboarding of qualified Mental Health Consultants (MHCs) in five of the six regions.

PROGRAM DEVELOPMENT HIGHLIGHTS

- ✓ Director and a total of 8 MHCs have been hired across 5 regions. The 6th region is contracting with a part-time MHC to provide services until a permanent MHC is hired.
- ✓ 3 new positions funded by the Federal PDG grant have been filled, all with bilingual, multi-cultural cultural consultants.
- ✓ Recruitment is underway for 6 additional MHCs and a statewide supervisor funded by the Fair Start Act.
- ✓ Implementation guidance and protocols for the MHC team are fully developed.
- ✓ Case management and referral systems are operational and undergoing continuing refinement.
- ✓ MHCs are engaged in ongoing professional development training and certifications, both as a group and to meet individual workforce development goals.
- ✓ Collaboration and development of referral practices between MHCs and Coaches continues to develop and expand.

During March of 2021, CCA of WA received a contract amendment from DCYF allowing for the hire of three additional MHCs funded by the federal Preschool Development Grant (PDG). The CCA of WA Member Council and network staff considered various options for placement of these new MHCs, based on population and community needs. They agreed, in collaboration with DCYF, that one bilingual Spanish-speaking MHC should be hired at the CCA of WA network office to serve monolingual Spanish speaking providers statewide, in collaboration with Coaches and MHCs in the regions. They also agreed that the other 2 MHCs should be placed in Pierce and King Counties, given that 48 percent of the state's child care providers are located in that region. All three MHC positions were filled by the end of April 2021, all of whom are bilingual and multi-cultural. This success helps the IECMHC program support its goal to be able to provide culturally and linguistically relevant mental health consultation to the state's diverse providers. Washington State's Fair Start Act for Families, passed in April 2021, funded six additional MHC positions, allowing for an additional MHC in each of the six DCYF regions in the state.

The Central Region continues to experience barriers to hiring a permanent MHC who meets the professional requirements as well as the cultural relevancy needs for this position. Catholic Charities of Central Washington contracted with an experienced LCSW part-time to temporarily provide MHC services until a permanent MHC is hired; however, as of this report's writing the position has not yet been filled. A newly hired statewide Spanish speaking MHC is focusing outreach efforts in the Central region to try to fill the gap in the interim as recruitment continues.

Consultation to Providers

Consultation for child care providers is the core of the IECMHC program. The MHC team offered increasing amounts and depth of provider consultation during their first year of operation, even with significant pandemic related challenges and while building a system and hiring and training new staff. The program developed a waitlist system but has had to refer few providers to the waitlist. This is due to several factors, including:

Service Delivery Highlights

July 2020 – June 2021

177 Provider Referrals for IECMHC support (individual providers)

105 Child care sites receiving MH Consultation

12,544 Children at programs with IECMHC services (licensed capacity)

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

300+ MHC referrals for external community based services for children and families

100+ outside referrals for child care directors/teachers

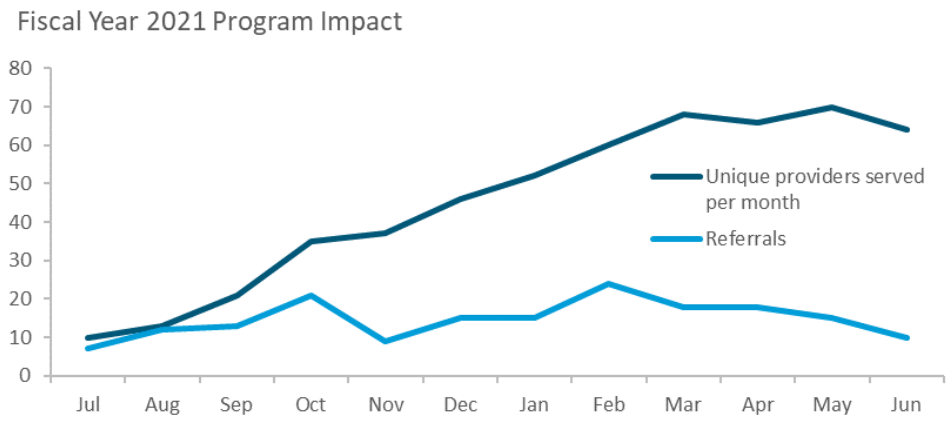
- Focus on basic needs and closure-related issues during the early months of the COVID-19 pandemic.
- Outreach and engagement limitations, given the need to engage virtually.
- Higher provider workloads due to staffing shortages and daily cleaning needs.

Overall, in the first year of operation, the program responded to referrals from 177 providers who serve a total of 12,544 children in their child care programs. Although individual focus children are identified at many programs, the impact of consultation often reaches all children in care, as consultants work at both the programmatic and classroom levels. As new mental health consultants are hired and trained, there is an opportunity for this program to reach even more of Washington State's child care providers and children. Challenges to reaching providers include those with the provider workforce, also detailed in this report, as well as limited IECMHC program capacity.

The chart below shows the expanding impact and numbers of providers reached by the IECMHC Program. Referrals remain flat because of relatively steady MHC capacity through this fiscal year. Provider availability and engagement may be lower during the summer months when families and staff take vacations or as a result of other seasonal provider programming changes. Understanding of IECMH Consultation has increased among providers and regional staff, and with additional consultant staff, the program expects to see increased referrals in the new fiscal year. Even with

relatively flat referrals, the number of providers served each month has increased, as consultants work with providers as long as needed to resolve specific issues and build capacity to respond to future needs. The program can expect to serve increasing numbers of providers each month as staff capacity grows.

Exhibit 1
IECMHC referrals have remained steady during the year, while the total number of providers reached continues to climb.



Source: July 30, 2021, MHC Program Report

Program Activity Detail

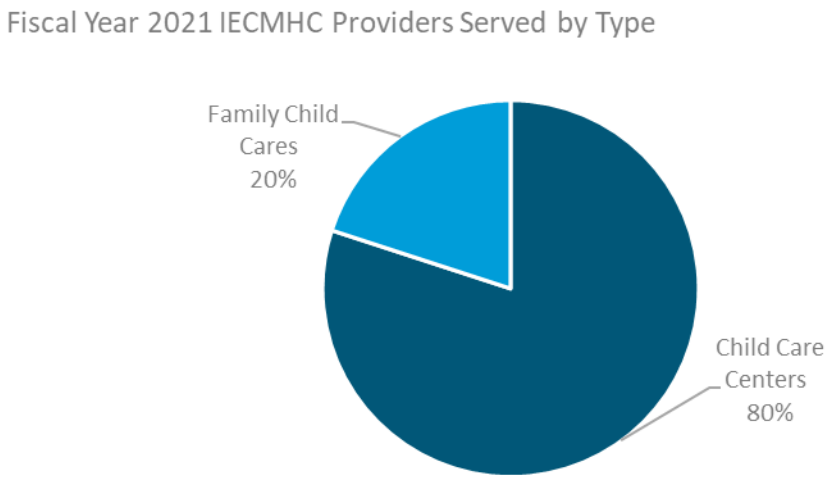
Types of Providers Served

Continuing a pattern we observed in the Interim Report, most providers served through the IECMHC program are Child Care Centers rather than Family Child Care (FCC) programs. Insights from interviews with regional supervisors and Coaches, as well as the MHC team, indicate there could be several reasons for this, including:

- The much higher number of teachers and children who are in Centers versus FCCs means that more referrals will naturally be for Centers.
- Successful consultations with currently-served Center Directors and teachers are frequently generating additional interest and new referrals at the same site and other sites under the same ownership.
- In most regions there are certain Coaches who are working the closest with their MHCs, while other Coaches are still gradually learning about IECMHC and how, when, and why to access their region's Consultant. Some of these Coaches work predominantly with Centers, which means additional Coach referrals will also be for Centers.
- FCC owners may be more hesitant to bring a professional or unknown adult into their family home, especially with a limited understanding of this new program and stigma around the term "mental health." This is especially true for FCC owners from other cultures.

- About 80 percent of providers in the Central Region are FCCs, however, the region has not yet hired a permanent MHC. Once an MHC is onboard, it is anticipated that the number of FCCs served will increase.

Exhibit 2
Most providers served by the IECMHC program are Child Care Centers



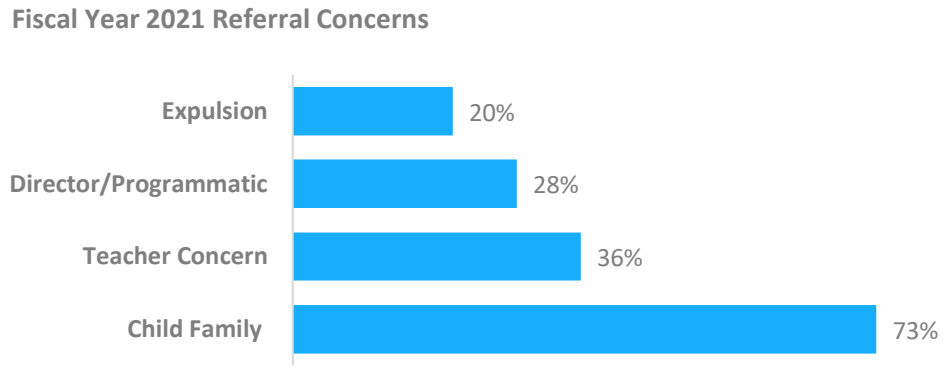
Source: July 30, 2021, MHC Program Report

Primary Concern at Time of Referral

The chart below indicates the primary concerns indicated at the time of referral to IECMHC services. There can be multiple primary concerns for referrals, so a referral with a concern about a specific child could also include a teacher concern and/or expulsion risk, for example. Over the full 2021 fiscal year, 20 percent of providers indicated that expulsion was a risk at the time of referral, which is consistent with feedback shared by the MHCs and in the regional interviews. According to the MHC team, expulsion is a risk in additional cases, even when providers don't indicate that at the time of referral. In these cases, providers have already taken steps that may include reducing a child's hours, sending a child home for behavior reasons, and/or instituting a "behavior plan" indicating that another incident will result in dismissal from care, etc. MHCs report that they often receive referrals from providers who have already determined that they can't maintain a particular child any longer and are not willing to take steps to engage the family and develop a support plan. In these cases, consultants focus on working to support providers and families to promote therapeutic transitions for children to other programs that can provide needed supports, and to support the referred provider with the goal of preventing future expulsions.

As illustrated in Exhibit 3, the most common referral concern is for a child or family (73 percent). This aligns with reports from MHCs in team meetings, our regional interviews, conversations with Coaches, and data from the needs assessment, which all indicated that the primary reason for initial referrals is "challenging behaviors." Once consultation begins, however, the Consultants usually uncover multiple underlying concerns that can include the adults, including Directors, teachers, and families.

Exhibit 3
Referrals can include multiple underlying concerns

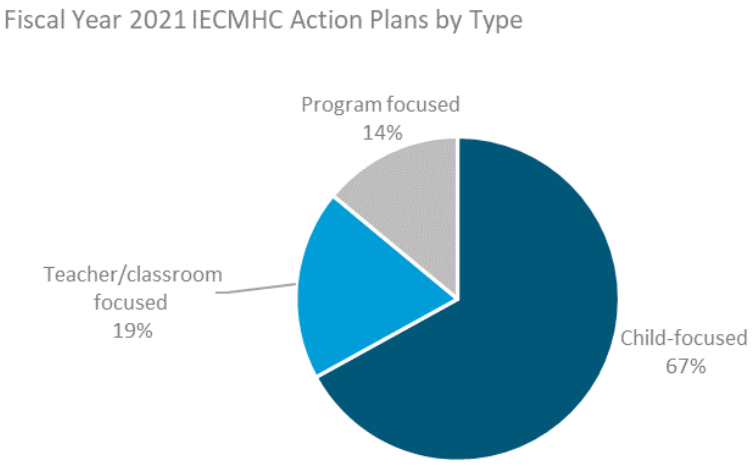


Source: July 30, 2021, MHC Program Report
Note: Numbers do not add up to 100% because there can be multiple concerns within individual referrals.

Action Plan Focus

IECMH Consultation for providers can be focused on classroom, program, and/or child levels. While there is a primary focus for each action plan, consultants often work at multiple levels, building capacity to address current concerns as well as improving relationships and classroom climate beyond what is addressed directly in the action plan and increasing the capacity of those engaged with consultation to respond to future challenges with more skill and confidence. It is not surprising that most IECMHC action plans are focused on a specific child. Often, challenges with a specific child are the first way providers, Coaches, and other regional staff think to engage a MH Consultant, and initial engagements often lead to broader, extended work with the Director, other children, and teachers.

Exhibit 4: IECMHC Action Plans are often focused on children



Source: July 30, 2021, MHC Program Report

"[MHC] can come in and see the needs of the teacher and the classroom. [MHC] communicates really well with me. Providers have shared their "aha!" moments with me. [MHC] really understands the social emotional needs of the teachers and children, which is really critical right now!"

- Coach, Southwest Region

Referrals by Region with Licensed Capacity

The number of IECMHC referrals are growing and differ between regions and staffing levels. In addition, each Region's unique provider and service system require different outreach, engagement, and support. For example, in King/Pierce, there are additional MH consultants available as well as a significantly higher number of providers than in other regions. As a result, King/Pierce consultation efforts to-date have focused more at the system level than other regions. The Central Region has not yet hired a full-time consultant, which explains its low referral numbers. In all Regions, the MHC is partnering with the B3QI (Birth to Three Quality Initiative) Coaches to share referrals based on B3QI eligibility, caseload, and geographic location.

Exhibit 5
IECMHC Referrals vary based on staffing and other resources within each Region

Fiscal Year 2021 Referrals by Region and Licensed Capacity		
Region	**Referrals for MHC**	**Total Licensed Capacity**
Central Washington	3	231
Eastern Washington	39	2,493
King/Pierce County	27	1,523
Northwest Washington	29	1,510
Olympic Peninsula	34	1,982
Southwest Washington	45	4,805
Total Washington State	**177**	**12,544**

Source: July 30, 2021, MHC Program Report

Program Activity for Fiscal Year 2021

Consultation to providers has continued to grow and deepen throughout Fiscal Year 2021, the first full year of operation for the IECMHC program in Washington State. Consultation program details for providers and for coaches are detailed below.

Exhibit 6
Cumulative MHC Program Activity, July 2020 through June 2021

MHC Activity		Total
Outreach and Initial Consultation for Providers	Referrals for MHC	177
	Total licensed capacity of referring providers	12,544
	MHC Consultation Total Sites Served	105
	Child Care Centers Served	*88*
	Family Child Cares Served	*17*
	MHC Waitlist	1
Action Plans	Total Action Plans	100
	Child-focused	*67*
	Teacher/classroom focused	*19*
	Program focused	*14*
	Child Care Centers	*80*
	Family Child Cares	*20*
Additional Provider Supports	External Referrals Made	439
	Child/family focused	*334*
	Teacher/director focused	*105*
Coach Consultation	Coach Contacts (duplicated count)	3,644
	Coach Consultation Hours[8]	663.40

Source: July 30, 2021, MHC Program Report and IECMHC Quarterly Reports submitted to DCYF

Program development successes

The Mental Health Consultants continue to engage in flexible, responsive, individualized, and proactive approaches toward meeting the needs of children, families, providers, and coaches during this time of extraordinary stress and challenge. Referrals are increasing, and caseloads are growing as MHC continues to be provided in a virtual environment, partnering with Coaches, B3QI

[8] Additional Coach consultation occurs during meetings and trainings with providers as well. These hours are tracked as provider consultation.

coaches, and others. Consultants are providing Individual and Group Virtual Consultation for providers and coaches on themes including: stress management, self-care, resilience, improving staff morale, understanding and managing challenging behavior, COVID-specific concerns, racial equity and anti-bias, trauma-informed approaches, reflective practice, grief and loss, domestic violence, ongoing complex trauma, supporting children/families in foster care, support for school-aged children with significant mental health needs, supporting children with sensory concerns and/or on the Autism spectrum, and support for children at-risk for expulsion. Some highlights include:

- Consultation has been provided regularly at some sites for long enough now that both providers and MHCs are noting significant improvements and progress, particularly with plans for individual children. Coaches are also expressing appreciation for being included in MHC conversations with providers and are noticing positive changes in classrooms.
- Consultants are supporting providers around managing emotional impact and transitions for children, families, and staff associated with staff illness, death and turnover, and temporary site closures due to positive COVID test results. Routines for many providers, children, and families have been significantly disrupted during this past year.
- Promoting family engagement and facilitating multi-disciplinary team meetings with providers around supporting children with challenging behaviors is occurring regularly, a service that was not available through CCA of WA and partner services prior to Holding Hope.
- As consultation has progressed, increased coordination with other service providers such as early intervention programs, school districts, regional therapists, child welfare caseworkers, and other community service providers.

Consultation Success Story

The MHC started supporting a provider with a child who just entered the foster care system and was experiencing difficulty in the classroom. MHC supported the provider and family in building a trusting relationship, creating safety, and considering the developmental and mental health needs of the child. The MHC introduced and supported the provider in implementing Trauma Informed Care Practices in her program. As a result, the child's relationship with the provider was strengthened along with the child's engagement in learning activities. In addition, the MHC and provider were also able to support the family in accessing speech therapy for the child's older brother while attending child care. Because of this successful experience, when an opportunity came to support another family (with 3 siblings all of whom had recently entered foster care) the provider was ready to support these children in her care. The MHC continues to work closely with the provider in building understanding and implementing Trauma Informed Care and the focusing on the importance of early relationship in children's lives.

MHC Workforce Development

The MHC areas of experience and expertise are consistent with the qualifications recommended for IECMH Consultation professionals by the Center of Excellence for IECMHC. All of the MHCs hired have advanced degrees and experience in providing mental health consultation or coaching in early childhood programs or Title 1 schools. They also have a range of experience in highly relevant areas including serving diverse populations, relationship-based therapy for young children and families, provision of IECMHC in Head Start settings, supervision of MHC teams, infant mental health specialization, mental health services embedded in First Nation communities, and trauma-informed approaches.

Professional Development

The MHC team continues to engage in self-study and group reflection on relevant readings and on-line trainings on the various competencies and guiding principles of IECMHC, and other relevant topics including attachment, trauma, reflective practice, professional ethics, virtual service delivery, and others. The MHCs have also received training organized by DCYF, Cultivate Learning, and others, as highlighted below:

- Trauma Informed Care pilot training offered by Cultivate Learning (20+ hours)
- Training and testing/certification in the CHILD (Climate of Healthy Interactions and Development) tool, provided by the Edward Zigler Center for Child Development at Yale University
- Inaugural IECMHC Annual Training Institute (facilitated by DCYF, and offered to MHCs and others across systems statewide)
    - What is IECMHC? How it works and who benefits – Kadija Johnston, LCSW, Georgetown University Center of Excellence for IECMHC
    - Foundational Elements of IECMHC: A deeper dive for practitioners of IECMHC – Kadija Johnston, LCSW, CoE for IECMHC
    - Evaluation for IECMH Consultation – Annie Davis, Ph.D., CoE for IECMHC
    - Introduction to Reflective Practice – WA Association of Infant Mental Health
    - Promoting Racial Equity and Disrupting Bias: The promise of IECMHC – Eva Marie Shivers, J.D., Ph.D., Indigo Cultural Center
    - Trauma-Informed IECMH Consultation: The Neurobiology of Trauma, Healing and Resilience – Bruce Perry, M.D., Ph.D.
- Coaching the Pyramid training offered by Cultivate Learning
- Reflective Supervision for Supervisors training with other CCA of WA system leaders – WA AIMH training and 6 months of WA AIMH facilitated reflective practice
- Two MHCs (King/Pierce and Northwest WA) concluded the ECHO training series offered through the Center of Excellence for IECMHC

- MHC serving Eastern WA continues in the Advanced Clinical Training in Infant Mental Health program through the Barnard Center at UW, a program which will run for 15 months
- Onboarding and professional development in the IECMHC model and service delivery for new staff (including self-study, team and individual support, shadowing other MHCs, etc.)

Reflective Supervision/Consultation practice

The MH Consultants each have a designated administrative supervisor within their regional hiring agencies, in most cases the Regional Coordinator, with whom they meet regularly. Consistent with the IECMHC model design, the IECMHC Director continues to provide regular individual and group Reflective Supervision/Consultation (RSC) to the statewide team of MHCs. Reflective Supervision and supporting MHC core competencies in reflective practice are a foundational element of Mental Health Consulting. *Reflective Supervision/Consultation is distinct from administrative and/or clinical supervision in that it includes shared exploration of the parallel process: attention to all of the relationships, including the ones between practitioner and consultant, practitioner and parent/teacher, and parent/teacher and child.* RSC for consultants provides them with a space to step back, process their work, develop reflective skills and consultation strategies. Other key objectives of RSC include:

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

The ongoing RSC continues to support deep reflective discussions and collaborative problem solving around complex casework with directors, teachers, children, and families, as well as the efforts to support Coaches in their work during this difficult time. The MHCs are supporting providers with the compounded stressors of the COVID-19 pandemic, in addition to the ongoing challenges experienced by the child care workforce, complex adult dynamics/concerns which impact care for children, ongoing complex trauma, supporting children with special needs in care, grief and loss, and concern for the well-being of child care providers.

Since the first quarter of program operations, March through July 2021, the IECMHC Director has provided a total of 271.85 direct hours of individual (180.35 hours) and group (91.5 hours) reflective supervision and professional development with the team of MHCs. In addition to the RSC provided at the Network level, MHCs are also receiving reflective supervision either within their agencies or through external Reflective Supervisors/Consultants. Several of the MHCs also lead or participate in regional peer Reflective Practice groups with other area mental health consultants and providers.

MHC Workforce Development Challenges

As discussed earlier, the Central region has experienced difficulty hiring a Mental Health Consultant who meets both the professional qualifications and also is a match with the racial, cultural, and linguistic requirements (Spanish fluency). These latter requirements are needed to ensure the position is culturally responsive, equitable, and effective. Several rounds of recruiting and interviewing yielded either unqualified applicants or candidates who dropped out of the process prior to coming on board. While current recruitment efforts (August 2021) appear promising, the Central region's child care providers remain largely without IECMHC services through CCA. This is a highly inequitable situation, especially given that the other five regions have been up and running and serving their providers for over a year. Additionally, providers in the Central region are unique in terms of its high Hispanic/Latino(a) population and percentage of FCC providers (approximately 80 percent), which raises concerns around the racial and cultural equity of IECMHC services in the region.

There are emerging and compelling IECMHC research and evaluation findings that demonstrate the impact of IECMHC on closing racialized gaps and promoting greater cultural responsiveness with Black, Indigenous, and children of color (Albritton, Mathews, & Anhalt, 2019; Davis, Shivers, & Perry, 2018; Shivers, Farago & Gal-Szabo, 2021; Silverman & Hutchinson, 2019). Specifically centering a racial equity orientation to Washington State's IECMHC infrastructure and model delivery can help ensure that the system makes every attempt to disrupt bias and perhaps even prevent young Black, Indigenous, and other children of color from entering into the 'preschool to prison' pipeline (Meek & Gilliam, 2016). One highly recommended strategy is to drastically increase the diversity of the IECMHC workforce – including supervisors and leadership (Davis, Shivers, & Perry, 2020; Shivers, Farago, & Gal-Szabo; Spielberger et al., 2021). See the Workforce Development: Opportunities section below for a more robust discussion of the relevant issues surrounding diversity and equity in IECMHC workforce development.

Regional Systems Building Efforts

MHCs in all regions continue to engage in intentional relationship building efforts both within their agencies and among Early Achievers staff, and also in their communities as they identify partners and additional resources to support children, families, and providers. Consultants have continued to join meetings and Professional Learning Communities (PLCs) of Coaches and providers to provide orientation to IECMHC, offer appropriate supports and reflection, and to identify providers who could benefit from further consultation. Examples of their systems-building efforts include:

- Developing agreements with mental health consultants from other agencies.
- Collaborating with B3QI and ECEAP to develop a more comprehensive approach to meeting the mental health needs of child care staff.
- Partnering with other regional staff to support book studies around racial equity and building anti-bias classrooms.

- Collaborating to explore barriers and ways to reduce the stigma associated with "mental health," such as re-framing IECMHC as "Holding Hope" consultation and as a resource for families to promote social/emotional learning and wellbeing in partnership with providers.
- Creating internal agency Behavioral/Mental Health Focus Group to strategize ways to organize resources for all coaching staff, as well as ways to move the work forward as a regional effort.

Program Delivery Challenges

As mentioned in the last report, the pandemic has highlighted the need for IECMH Consultation, and has presented some unique challenges as the program was launched and grew under these circumstances. Providers continue to experience stress with many complex issues including: the health and safety of children, staff, and families; financial sustainability and survival of their businesses; children with special needs in care; complex social-emotional needs for children, families, and providers themselves; and personal, community- and state-wide trauma and loss. The evaluators learned of many of these challenges through many conversations with the MHC team, some of which included:

- Providing MH consultation virtually limits the ability of Consultants to fully assess the concerns and understand child and provider needs and strengths. Consultants have to rely on self-reported descriptions of behaviors and classroom environments, which do not always reflect the full extent of the situation.
- Providers continue to have limited capacity to engage in virtual consultation due to other pressing demands, staff shortages and limited time that teachers can be freed from classroom responsibilities to engage with consultants. There has been an increase in provider no-shows, cancellations, and low responsiveness due primarily to staffing shortages. This is especially true for centers, which are experiencing extreme staff shortages.
- Some Coaches have limited capacity to partner with consultants to engage in joint collaborative consultation/coaching due to Coach caseloads and responsibilities.
- Some providers report a spike in concerning behaviors and regression among children, leading them to seek additional supports and strategies.
- Many children/families are not receiving the educational and therapeutic supports they received before the Pandemic, placing additional burdens on child care providers.
- Continued stress and pressures associated with supporting emotional needs of young school-aged children for whom on-line learning is not developmentally appropriate.
- Providers report increased stress, conflict, and tension among staff at sites with increased demands, reduced or erratic attendance, staff turnover, and temporary closures due to positive COVID test results.

- Many providers continue to have limited access to technology and internet access which impairs their ability to connect and participate effectively with the MHCs and Coaches.
- Compounded stressors associated with the pandemic and racial justice crisis, including unique, longstanding, and deep stressors for BIPOC staff, providers, and families.
- Ongoing significant stress and fatigue at all levels within the CCA of WA system, even as hopes grow for safely returning to on-site supports for providers in the future.

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

PROGRAM REFERRALS AND SYSTEMS

Understanding Provider and Coach Needs

During the first half of this project, the evaluation team conducted a needs assessment of IECMHC for the Interim Report, which was published in February 2021.[9] In addition to a landscape scan of the availability of IECMHC, the needs assessment included survey questions for both Providers and Coaches about IECMHC related needs, analysis of referral data, and interviews with the MH Consultants about the nature of the cases they are working on. Key highlights of the Needs Assessment include the following:

- Most common reason for referrals is "challenging behavior," but underlying causes are more complex, such as family and child trauma, involvement in foster care or child welfare systems, developmental delays, and systemic inequity, racism, and bias.
- Providers across the state are under a great deal of chronic stress and many are not able to be fully present to support their classrooms and children. This situation has only been heightened by the pandemic and the additional threats to their safety, wellbeing, and financial security. An "Effective Workforce" is the foundation of the Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children, and high stress levels unquestionably impact their effectiveness. This is a particular challenge in regions and communities with elevated risk factors.
- Providers need more training and supports around understanding behaviors, social, and emotional development.
- Coaches need more training and strategies so they can better support their Providers around challenging behaviors.
- Relatively few providers inform their Coaches or ask for help before expelling a child.
- Coaches want more information and skills to help address expulsions earlier rather than later, and to prevent disproportionate exclusionary treatment and expulsions

Additional questions raised

These early needs assessment findings gave rise to follow-up questions on the part of the MHC Program Team and the desire to collect more evaluative data and information in several areas. These included a desire to better understand:

1. Region-specific needs and who the higher needs providers are in each region;
2. What Coaches need in order to effectively identify the need for IECMHC services and collaborate with their MHC; and

[9] Full results of the Needs Assessment can be found in the Interim Report.

3. What would be needed to proactively address the issue of expulsion and related disproportionate exclusionary treatment of children of color.

Specific follow-up questions included:

- What are the Region-specific needs for IECMHC and other social-emotional supports? How are the different regions using their MHCs to meet the need?
- How are MHCs effectively collaborating with Coaches now and what does this look like? Can any of these practices be expanded upon and shared with other Regions?

> **"There are tons of strengths to this program! Our MHC has been a tremendous asset and has been an important connector between programs, families, Coaches, and external specialists."**
>
> – Regional Coordinator

- What do Coaches need in order to proactively engage and support providers around challenging behaviors and help prevent expulsions? How about addressing disproportionate treatment and inequities?
- How can the IECMHC program and referral system ensure that its services are fully and equitably accessible by the higher needs providers?

Refining referral systems and MHC-Coach collaboration

For the first six months after the program was launched in April – May 2020, program development naturally focused on hiring and onboarding a consultant in each region, developing the infrastructure, procedures and systems needed to support administration and consultation practice, providing information and outreach to Coaches on how to refer providers to their MHC, and establishing routine Consultation and case management practices in each region. Referrals were dependent on the Coaches submitting them and the relationships developing between the Consultants and Coaches in their regions, on a "first-come, first-served basis." Because referrals grew somewhat slowly and all Consultation has been online, there was little need for "triaging" cases or developing waiting lists. However, with growing referrals and caseloads, onboarding of new MHCs, and the start of in-person Consultation and the resulting need to reduce caseload sizes, questions arose from the MHC program team and Region staff about whether the program should have a more strategic needs- and equity-based approach to conducting outreach, prioritizing services, and building caseloads.

In April 2021, the evaluation team engaged the Advisory Group and the MHC team in conversations around current IECMHC outreach, early referral patterns, and case characteristics. These collaborative conversations generated questions around how to ensure equitable program access by higher needs and marginalized populations, what is needed to encourage more coaches to engage with their MHCs, and how to help ensure the systems are equitably reaching those in

need. The decision was made to engage the Regions to develop a clearer understanding of community-specific needs, so that the MHC Team in partnership with the regions can develop a more strategic community-informed approach to outreach and engagement, referral systems, and consultation services.

Regional Interviews

The evaluation team met with a combination of Regional Coordinators, Supervisors, and Coach Leads from each of the six regions. The purpose of these conversations was to engage the regions in a discussion of the specific needs they are seeing in their community of providers, Coach roles and collaboration with MHCs, and their ideas and recommendations for ongoing program development and systems-building.

Discussion of Provider Needs for IECMHC

All regional interviews emphasized that all providers are experiencing extreme workforce challenges including job insecurity, high turnover, inadequate pay and benefits, low job satisfaction, understaffed facilities, etc., which has only been compounded by the COVID-19 pandemic. This is universal and regions emphasized that all teachers need supports around fundamentals such as stress management and self-regulation. The regional conversations produced a number of similar themes around patterns or the characteristics of child care providers who have the greatest need for supports around child social-emotional wellbeing, behaviors, and development supports. The following provider characteristics were repeatedly identified:

- Serving children/families in **Foster Care** and the child welfare system who are experiencing underlying trauma.
- Serving children/families experiencing disruptions such as **homelessness/housing instability, substance abuse disorders, and divorce.**
- Serving lower income **families who lack health insurance** and do not have access to health care supports such as a pediatrician, regular developmental screening, or behavioral health resources for the family or child.
- Programs that are **geographically isolated** or in rural areas where there are fewer community resources.
- Programs with lower quality Early Achievers ratings **that have higher turnover, may lack a well-trained director and staff, and also have limited provider-family collaboration**, communication and cooperation.

Many of these provider and family factors are co-existing, and providers with the greatest needs are those who work in regions and communities with multiple underlying economic and social risk. Regions also shared evidence of what the field of IECMHC is already aware of: the challenges listed above compound each other to create environments where directors/owners and teachers are overwhelmed and have difficulty remaining grounded and self-regulated especially when faced with challenging behaviors they do not fully understand. They will often use reactive responses to

escalated behavior versus proactive behavior management strategies, and the result can be exclusionary treatment such as sending children home early or to the Director's office, suspension, and permanent expulsion, rather than leaning in to understand the underlying factors associated with behavior and to engage in problem solving around alternative strategies.

Research shows that disproportionate treatment based on race, ethnicity, gender, and other bias often occurs with youth of color experiencing expulsions and suspensions at higher rates, often leading to families of color being "disengaged" from early learning opportunities, delaying important early education experiences, and setting children on a "pipeline" to poor experiences with schooling. As discussed in the Interim Report and Literature Review (in Appendix B), one of the primary goals of IECMHC programs is to support child care providers around understanding and supporting "challenging behaviors" and adults' roles in these behaviors, and to prevent expulsions, particularly the disproportionate use for children of color.

> **"Expulsion is an adult behavior!"**
>
> – Regional Mental Health Consultant

Discussion of Referrals and Case Assignments

Our conversations with the Regions also revealed many similar approaches to referrals and case management, including:

- Referrals come mostly from Coaches, with a few coming directly from providers through word of mouth.
- Close collaboration is occurring between the MHCs and the regional B3QI/Infant-Toddler Consultation Coaches[10], often with division of caseload by age of classroom or child (with MHC taking cases for ages 4-5).
- Geographic coordination is also occurring. In counties that lack B3QI Coach funding, the MHC is providing coverage. Some B3QI county funding does not align with CCA of WA's regions so some cross-Region assistance is occurring on the part of MHCs.

MHC and Coach Collaboration

The evaluation team learned from conversations with the regions (confirmed by conversations with MHCs and Coaches) that most regions have a core group of Coaches who are working most closely with their MHC. Other Coaches are still learning about the program and the supports it provides and not yet submitting referrals. Regional Coordinators and Leads would like to develop more clarity around how the two roles intersect and complement each other. Coaches within regions and across the state also have differing levels of skills in supporting social-emotional health and

[10] The Infant Toddler Consultation program, or Birth-Three Quality Initiative, is funded by DCYF for Early Achievers sites that accept infants and toddlers on the Working Connections Child Care subsidy. Consultation is available to infant and/or toddler teachers in areas such as mental health support (behaviors), developmental screening, teacher-child interactions, and classroom environments.

providers around challenging behaviors, and Regional Coordinators and supervisors would like to develop more clarity around how Coaches can best support the program through identifying needs, submitting referrals, and supporting the provider during and after consultation.

Themes from Region conversations

The Region Coordinators and supervisors also had ideas and suggestions when asked what Providers and Coaches need to help build knowledge, skills, and capacity to support early childhood mental health. They shared that most Providers need **additional supports around positive, strengths-based approaches** to understanding social-emotional development, adult and child wellbeing, how to support children around challenging behaviors, trauma- and resilience-informed child care practices, and preventing expulsions. This feedback is supported by the survey results of Early Achievers Providers the evaluation team conducted in Fall 2020, which showed very high Provider need for and interest in these subjects. Previous Early Achievers surveys of Providers have consistently asked for more supports around "challenging behaviors," but this was the first time the evaluation survey included more detailed questions.

> **"We need a tiered level of supports…more supports for Providers prior to involvement of MHC such as a set of tools teachers could use for observation and for parent communication."**
>
> – Coach Lead, Northwest

Additionally, many RCs and supervisors shared that all coaches (but especially newer ones) would benefit from more focused skill-building in these same areas to enable them to better support providers and identify when a Provider would benefit from referral to a MH consultant. Again, this is supported by data from the 2020 Coach Early Achievers survey in which large majorities of Coaches expressed a need for more education and skills around early childhood mental health, especially "challenging behaviors," in addition to more information on disproportionate exclusionary behaviors and expulsions of children of color.

Other themes identified

- The IECMHC program and services has been needed "for decades." Their support of child care programs, and their ability to connect teachers, families, and children, **fills a crucial gap**. Many more MHCs are needed to meet the needs of providers and families.
- MHCs have been an **incredibly valuable consultative resource for Coaches,** providing opportunities to discuss potential strategies to best support a provider and/or determining if a referral is warranted.
- Desire for **more clarity on roles and responsibilities** of MHCs and Coaches
- Coaches and most regions would like guidance on how to leverage and **build Coach capacity to identify and support social-emotional health and needs**.
- There is a need to **broaden Coach understanding of IECMHC**, especially that it is primarily intended to work with adults (directors and teachers) at the program and classroom level, as well as with individual families/children.

- Need to **build connected systems around Infant/Toddler supports**. There are too many different partners and silos, community resource lists are hard to maintain, and regional practices vary widely.
- Regions want guidance on **how to leverage Coaches and build capacity to:** Provide generalized coaching to Providers; Recognize/identify provider needs for behavioral/SE/MH supports; and know when to refer to the MH Consultant.
- A **stigma exists around "mental health**," there is a need to reframe what IECMHC is, normalize it, and address provider and family fears around being labeled. This is a particular challenge with families of color who do not want to be identified or have their children identified as having mental health issues and may have been harmed by similar programs in the past. In many cultures, mental health is not even an accepted term.

> **"Coaches need a resource to check with someone about what to do, whether to refer, before the actual referral. Our MHC rocks and is doing this now! *And* we need more resources so our MHC can focus on caseload."**
>
> – Regional Coordinator and Lead

Several common questions emerged from the conversations with the Regions, some of which are within the scope of the IECMHC program, while others are within the purview of DCYF and the broader Early Achievers systems. They include the following:

1. How do Regions **integrate MHC with coaching** practice? Could guidelines be provided to help regions understand what priorities they should focus on and what is expected of Coaches?
2. What training and/or strategies could be provided to **enhance Coach capacity** to support providers, and learn **how to effectively identify needs, submit referrals, and partner** with their MHCs?
3. Is there early education training or strategies that Coaches and the Early Achievers system can provide to Providers to further build their ability to **support children around social-emotional development and behaviors**? Can this be required for all providers as part of the new Early Achievers?
4. Several regions wondered whether it would be possible to develop "**tiered" levels of supports for providers** including basic curricula provided or required for all providers, Coaching assistance as part of Early Achievers, and MH Consultation.
5. The MH Consultants have indicated the **relational model between MHCs, Coaches, providers, and families has been very effective**. How can this relational model continue to be enhanced?

6. How can the IECMHC program and Coaches **collaborate to increase diversity, equity and inclusion,** strengthen provider self-efficacy to support classrooms and meet children's developmental needs, and **decrease expulsions and racial disproportionality**?

Coach Listening Sessions

The evaluation team convened two listening sessions with specific Coaches from across the state who have been actively engaged with their MHC, sending referrals, and collaborating on cases. The purpose was to gain insights into different practices between the regions, learn what was working well and document current successes, and hear what might be needed to sustain, expand, and scale effective collaboration practices within regions and across the state. The sessions were held virtually in late June and early July 2021 and included a total of 21 Coaches from all five regions with active MHCs at the time.

Effective Coach-Consultant collaboration practices – what's working well

Coaches identified multiple ways that collaboration works well with the MHC team. Overall, Coaches said that they really appreciated their MHCs and thought that they provided valuable services for providers as well as for their own professional development. The list below includes items that Coaches value related to *how* MHCs work with Coaches.

> **"How do we build a regional (child care) system around Infant/Toddler behavioral health? We have (many different roles including) RCs, Leads, Early Achievers Coaches (all) with different levels of experience, (in addition to) B3QI Coaches (and) MHCs…We need to build an internal [regional] team (to integrate all of these roles and resources)."**
>
> – Regional Coordinator

- MHCs offer **quick response** to referrals and available for questions and providing resources informally, even though MHCs are very busy. They are flexible with meeting times.
- MHCs are **respectful** of coach expertise; MHCs ask coaches for their insights and respect the longstanding relationship they have with each provider.
- MHCs are **responsive** to Coach availability; MHCs **include C**oaches in meetings and invite coaches to observe and participate. If coaches can't attend, the MHCs catch them up to ensure shared knowledge of what is happening with the provider.
- MHCs **build coach capacity**. Coaches can apply new skills and tools (or better utilize their existing expertise) with other providers after participating with MHC cases.

- **MHCs offer support for coaches** when there are particularly heavy referrals.

In addition, there are areas of expertise and particular content that MHCs offer for Coaches, that are very much appreciated. Coaches particularly appreciate that MHCs can work with families on issues related to specific children, which aligns with insights from the Coach survey earlier in the evaluation.

- MHCs assist with **language** around social-emotional health and wellbeing, asking **informed questions** to probe deeper into behavioral issues, and **facilitating conversations** with providers that can be difficult. MHCs can also **see patterns in behavior**, even from short Coaching Companion videos, that Coaches say they didn't notice.
- MHCs have the authority to work with **parents and families and ability to pull together multidisciplinary teams** of providers, teachers, families, and external specialists, which is not part of Early Achievers coaching work. This helps bring everyone together on the same page. This includes working with families, teachers, and external specialists on individual focus child cases as well as offering mini-trainings for parents on Zoom.
- Early Achievers Coaches highly value the expertise of MHCs and the **focus of the IECMHC program on The Teaching Pyramid model,** which some see as the foundation of quality improvement work and reducing expulsion. Many also appreciate the clarity of the strategies available through the Conscious Discipline training they have received.
- MHCs are helping Coaches and providers with quality improvement in the CLASS areas (interactions and relationships) which is **strengthening the Quality Improvement (QI) efforts with providers**.

What's needed to help Coaches effectively collaborate with their MHC

> **"Providers and parents need help with strategies…education and tools. How do we support them in a partnership?**
>
> – Lead, Central Region

Coaches also provided recommendations for continued and improved collaboration with MHCs. Primarily, Coaches suggested having more consultants and more culturally diverse MHC staff, as well as clarifying processes around roles, referrals, and system supports. Coaches also value time on-site with providers, which enables them to more fully understand needs and support the programs, teachers, and children. Virtual Coaching during the pandemic has prevented them from experiencing classrooms and observing teachers and children first-hand, which has limited the coaching work they could do with their providers. It also impairs their ability to determine if a referral to an MHC is needed.

- **Funding for more Mental Health Consultants** – the need is great and significantly more than one or two MHCs per region is needed.

- More **MHCs who are bilingual and bicultural** so that the program can effectively and equitably serve BIPOC communities with culturally relevant communication and consultation practices.
- Continue to enhance the **collaboration process in the following ways:**
    - Whenever MHCs come to Coach or regional organization **meetings**, Coaches learn more about the IECMHC program and are more equipped to make referrals.
    - When MHCs **connect with each Coach** and build a relationship, coaches feel comfortable reaching out when they need support.
    - It is helpful for **Coaches to participate in meetings** with teachers, directors, and families along with the MHCs, when families give permission.
    - **Additional training** would be beneficial for Coaches who have not been engaged with their MHC, on how to collaborate with MHCs. This would help ensure equal access to MHCs across all providers in each region.
- When MHCs attend provider staff meetings and provide trainings for teachers, **Coaches can follow up to support implementation** and would appreciate guidance on what to do.
- Offering **on-site observations** with Coach and MHCs as soon as possible will help more effectively identify and respond to provider needs. Relying on provider descriptions of behavior and situations limits the ability of Coaches and Consultants to understand complex situations. Complex dynamics cannot be understood virtually.
- **Continue to clarify Coach/MHC roles**; Some Coaches are very interested in receiving more advanced training and perhaps developing a specialization in infant mental health (and some already have). They suggested this could be a way to build Coach capacity to strengthen the referral process and partner with the MHCs. Other Coaches felt that the roles were clearly complementary and should remain more separate, with more of a focus on refining the coordination of roles (when to refer, how to partner on a case, how to support the providers after the consultation is over).
- **Clarify referral processes**: Some coaches felt that they understood how to make referrals, while others felt that either the timing or process was unclear, which could sometimes leave them confused about when to reach out.
- **Waiting lists**: Questions also arose about **what Coaches could do if their referred provider is placed on a waiting list**, so that some support or resources could be provided until the MHC can take the case.
- Standardizing or extending **system supports** across regions, which include things like trainings for providers or coaches and support for provider resources on topics such as expulsion and suspension, so these supports are accessible across regions.

What's needed to help Coaches address risk of expulsion and racial and gender disproportionality

The discussion with Coaches also included the topic of expulsions and other exclusionary practices by teachers and directors/owners, with questions about their own skills as well as around their experience with the MHCs. We also discussed what the Coaches need to further support the IECMHC program goal to identify expulsion risks and support Providers around challenging behaviors. Coaches proactively indicated concern about expulsion and racial and gender disproportionality in the listening sessions and recognize it as part of their scope of work. Some of the patterns around disenrollment and expulsion they are observing among their providers include:

- Corporate child care owners (who are not in the classrooms or on site) may want to expel thinking that it's better for their business.
- Providers (teachers and/or directors) may not have the training to effectively support children's behaviors.
- Some providers may perceive that children's behavior is getting "worse" every year. Some comments from coaches also indicated a perception that provider training is not keeping up with the increased needs of children.
- Providers need time to plan and work as a team to support challenging behaviors. They currently don't have time, so follow through is lacking.

Coaches also offered some specific examples of how the IECMHC program is effectively reducing the risk of expulsion for their providers.

> **"Coaches have received many related trainings such as Pyramid Model, FIND, FlipIt, Conscious Discipline. Some Coaches have a keen interest and are WA-AIMH endorsed, or are B3QI Coaches with experience in FIND. But I have also seen where other Coaches step back and second guess their abilities now that we have an expert MHC on staff. We are talking with Leads about how to build Coach capacity around Infant/Toddler behaviors."**
>
> – Regional Coordinator

- MHCs **start with the relationship** between child and provider before offering strategies for behavior management.
- MHCs let providers know they are there to **help the provider experience more self-efficacy about working with the focus child,** and not to "fix the child."
- MHCs have followed children who were disenrolled to a new center, which shows providers that **transitions** are important and helps ensure the child is well served in the new center.

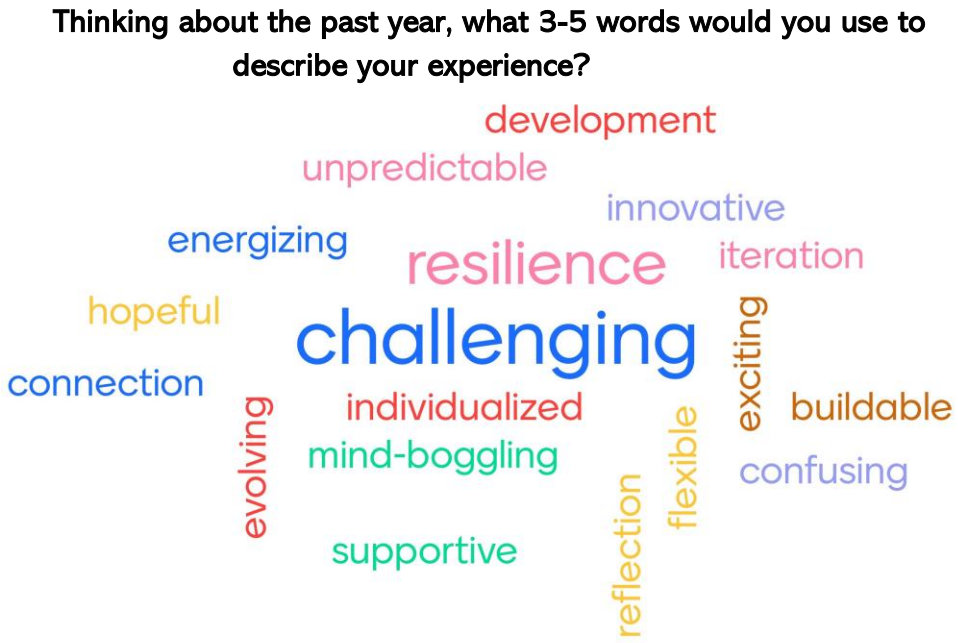
- **Regular meetings with the provider** (weekly or biweekly) are more helpful than prior supports Coaches could provide, which were usually one-time visits or training. This results in more growth for the provider.
- **Connecting all parties**: teachers, families, and administrators also help improve capacity to support challenging behaviors. Getting the director on board has helped.
- In some cases, the **MHC can help get 1:1 supports** for a child so they can stay at their center.

MHC Team Conversations and Interviews

The evaluation teams facilitated several MHC team discussions and individual interviews with the Director and three of the MHCs around the results of the Coach listening sessions and regional interviews. The purpose was to share and collaboratively make meaning of the data gathered from the regions, reflect on their experiences over the past year, and identify recommendations for ongoing program development.

The word cloud below describes the words that several of the MHCs used to describe their experiences over this first year of program roll-out. Individual interviews with the MHCs revealed similar themes related to challenge and excitement, unpredictability, and resilience.

Exhibit 7
MHC descriptions of their experience



Source: August 20, 2021, MHC team conversation

In the interviews, MHCs shared the high needs they are observing among child care providers and families, and the early impacts and successes they are already seeing during their consultations. These interviews reinforced what the evaluation team learned from the regions: that child care providers are experiencing high levels of stress and staffing instability. Overall, the MHCs are very positive about their first year of program delivery, how program administration and systems are developing, and how their roles are becoming integrated within their regions. They also shared some suggestions for strengthening some internal aspects of their work, including:

- Creating a centralized resource library for MHCs to improve their ability to share tools, resources and ideas, and better align their efforts.
- Developing guidance around program-wide priorities and approaches.
- Continuing to refine case management systems and streamline documentation processes.

The MHCs are also particularly positive about the relational model they are helping to develop between themselves, Coaches, providers and families, and excited about the potential long-term effectiveness of it. They shared ideas and suggestions for further developing this model and creating a stronger, more integrated system of supports for providers. The themes and suggestions from conversations with them fall under three areas: supporting the social-emotional needs of providers and families/children, building coach capacity to support providers, and leaning into equity and expulsion-prevention, as summarized below.

Supports for Providers

- Provider workforce is experiencing extreme challenges, high turnover, and staffing shortages. They need help with basics such as managing their own stress and emotions in the classroom and learning self-reflection and self-awareness techniques. This currently makes it difficult to work on skills "higher up the Pyramid."
- Providers need more fundamental training and education in understanding child development, behaviors, underlying trauma, and implicit bias. They would also benefit from having supports and tools to support healthy social emotional development such as games and activities that help children recognize emotions and develop empathy, manage impulse control, and teach co-regulation and de-escalation techniques.
- One MHC has a "starter pack" of social-emotion resource links that is sent to directors and teachers. Another MHC mentioned that video vignettes that model behaviors are particularly effective for providers (a need that we also heard in the regional interviews), but it is time-consuming to look for them every time they are needed. The MHC group discussed develop a joint library of resources that they could all readily share with each other, providers and Coaches.
- The MHCs are using a lot of Pyramid Model principles in their work and believe it would be beneficial for all child care providers receive this training..
- The stigma associated with "mental health" is a barrier. Providers need more information on IECMHC to help break down misconceptions. Some ideas include: having the Mental Health Consultants be introduced to group of providers at a community meeting so that

parents can put a face to the name and see this is a service for everyone; using terms such as "emotional well-being;" providing examples, videos, and video testimonials.

Building Coach capacity to support social emotional health of providers and children

- The regions and Coaches are asking for practical tools and activities, but they themselves are the tool! The ability to build connections with providers, lean in, listen help them reflect, and to apply the MHC "consultative stance" is what's needed. Coaches would really benefit from receiving more training on being reflective and attuned. The MHCs are receiving training in Fall 2021 on the Facilitating Attuned Interactions (FAN) model; this would be helpful for Coaches as well.
- Would be helpful if Leads could reflect with Coaches during their regular meetings around the needs of providers on their caseload, whether there are particular social-emotional challenges, and what the Coach might need to support the provider.
- Providers are experiencing high stress and anxiety. Coaches could be provided with some basic tools, such as a one-page list of reflection questions, that would enable them to "hold space" with their providers.
- The Early Achievers revisions and emphasis on Coaches working to co-create goals with their providers is a great opportunity for Coaches to learn and shift their "way of being" with their providers. One MHC said, "Coaches can do this!"
- The Early Achievers program and regions could develop a more standardized approach to helping identify child developmental delays and behavioral concerns such as supporting the use of screening tools like the ASQ and ASQ-SE. This could be done by providing more training to providers around the purpose and use of the tools, and having Coaches support as needed. This would enable Coaches and providers to collaboratively problem-solve and also determine if referrals to the MHC or external specialists are needed.
- Continue to support Coach interest in WA-AIM's Reflective Supervision endorsement. This will build Coach capacity to support their providers, understand when a referral to the MHCs is needed, and continue to support providers during and after consultation.

Preventing expulsions, addressing disproportionality.

- Coaches and providers would benefit from more education around what exclusionary practices look like, aside from suspension and expulsions. For example, sending children to the director's office or having them picked up early, and not effectively engaging with families around challenging behavior can all be exclusionary.
- Providers would benefit from having books, games and activities to help themselves and their children understand racial equity, cultural differences, and implicit bias.
- Providers need more training and assistance with Family Engagement and helping them build connections. This will help them support their children and reduce expulsions.

- Providers need more trauma- and resilience-informed teaching strategies to help them better understand the reasons for child behaviors, and how to reflect and better understand how their own teaching practices can affect child behaviors. Having reflective conversations with providers around this is very important.

Importance of onsite consultation

Lastly, the MHCs strongly emphasized the importance of being able to do onsite, in-person consultation with providers and children, especially for observation. Phone and video has been better than nothing during the pandemic, and notably has improved the easy of holding group meetings with directors, families, and outside experts. However, the MHCs shared stories of how the shift to onsite consultation can make a critical difference in the effectiveness of their consultations. Additionally, one MHC shared that they are experiencing fewer cancellations now that appointments are in-person, in part because the directors/teachers do not need to leave the classroom or be distracted by a phone in order to participate in a consultation or observation. The callout box below provides recent examples from two MHCs of the difference onsite consultation made.

Teachers have said it was so hard to do consultations over Zoom. And we also couldn't get the full picture of what was going on in classrooms…I am seeing so much more now. For example, I had been working for a while with a teacher who had a classroom with several foster kids. During my first onsite visit I realized the teacher had a very strong, loud voice and I could see she was actually scaring some of the kids with her body language. I worked with on her voice, not getting too close to the children, and getting down to their eye level. The teacher had never thought about this and convinced the teacher assistant to try it too. The classroom calmed way down - the kids really responded to this.

I'd been working with a teacher for some time, meeting every few weeks about challenges she was having with 4-5 focus children. When I in-person I could see what I was missing. The teacher was the issue, not the children. She was overly controlling during whole group activities…she had experienced trauma herself and her behavior was retraumatizing the kids. I worked with her on trauma-informed teaching strategies…and shifted from a child focus to a classroom focus.

- Regional Mental Health Consultants

PROVIDER SATISFACTION AND OUTCOMES

Feedback Questionnaires sent to select providers

In June 2021, the evaluation team worked with the IECMHC Director to develop a series of program assessment tools to gather initial outcomes from participating child care providers and lay the groundwork for future program outcome evaluation efforts. Provider Feedback/Satisfaction questionnaires were designed to collect information from Center directors, teachers, and FCC owners about their recent experiences with their MHCs. These feedback surveys are designed to gather information about perceptions of changes in teachers' practices, engagement with families, children's behavior, disciplinary practices, and utilization of community resources. These Feedback/Satisfaction questionnaires are designed to be collected after 4-6 months of consultation.

In addition, the evaluation team worked with the IECMHC Director to develop Provider Self-Report surveys. These surveys (for directors and teachers) are intended to capture detailed demographics as well as impacts of consultation to gather baseline data on the following:

- Teacher and director background demographics
- Program and classroom characteristics
- Current and past suspension and expulsion patterns
- Teacher and director self-efficacy
- Teacher well-being

The Self-Report surveys (teacher and director) are designed to be used as a baseline at the outset of consultation and again after receiving 6 months of consultation.

Because of the relatively small numbers of providers who had engaged in extended consultations at the time of this report, and because their consultations were already underway or complete, the decision was made to send only the Provider Feedback/Satisfaction questionnaires, the tool intended to be used after 6 months or at the end of a consultation engagement. This would enable the Holding Hope program to gather important qualitative data on initial provider experiences and outcomes, and to test the administrative processes established to send the surveys and collect the data. The Teacher and Director Self-Report surveys, the tools intended to be used at the beginning of consultations, will be sent beginning later this fall (2021).

> **"(MHC) is a great listener and I feel safe opening up. (MHC) acknowledges the struggles that their clients are having and provides validation and neutral guidance. (MHC) is open and kind, and it's obvious that they really care."**
>
> – Center Teacher, Olympic Peninsula Region

The potential uses of findings from these tools as well as the addition of more evaluation tools are four-fold: 1) to evaluate the results and outcomes of the Holding Hope program and whether it is meeting its stated objectives; 2) to inform Holding Hope's ongoing design and implementation (e.g., continuous quality improvement); 3) to provide findings that will guide ongoing growth and expansion of the program and inform Washington State efforts to develop a comprehensive system of quality enhancement initiatives for the continuum of early care and education settings; and 4) add to the field of national literature on effective strategies for IECMHC.

> **"…most important, (the MHC) acknowledged me and helped me to realize if I'm not "healthy" my program won't be. That my feelings matter."**
>
> – Family Child Care Provider, Olympic Peninsula Region

Themes and Results from Questionnaires

The MHCs selected several providers who had engaged in enough consultation to effectively answer the questions. The Consultants sent Provider Satisfaction questionnaires to a total of 54 Directors, teachers, and FCC providers. Twenty-two responses were received from all five regions with MHCs: Eastern, Northwest, Southwest, Olympic Peninsula, and King-Pierce Regions, for a 40 percent response rate. They included three (3) Family Child Care (FCC) providers, four (4) Child Care Center Teachers, and 15 Child Care Center Directors.

Feedback from these surveys was overwhelmingly positive. Providers are so appreciative of the support of the IECMHC Program as well as the way consultants work with them. Providers most appreciated the following:

- Listening and support
- New ideas, activities, and tools for classrooms and child interactions
- Help with difficult behaviors
- Help with shared language between families and staff and how to work with families

Directors responding to the survey **reported many positive improvements in the classroom and at the program level** including improvements in:

- Teacher attitudes, beliefs, and knowledge about early childhood mental health (most reported "very much" improvement)
- Supporting children with challenging behaviors
- Meeting the social-emotional needs of children
- Improvements in the emotional climate in the classroom
- Teacher-child interactions

The main suggestions for improvement included increasing the number of **MH Consultants**, and also allowing **on-site observations and meetings**. One Center Director mentioned a need for more role clarity to ensure that they knew when to reach out to the MHC and what the program could expect from the experience.

Child Focused Consultation Success Story - Expulsion Prevention (Olympic Peninsula Region)

This child was referred to IECMHC services in November of 2020 due to biting, physical aggression, and non-compliance and was at risk of expulsion. Upon receiving the referral, the MHC reached out to the family and scheduled weekly calls in order to streamline interventions between home and child care and also to support the family with getting the child assessed for additional services. The MHC was able to call and text this single mother regularly to support her with preparing for different assessments and help her reflect on concerns to highlight so that her child could receive as much support as possible. Thankfully, this child was able to receive a diagnosis that opened up many supports including occupational therapy and a behavioral service that works in child care with him. The MHC supported the teachers with virtual zoom meetings every other week to discuss interventions and social and emotional skills to practice. Additionally, the MHC was able to contribute noise cancelling headphones to support this child with transitions to and from home to child care to decrease his tension and support with successful transitions. Further, the MHC supported this mother as well as the teaching team with laminated pictures and instructions on how to make a visual schedule to promote communication around transitions. The team identified that this child learned best by singing songs and we worked on ensuring that both the mother and teachers used songs to sequence and teach routines which also helped this child tremendously.

Currently consultation with this child's teachers highlight the amazing progress he has made and the joy and delight he brings to their classroom. In April, the MHC received the amazing news that this child who was previously at risk of expulsion was welcome to stay at the child care center due to the sustained progress of the child, family, and teacher.

MHC plans for ongoing outcome tracking and evaluation

The MHC Program plans to continue soliciting feedback from providers about their experiences as a regular ongoing practice. The Provider Feedback Questionnaires will be administered when a case is closed, or more frequently if the consultation has an extended length. With more responses, the team can use the information for program planning and adjustment, as well as for MHC training and workforce development. Questions on the Feedback Questionnaire about expulsions and discipline will provide critical information to continue monitoring expulsion risk and disproportionality.

In the near future, the Holding Hope Director also plans to begin collecting outcome data using a pre- and post-program survey. The evaluation team worked with the Director to draft this survey in preparation for its future use. The assessment tools embedded in the survey includes measures of teacher self-efficacy, teacher-child relationship strength, and expulsion risk, as well as detailed demographic data on the programs, director, and teachers. In addition, the program will collect more in-depth data on the focus children for each site to ensure program accessibility and track improvements to discipline policy and practice. These tools will enable the Holding Hope program to begin monitoring impacts and outcomes at the program, teacher, classroom, and child level, and lay the groundwork for a future formal outcome evaluation. The MHC team regularly documents consultation activities, reflects on progress, and qualitatively captures successes and outcomes.

Multilevel Consultation Success Story - Provider/Classroom/Child/Family Focused Consultation (Eastern Region)

In April, the ECMHC engaged in regularly scheduled consultation sessions with an Early Achievers Coach and a site director who had been experiencing an extended period of life stresses. In addition to the challenges of leading a child care program during a pandemic, the site director had been attempting to sever a long-term marriage to an abusive partner. The site director received a variety of regular consultative support from the IECMHC during this period and ultimately acted on recommendations to connect with a licensed therapist for personal therapeutic support. The site director's path to independence was fraught with many obstacles, including lack of access to resources needed to live independently, exposures of family members to COVID-19, which resulted in hospitalizations for several family members and leading to one death. Throughout these adversities, consultation continued around the needs of focus children and families and staff skill-building remained a focus. Ultimately, through support provided by the Early Achievers Coach/IECMHC partnership, the site director was able to transition to independent living, which marked a turning point for her program, and a shift from chronic distress towards setting the childcare program back on a trajectory of positive professional growth.

ANALYSIS AND ASSESSMENT

As discussed earlier, the evaluation team held multiple group discussions and individual conversations with the IECMHC Director and the MHC team, to help interpret the program activity and evaluation results data. The discussion below around these results reflects the evaluation team's analysis of the results and conversations with the MHC team, framed around the Four Essential Building Blocks for IECMHC program design.

Eligibility:

The population the program serves; defining the target population, geographic reach, and service delivery setting.

Successes achieved

Service population. The new IECMHC program began with a solid foundation on which to build. It had a clearly defined target population of licensed child care providers enrolled in the Early Achievers program, with a well-established network of quality Coaches who already had established trusted relationships with most Providers. This pre-existing foundation of systems and Coach-Provider relationships enabled the IECMHC program to hit the ground running. The pandemic began at the exact time the Director and first MHCs were hired, and the Director and staff immediately recreated a new virtual service delivery model to meet the growing crisis. The MHCs immediately started outreach, engagement, and effective relationship building with the Coaches, provided critical social-emotional supports to providers and Coaches through the early months of the pandemic, and begin building their regular caseloads. The MHCs have become well integrated within the community partner organizations that employ them, they continue to build and expand their relationships with Coaches and Providers, and caseloads are growing.

> "This new program couldn't have come at a better time. It has undeniably positively impacted providers and children this year."
> - Supervisor, King-Pierce Region

Provider needs. As discussed earlier, additional evaluation research was conducted to help the MHC team develop a more detailed understanding of provider needs for IECMHC supports at the regional level. The Holding Hope program intends to use this information to inform its priorities and strategies to help ensure that access to the program is equitable, accessible, and reaching those providers and populations with higher needs. This may include sending communication and outreach information to Coaches who serve providers with these characteristics and reaching out directly to Providers and communities.

Growth opportunities

Developing priorities and strategies to meet IECMHC program goals and strengthen referral systems. Over this past year the environment has presented many challenges and required constant pivoting to respond. The Holding Hope program, the Regions, and the Coaches have had to repeatedly react as the pandemic has upended providers' ability to engage, MHCs ability to do outreach, consultation and observations, and Coaches' ability to understand what is happening with teachers and classrooms. Child care providers in Early Achievers, all of whom are eligible for IECMHC services and within the "target" population, are struggling and need assistance now. In most cases there is only one MHC in each region and Coaches are still learning how to refer and collaborate. Given these circumstances, it is understandable that the referral system has evolved organically, with most referrals accepted on a "first-come, first-served" basis from Coaches who felt more prepared to engage.

> **"We need to build opportunity for providers to access the program and be equitable. What is the process to ensure we're reaching high needs' programs? For B3QI we used to get a list of risk factors. At least it was a starting point."**
>
> – Region Supervisor

Now that the program is beginning to grow and scale its services, waitlists have begun, and return to onsite services is slowly restarting, it is important for the IECMHC program to begin establishing some strategic goals and strategies for use of limited MHC resources. Important priorities that have been raised and are core to IECMHC include the following (not in priority order):

- Allocating resources as strategically as possible to reach providers with higher needs.
- Providing supports to reduce suspensions and expulsions, particularly for children of color.
- Ensuring equitable access and service delivery, including providing a cultural and linguistic match between consultants and providers.

It is commendable that the Holding Hope program is prioritizing partnership with the regions to develop a community-based definition of who the higher needs providers are. The partners and staff in each region have a much deeper understanding of community needs and cultural nuances and can inform future program priority setting to focus on high needs and ensure equitable access and utilization of IECMHC services. This initial effort could be expanded upon by continuing efforts to work with DCYF to obtain provider data that could inform this effort including data on characteristics of the children they serve (such as those in the foster care or child welfare system, with special needs, receiving child care subsidy, etc.) as well as data on provider expulsion rates. In the meantime, the IECMHC team has a list of risk factors that are being used by the MHCs for case management purposes.

As discussed, MHCs, Regions, and Coaches shared that there is uneven program utilization by Coaches in most regions that has resulted in larger number of referrals coming from specific Coaches. The result is that providers served by these particular Coaches have more "access" to the

IECMHC program than others. The program case management database does not currently track referral sources as it was initially assumed that all referrals would come from Early Achievers Coaches. At this time, it is not possible to determine to what extent this is occurring; however, it is something to monitor and address because even if unintentional it could result in inequitable systems and service delivery. The Holding Hope program plans to add this capability to the database in order to track increasingly diverse referral sources.

While this approach was necessary given that only five MHCs were funded to cover the entire state, and because of the crisis presented by the pandemic, it does raise the following questions:

- Which providers are gaining access to the program, and which are not?
- Do providers in regions have equal and equitable information about and access to the program?
- Could this be one of the reasons why more referrals have come in from Centers than FCCs?

> **"We are not reaching the FCCs and aren't sure why. Maybe staffing is more stable and there is less turnover? Maybe it's because our MHC doesn't speak another language (besides English) and many FCCs are from other cultures and prefer to connect in languages other than English?"**
>
> – Regional Coordinator

Some information is available on whether providers with the higher needs identified in the regional conversations are being served. For example, caseload data shows that at least 20 percent of referrals have a risk of expulsion associated with them and reducing expulsions and associated racial disproportionalities is a primary goal of Holding Hope. The demographic and racial makeup of the providers and children in each region, and in the classrooms being served, is currently not available, so beyond anecdotal information it is not possible at this point to answer the question of whether the program is serving providers in a racially and ethnically equitable manner.

Other key provider data is not readily available, such as whether the providers on MHC caseloads have higher percentages of children experiencing foster care, child welfare, homelessness, and family substance abuse, data on the racial/ethnic makeup of programs and classrooms, and whether providers are serving a higher percentage of economically marginalized families. Additionally, anecdotal information indicates that direct referrals from providers (as opposed to from Coaches) are increasing in addition to Coach referrals, and it is the evaluation team's

> **"Programs with high expulsion rates tend to be programs with higher percentage of children in Foster Care or experiencing underlying trauma. Our Coaches know this. There is a clear connection."**
>
> –Supervisor, Eastern Region

understanding that this practice will grow in the future. It will be important for ongoing program management to obtain this data in order to understand how providers are gaining access to the program and who they are, to help ensure access and service are equitable and aligned with program priorities.

A framework for ensuring equitable access for providers is a crucial element of IECMHC programs. The ability to understand the service population, identify priority needs and strategically allocate scarce IECMHC resources will be important as the program enters into its second year of operations. There is a risk of creating inequitable access to this important program if strategic priorities are not established for referrals and service delivery. At the same time, fully equitable access will only be possible with significantly higher MH Consultant staffing resources in each region, something that is beyond the control of the Holding Hope program and will depend on additional state-level investments.

Service Design and Delivery:

How the program delivers IECMHC services including service dose, consultant capacity, and service access.

Successes achieved

Smooth program rollout and implementation. As noted, the IECMHC program was effectively rolled out statewide in five regions in the midst of a pandemic and was able to immediately begin delivering much needed direct IECMHC services to providers and children. The program came at the perfect time. The MHC team effectively designed protocols, support systems, and modified virtual consultation services to deliver direct services in a short period of time. The program also immediately engaged in engagement and relationship building with their regions to inform staff of the new services, explain referral practices, and provide training and professional development around social-emotional health and behaviors to Leads, Coaches, and providers.

> **"Such an incredible program! (MHC) has been an answer to our dreams!"**
>
> –Center Director, Olympic Peninsula

Early successes and outcomes. MHCs and regions report that the referral system and case management system is working well and that they appreciate the continuous quality improvement efforts. Regional Coordinators, Leads, Coaches, and MHCs all shared examples of the positive results and outcomes that are already occurring during the first year of the program. Feedback from the Regions and Leads about the IECMHC program, its services and early outcomes is universally positive. This is evidence that the development of a relational model that addresses adult (provider staff and parents) self-efficacy and includes reflective supervision is effective and is much needed to support providers around social-emotional health and behaviors. Important initial

steps have been taken to develop outcome tracking and assessment tools that will be used on an ongoing basis to monitor satisfaction with the program as well as impacts and outcomes for the directors, teachers, and focus children. Initial Provider Satisfaction Questionnaires are universally positive and show high levels of satisfaction with IECMHC services.

Growth Opportunities

Developing clarity on Coach roles in collaboration with MHCs. There is a need to more clearly define how to integrate MHCs with Coaching practice, determine where the two intersect, and how the two roles can best work together to support the IECMHC program, providers, and children in their care. One of the ideas raised by the Regions, Mental Health Consultants, and members of the Evaluation Advisory Group included developing **tiers or levels of supports for providers** similar to the following:

- All providers, especially new ones, could receive basic training and curricula through the Early Achievers program to support healthy social-emotional development and learning, support around challenging behaviors, and racial equity in child care.
- Coaches could support providers around these trainings and curricula and provide individualized coaching and quality improvement guidance as needed. MHCs could provide consultative advice to Coaches, share resources, and help determine if a referral is needed.
- Providers with more advanced needs for supports (higher on the Pyramid) and needs requiring consultation around the full IECMHC model (Director/Program, Teacher/Classroom, and Child/Family) would be referred to MHCs.

Identifying how to leverage Coach capacity. The Holding Hope program, Regions, and Coaches shared that this unique IECMHC model that includes quality improvement Coaches has powerful potential to

Suggestions for provider education and training

"The change needs to start with us and the teachers before the children. A Social-Emotional learning curriculum is needed for the Providers, such as Managing Emotional Mayhem and Conscious Discipline."
– Coach Lead, Eastern Region

"I wish the Early Achievers revisions required a component for Behaviors and Racial Equity. This would be good for all new Coaches too."
– Coach Lead, NW Region

"Having a required training for Providers around reflection and resilience would be good. It would help providers catch and support behaviors early on."
– Coach Lead

"We need to start with basic social-emotional development practices with providers."
–Supervisor, Eastern Region

"A toolkit on Positive Behavior Supports for providers would be helpful."
– Regional Coordinator

"We know it's not all about the child. It's about the adults. Providers need our support to learn and reflect."
– Regional Coordinator

strengthen IECMHC services and supports for providers. They shared that enhancing Coaches' capacity to understand and support social-emotional and behavioral health could help them identify provider needs and expulsion risks before a crisis occurs and enable more proactive intervention and referral to MHC services. Surveys completed for the Interim Report's needs assessment also indicate that most Coaches are interested in more training and support in this area. Ideas for building Coach capacity that emerged include:

- For all Coaches, especially newer ones, **provide professional development to enhance their understanding and self-efficacy** to support providers around child behaviors and to effectively refer and engage with their regional MHC.
- Build on existing practices for some **Leads and Coaches to specialize in infant/early childhood mental health**. This is already occurring in some regions where some Coaches are obtaining WAIMH endorsements in Infant Mental Health and training in Reflective Practice. These staff could potentially serve as connectors between MHCs and Coaches and help guide regional needs assessments and strategies.
- Leverage coach support for follow-up and ongoing, long-term implementation of skills, classroom changes, and/or training after MHC engagement.

Developing an integrated system of social-emotional health supports for Providers. This system would integrate MH consultation and coaching, strategically identify program priorities and regionally-informed strengths and needs, and support coaches and providers in understanding how underlying trauma, and provider, staff, and parent dysregulation drives escalated behavior. This would also include supports to improve equity and inclusion through understanding of trauma, resiliency, family protective and risk factors, as well as community protective and risk factors.

Strengthening processes to identify providers in need and to establish referral systems. Opportunities exist to improve access to data and information to effectively identify providers in need. These include:

- Obtaining data from DCYF on providers who report child expulsion histories, in the hope that preventative MH consultation and/or coaching support could be offered to these programs in the future. Higher expulsion rates are frequently an indicator of underlying factors and circumstances such as high levels of stress or trauma among teachers, classrooms, and families, which IECMH Consultation can help address.
- Data on demographics and characteristics of Early Achievers providers and children in their care that are associated with higher provider needs for IECMHC identified in this evaluation. CCA of WA recognizes there are challenges in collecting demographic information and is open to partnering with DCYF to identify opportunities to track demographics at the program, staff, family, and child level. A potential first step in collecting data that will support our racial equity goals and allow CCA of WA to target services to marginalized populations is to collect child level demographic data through the subsidy system. Availability of this data would enable the Holding Hope program to ensure that outreach and communication about IECMHC services is effectively reaching these providers. It would

also allow Regions, MHCs, and/or Coaches to better understand the characteristics and needs of the providers in their service area and offer them preventative supports. Examples of needs-related data include providers serving: higher numbers of children in foster care or in the child welfare system (high incidence of underlying trauma); higher numbers of families receiving Working Connections Child Care subsidy (economic marginalization and limited access to health care); children with special needs or on the Autism spectrum; etc.

The Holding Hope program has also identified an opportunity to build connections with DCYF's Child Welfare/Early Learning Liaisons regarding a collaborative referral process. Such a process would link families involved in the child welfare system to early learning programs that have the support of mental health consultants, and thus important social-emotional supports for the children involved.

Infrastructure:

The support mechanisms that must be in place to implement an IECMHC program, including a theory of change, a logic model, a service organization, policies and procedures, and a manual.

Successes achieved

Program model, procedures, implementation guidelines, and systems. The IECMHC program has successfully developed the key infrastructure mechanisms needed to effectively support this program. The program Director's expertise and experience both as a supervisor and a MH Consultant enabled her to quickly develop the implementation guidelines, procedures, and case management systems needed to quickly launch program operations in an orderly and highly expeditious way. These systems were operational within a couple months of program launch, and continuous quality improvement continues to occur for the IMPACT case management system and program reporting. The first task for the program evaluation team in Summer 2020 was to discuss program theory and operations with the newly hired MHC team and to develop the Theory of Change and Logic Model for this new program. It would be beneficial to revisit and refine this model as the program evolves and grows, especially with

Family Success Story

"My husband and I have been working with a mental health consultant from the holding hope program for nearly a year. We have been so thankful for this program! It has been incredibly helpful in developing intervention plans for our child's withholding challenges at preschool and any other behavioral questions we have. All of the strategies have helped us feel more successful as parents in helping our child to overcome his fears and the behavioral challenges that come with his tummy hurting at preschool. Her suggestions have also helped his daycare provider to understand his struggles and strategies to try. This is a wonderful program for families!!"

the new MHCs coming on board and as the model for Coach-MHC collaboration becomes more clearly defined.

Enhanced staffing capacity. Another incredibly important success this year was the additional funding approved to hire nine additional MHCs as well as a new Supervisor to support the work of the Director. As described earlier, these new staff included three bilingual, multi-cultural positions, one to serve Spanish-speaking providers statewide (located in the CCA of WA network office) and two multilingual MHCs for the King-Pierce region, all of which have been onboarded and working since May 2021. An additional six MHCs were funded, one for each region, for which recruitment and hiring is underway. These additional MHCs will help meet the overwhelming need for MHCs services and also provide the beginnings of an MHC "team" in each region. The new Supervisor in the CCA of WA network office will provide assistance to the Director with Reflective Supervision/Consultation of the MHCs, as well as with program planning and operations. The Fair Start Act also provided funds for DCYF to support IECMHC professional development for this program and other state efforts.

Opportunities

The additional MHCs will increase the capacity of the program to serve providers; however, given that an MHC conducting on-site consultation will typically carry a caseload of about 10 cases at a time, the need still far outstrips the demand. Significant additional MHC resources are needed if the program is to grow to meet recommended ratios and caseloads, and if it is to ensure it is equitably reaching providers with the highest needs in marginalized communities.

Workforce Challenges. The stresses being experienced by child care providers, already high before the COVID-19 pandemic, is even higher now. This level of stress can have a significant and negative impact on all aspects of early childhood mental health, including child behavior, provider/family relationships, emotional dysregulation (for children, parents, and providers), reduced resiliency and increased expulsions and suspensions. MHCs and Coaches both reported that providers are struggling. An effective workforce is the foundation of all relational models of care and specifically of the Pyramid Model for Supporting Social-Emotional Competence in Infants and Young Children. Young children and their families depend on a child care provider workforce that is stable, consistent, supported, and effective. Significant resources and efforts will be needed at the state level to address these challenges to meet the health, wellbeing, and social-emotional needs of Washington's young children.

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

Significant resource investments are needed at the state systems level to enhance workforce stability in Early Childhood services, to increase the financial security of these vital professionals, increase staff retention, decrease turnover, and enhance direct services staff satisfaction. A recent report issued by the Washington State Department of Commerce and the Child Care Collaborative Task Force details the crisis in recruiting and retaining child care being experienced in the child care field.[11] These supports are necessary to support the ability of all child care providers to provide quality care and support the social-emotional health for all children.

> **"Having a statewide cohort of Mental Health Consultants was brilliant. Behavioral health was not my background, and this gives me and our MHC important support."**
>
> – Regional Coordinator

IECMHC Data Systems. Input from the MHCs and Coaches showed overall appreciation for the ease of use of IMPACT and other case management and referral process as well as for the approach to continuous quality improvement being used by the IECMHC Director. Continuing to engage the MHCs (especially less experienced staff) and Coaches in conversations around expectations and clarity of processes would be a good practice to continue.

Provider demographic data. As noted earlier, the IECMHC program and region staff do not currently have access to important provider data that would help them understand the needs of providers in their regions. Data on provider demographics and characteristics is needed to inform program decisions around outreach, engagement, and services to higher needs providers, and help ensure services are equitably delivered to culturally and racially diverse providers and children.

MHC Workforce:

Describes the preparation and support required to be a consultant, including training, qualifications, and reflective supervision.

Successes achieved that can be built on

Cultural and Linguistic Diversity. The three new positions funded by the Preschool Development Grant include bilingual and bicultural requirements and are helping the program meet the goals of providing culturally and linguistically relevant and equitable consultation services. The Spanish-speaking MHC located in the network office is helping to fill a large statewide need, while the other two are meeting needs locally in King and Pierce Counties. Current language capacity in the King/Pierce region includes English, Somali, Dutch, Vietnamese, and Indonesian.

[11] https://www.commerce.wa.gov/wp-content/uploads/2021/08/FINAL-June-2021-C3TF-Legislative-Report.pdf

Ongoing reflective supervision/consultation. The IECMHC Director has provided regular individual and group RSC and professional development to the team since initial launch of the program. One of the initial organizational steps was to hold a regular weekly meeting with the cohort of MH Consultants for group RSC, professional development, and program planning (including several workshops with the evaluation team). Evaluator conversations with the consultants indicated that they have highly valued having this group of peers as a support and resource, especially given that there are few or no other mental health professionals in their organizations.

MHC training and professional development. The MHC team has participated in extensive professional development opportunities over this first year to deepen their shared practice knowledgebase and further develop individual skills. All eight MHCs who have been hired meet the professional IECMHC requirements for their positions. The IECMHC director has also developed comprehensive new hire training and materials that she is using to onboard new staff as they are hired. Additionally, the Fair Start for Kids Act provided additional statewide funding for IECMHC professional development, and DCYF and Cultivate Learning have collaborated with CCA of WA to provide customized training for the MHCs and Regional staff.

With specific regards to racial equity in IECMHC, all MHCs have received orientation to the Diversity Informed Tenets for Work with Infants, Children, and Families, (Irving Harris Foundation) and they have all participated in the Equity in IECMHC webinar series offered by the Georgetown Center of Excellence (CoE) in IECMHC. They have also done self-study in the CoE Racial Equity toolkit (multiple resources), the recently revised IECMHC Competencies which have an explicit focus on equity across each domain, and a full day of training on Promoting Racial Equity and Disrupting Bias: The promise of IECMHC with Eva Marie Shivers, J.D., Ph.D., Indigo Cultural Center. Questions around racial equity and exclusionary practices come up and are addressed regularly in group and individual RSC. Also, some MHCs read "Coaching for Equity" along with the Coaches.

Opportunities

Perhaps one of the most immediate opportunities for offering IECMHC in the State of Washington is for DCYF and partners such as CCA of WA to **continue focusing on equity.** Providing funding for enhanced professional development opportunities for consultants, supervisors, and IECMHC program leadership that include an explicit and purposeful **integration of a racial equity lens** into IECMHC (Davis et al., 2020) is highly important. Additionally, national discourse and narrative surrounding IECMHC has highlighted the need for a **more diverse IECMHC workforce** as one of the promising strategies to reducing racial disparities in harsh, exclusionary disciplinary practices such as suspension and expulsion (Center of Excellence in IECMHC, 2020; Davis, Shivers, & Perry, 2020; Shivers, Farago, & Gal-Szabo, 2021). Nationally, the vast majority of the IECMHC workforce is white and female (Equity Webinar from the Center of Excellence in IECMHC, 2020; Shivers et al., 2021). **There is emerging research demonstrating that diversity and racial/ethnic matches among consultants and teachers is a promising disrupter of racial disparities.** Additionally, a recent study using IECMHC data out of Arizona found that a strong consultative alliance predicted greater improvement in child attachment, with stronger results seen when MHCs are highly trained and

consider themselves "experts" in diversity informed, antibias, anti-racist practices, as well as when MHCs were racially and ethnically matched with teachers (Davis, Shivers, & Perry, 2020).

There are many reasons why growing, recruiting, retaining, and promoting a more diverse IECMHC workforce is challenging to so many states and communities around the country. First, there are strong cultural and historical negative stigmas around mental health in general that make it difficult to attract Black, Indigenous, and other people of color (BIPOC) into the mental health profession. Second, there are structural barriers related to systemic racism that continue to marginalize and push-out BIPOC mental health professionals (e.g., uneven opportunities in gaining mental health experience and implicit biases in the job interview process). Third, the organizational climates of many community-based mental health organizations are fraught with micro-aggressions and organizational climates that are not conducive to retaining and/or promoting BIPOC mental health professionals. And finally, mental health consultants who identify as BIPOC and bi-lingual are in very high demand. These professionals are often lured away from IECMHC programs and into positions that offer more money and promotions. The State of Washington's IECMHC community is currently making efforts to address, disrupt and transform many of those trends. Those efforts are urgently needed and should continue to grow deeper and stronger at every level of the IECMHC infrastructure – including state, local, and organizational levels.

The Holding Hope program is prioritizing and making important progress towards building an MHC workforce that is racially, culturally, and linguistically diverse, and reflective supervision practices and professional development during the first year demonstrates that this remains a very high priority for the program. However, a clear example of the challenge to develop a diverse workforce and the impact on communities is the challenging situation in the Central Region. The region has not been able to recruit a Mental Health Consultant who meets the professional IECMHC requirements and is also a cultural and linguistic match for the community. This situation has resulted in the region lacking IECMHC services for over a year, while the other regions have been actively serving providers. The IECMHC field as a whole is challenged by situations like this, and professional conversations are taking place about how to solve it. Perigee Fund has published a series of Issue Briefs on IECMHC in Washington, including one focused on Workforce, that provide additional insights in to this issue.[12]

Important considerations for the ongoing development of the Holding Hope IECMHC program will include:

- Increasing workforce diversity so the program can aim for cultural and linguistic matching as much as possible.
- Creating and supporting a programmatic infrastructure so that mental health consultants have the opportunity to come to see themselves as having expertise in issues related to culture, anti-bias, and racial equity.

[12] 4_WhatProvidersNeed-1.pdf (perigeefund.org)

CONCLUSIONS AND RECOMMENDATIONS

The learnings from this evaluation demonstrate the important program development, progress, and impact the IECMHC program has achieved in a short amount of time. CCA of WA and the IECMHC program team have thoughtfully and effectively created and established foundational design and operational elements that are crucial to the development of a sound program and thoroughly aligned with all Four Essential Building Blocks of Designing an IECMHC program. The program was staffed and rolled out effectively in five regions with five different partners across the state, despite the immense amount of pivoting that had to occur due to the pandemic. Feedback about IECMHC services from CCA of WA's regional partners and participating child care providers is highly positive and promising. It is clear that the additional MHC staff funded and hired this year are much needed and will likely generate similar results and successes across the state.

Family Testimonial

"Honestly, your impact on myself and my family has been very valuable. You communicate and strategize with me as someone who wants my child to succeed, and it's obvious in the day to day how much my kiddo benefits. I feel safe and comfortable to talk to you, especially about more difficult topics that are instinctual for me to push inward. I feel validated and inspired after our sessions and am incredibly grateful for your counsel."

- Parent

The recommendations below address the primary opportunities for program growth as discussed in this report. They intentionally integrate equity principles to help ensure equitable practices are seamless incorporated into regular program operations rather than considered as a separate effort. A long-held, central tenet of the IECMHC theory of change emphasizes that this intervention strategy is aimed at supporting the adults (the workforce) in early care and education settings and resists the common trend of "pathologizing" or victimizing children and families.[13] This stance is consistent with an equity framework. The recommendations for DCYF, CCA of WA, and the Holding Hope Director's collaborative focus on IECMHC practices and policies are intended to help level the playing field in terms of power so that implementation of equity at all levels of an IECMHC system is a shared responsibility of a representative and inclusive leadership. The IECMHC program should continue its commendable work to integrate a racial equity lens into program practices and infrastructure design, including continuing to build on the following practices as the program grows and solidifies its practices across the state.

[13] Davis, Shivers, & Perry, 2020; Georgetown Model of ECMHC Manual, 2016. Center of Excellence for IECMHC, 2020; Davis, Shivers, & Perry, 2020; Shivers, Farago, & Gal-Szabo, 2021.

1. **CCA of WA should develop priorities and strategies for delivering IECMHC services to help ensure scarce IECMHC resources are used strategically.** This may include identifying providers with higher needs and at higher or disproportionate risk of exclusionary practices and expulsions. This will involve continuing to work with regions to identify providers with higher needs, continuing to work with DCYF to obtain access to important up-to-date provider data on expulsions, demographics, and underlying risk factors, and developing strategies for outreach, engagement, and referral methods to reach them. Working collaboratively with the regions on these steps will also help ensure local community needs are met and that IECMHC program activities are tailored and customized according to the unique needs of regional partner organizations. This recommendation also includes collaborating with state leaders to secure the additional MHC staffing and investments needed to connect children and teachers in marginalized communities with meaningful access to IECMHC.
2. **CCA of WA should continue collaborating with regional leaders to strengthen systems and processes for accessing IECMHC services.** This includes efforts to ensure more Coaches understand IECMHC and the services provided, how to place referrals, and more clearly define what effective Coach-MHC collaboration looks like.
3. **CCA of WA, DCYF, and Regional partners should engage in collaborative planning** to address the following questions that have arisen in this evaluation:
    - What is needed to **develop integrated systems** of social-emotional health supports for Early Achievers Providers that leverages regional resources such as MHCs, Coaches, and B3QI consultants?
    - How can **Coach capacity be strengthened** to identify social-emotional needs of providers/teachers/children, expulsion risk factors, and developmental concerns, enhance their ability to determine when an IECMHC referral may be needed, and support their providers after an IECMHC consultation is complete?
    - Are there ways that coaching practices can be enhanced to enable Coaches to support social-emotional health of providers/teachers/children when the challenges do not rise to the level of an MHC referral, or while a provider is on the waiting list?
4. CCA of WA and DCYF should **explore ways to more closely integrate IECMHC and Early Achievers**. Specifically, it would be beneficial if the Early Achievers' provider professional development opportunities could include additional foundational education and training around social-emotional health, child development and wellbeing, equity and expulsion prevention, to strengthen their ability to support their programs and children.
5. The Holding Hope program should **continue its excellent work to create a strong program infrastructure.** This includes developing, refining, and strengthening program processes and infrastructure, case management and reporting systems, and guidelines around caseloads and consultation dosage as the number of MHCs increases, and eventually returns to in-person or hybrid consultation.

6. CCA of WA and the Holding Hope Director should continue their excellent collaboration with DCYF, Cultivate Learning, and other partners to **provide strong professional development opportunities for the MHC team**, including enhanced professional development opportunities for mental health consultants, supervisors, and IECMHC leadership that include a purposeful integration of a racial equity lens into IECMHC. Additionally, the IECMHC Director should continue to communicate and collaborate with the MHCs and regional leaders (Member Council) to monitor and ensure the effectiveness of the dual supervision arrangement, especially as the number of MHCs increases in the coming months.
7. CCA of WA, DCYF and their regional partners should continue its efforts to **support the development of a diverse workforce** of MHCs that provides as much of a cultural and linguistic match with the populations served as possible. This includes:
    - Ensuring that all mental health consultants are housed in regional organizations that demonstrate robust support and commitment to ongoing equity transformation at the organizational level.
    - Supporting regional partners' efforts to build, recruit, retain, and promote an MHC workforce that is diverse and matches the communities served, and help ensure cultural and linguistic matching of consultants with early education teachers.
    - Identifying forward-thinking solutions to ensure the Central region obtains the culturally relevant IECMHC services its providers need and to resolve the inequitable situation that currently exists.
    - Supporting reflective supervisors' capacity to discuss equity issues during supervision.
8. The IECMHC program should continue building on the groundwork laid during this evaluation to **document program delivery activities, successes and outcomes**, including use of the Provider Satisfaction Questionnaires and Provider Self-Report Questionnaires. This data will provide important information on service delivery as well as program impacts and outcomes for providers, families, and children that will be crucial for demonstrating the value of IECMHC. The program should also continue to explore opportunities for collecting feedback and outcomes from participating families.
9. CCA of WA and the Holding Hope program should **continue its ongoing focus on program quality improvement, monitoring and outcome assessment** that they have been committed to all along, including:
    - Engaging and supporting the MHC team and new staff in dialog around the effectiveness of program systems.
    - Engaging regional partners in dialog and monitoring around ongoing refinement of supervision and program systems.
    - Employing a developmental participatory approach with stakeholders to ensure equitable and effective access to the program.

- Continuing existing practices to involve regional, teacher, and family perspectives during service delivery and to identify ways they can directly inform future service delivery
- Promoting and investing in outcome evaluation to measure and demonstrate program impacts and outcomes.

APPENDIX A: EVALUATION SCOPE AND OBJECTIVES

The evaluation objectives are to answer the following questions:

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

The evaluation design is framed around the Georgetown University Center for Child and Human Development's *Four Essential Building Blocks* of a successful IECMHC program.[14] Sound development of these four foundational program components will help ensure the program's purpose, target population, and services are well defined, and that the structures, systems, personnel, and funding necessary to support effective program operations are identified.

Eligibility describes the population the program serves, and is determined by defining the target population, geographic reach, and service delivery setting.

Service Design describes how the program delivers IECMHC services; it includes service dose, consultant capacity, and service access.

Workforce describes the preparation and support required to be a consultant, including training, qualifications, and reflective supervision.

Infrastructure describes the support mechanisms that must be in place to implement an IECMHC program, including a theory of change, a logic model, a service organization, policies and procedures, and a manual.

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

[14] https://www.iecmhc.org/documents/iecmhc-buildingblocksguide.pdf

APPENDIX B: IECMH CONSULTATION LOGIC MODEL

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

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

Consultation Activities	Theory of Change	Short Term Outcomes	Long Term Outcomes
Child/Family-focused: Support providers with specific child/family needs.	MH Consultants provide support for teachers and directors in responding to child/family-specific needs, to build capacity of teachers, providers, and families.	• Children with identified concerns receive increased referrals. • Children improve social skills and emotional competency. • Families experience improved communication with staff and improved ability to support child.	• Decrease in parenting stress for families and children have increased access to and availability of community resources.
Teacher/Classroom: Support providers with stress management, regulation, training on social-emotional development. Help teachers explore, understand, and shift biases about children.	MH Consultants address adult self-regulation and provide reflective support and professional. development to improve practice. Teachers shift their understanding of the meaning of child behavior and treat children more equitably.	• Teachers feel less stress and understand impact of their state on children. • Teachers know more about social-emotional development and improve. relationships with children and families • Classroom environment is more positive.	• Teachers have reduced burnout and improved job satisfaction.
Program/Provider: Support providers with stress management, guide program planning, staff training and improvement efforts.	MH Consultants support organizations to plan for and integrate principles of social-emotional development and equity into program practices.	• Improved provider-staff communication and teamwork. • Providers more confidently apply social-emotional practices. • Increased awareness and attention to preventing suspensions, expulsions, and exclusionary practices.	• Decreased staff turnover, child suspension and expulsion, improved program quality. • Increased program attendance, reduced parent stress and loss of work.

Early Achievers Coaches: Provide reflective practice, group meetings, and training on social-emotional and trauma-informed practices.	MH Consultants support Coaches with secondary trauma and provide expertise and resources to integrate social-emotional informed practices into quality improvement coaching.	• Relationships and trust built between MHCs and Coaches. Immediate needs for reflection and support are met. • Coaches learn when to engage MHCs for help with providers. • Coaches better equipped to help regulate and support provider needs.	• Reduced coach stress, increased knowledge of resources. Coaching on quality child care integrates social-emotionally-informed practices. • Consultants & Coaches work as partners to support MH needs of providers, children & families.
Systems Level Work: Support regional organizations, develop resource libraries, training, and other tools.	MH Consultants address pandemic, racial equity, and operation needs with a social-emotional lens, increasing capacity of the EA system and partners.	• Coaches and regional partners effectively respond to key needs in the field. • Relationships, trust, and shared knowledge built.	• Increased coordination and capacity to provide equitable social-emotional services and resources.

APPENDIX C: SUMMER 2021 PROVIDER SATISFACTION SURVEY RESULTS

	Race/Ethnicity Information	Regions	Years of Experience	Income and Service Profile	Method and time working with consultant (MHC)	Most helpful from MHCs	Suggestions for improvement
Center Teachers (4)	White/European teachers at predominately White classrooms	Northwest, Olympic Peninsula, Southwest	5-15; classroom size from 9-20 children.	0-15% estimate of low income families or no answer.	From 4-7 months, 2 said about 6 months. One teacher said they had both virtual and on-site services. All others said virtual only.	* New classroom ideas * Activities for consistency among partners * New perspective to challenging behaviors, creates common language between families and staff *Listener, neutral guidance	Onsite, classroom observations (3 out of 4)
Family Child Cares (FCC) (2)	White/European providers offering English speaking care. One provider said 100% White children, the other didn't answer	Olympic Peninsula	27 and 31 years; 11 and 10 children in care	0% of 5% working subsidy, estimated 90% or 100% middle income families, one serves children in foster care	From 2 months to 6 months. Both virtual only interactions.	*Listens, brought a new perspective, cheerleader, sounding board. * Ideas, identify what's working ad not, acknowledge me and my feelings as important to program health.	None offered.
Family Child Care (FCC) (1)	Hispanic/Latina(o) offering Spanish care for 97% Hispanic/Latina(o) children.	King/Pierce	2 years in operation, 7 years in child care; 13 children in care	99% of families receive subsidy and estimated to be low income; serves foster, homeless, and special needs children	About one year. Virtual interactions only.	* Great information, how to speak with families, advice on activities and books and coping methods for children.	None offered.

	Race/Ethnicity Information	Regions	Years of Experience	Income and Service Profile	Method and time working with consultant (MHC)	Most helpful from MHCs	Suggestions for improvement
Center Directors (15)—2 of these didn't answer any satisfaction questions below	1 African American or Black, 2 Hispanic or Latina(o), 12 White; English speaking, predominantly White children at centers with Chinese (SW), Farsi (Eastern), Ukrainian and Romanian (SW), Somali (Eastern), and Russian (Eastern & SW) spoken by children	King/Pierce (1), NW (4), OP (3), Eastern (4), SW (3)	Wide range in management experience- 0-17 years, big range in child development education as well; programs from 11 children to 50+ (5); most above 20	Anywhere from 3% to 75% subsidy. Only 1 listed no populations served, special needs (11), foster care (10), tribal communities (6), homelessness (5), teen parents (4), migrant families (2)	Ranges from a couple of months to one year.	* Listening and support (3) * Resources and ideas * Help with difficult behavior * Getting to know the center, assistance and advice	More MHCs (3) On-site services (3) 1 comment for more role clarity of consultation

APPENDIX D: WHEN TO REFER TO YOUR MENTAL HEALTH CONSULTANT

When to Reach Out to your Regional MHC

(The following guidance can be used by Early Achievers Coaches to consider when it might be helpful to reach out to your region's mental health consultant.)

- When a child's social-emotional development or behavior is a concern, a child is at risk for expulsion from care, and/or you and a provider are looking to explore additional strategies to support a child/family.
- If a provider has a history of suspending, expelling or otherwise excluding children due to challenging behaviors or difficult relationships with families.
- When you are concerned about a provider's wellbeing (extraordinary stress, difficulty regulating, major crisis, concern about mental/emotional wellbeing or ability to cope).
- When a program experiences a serious illness or loss, such as the death of a staff member, parent, child, or other important person which is likely to have an impact on children, families and/or staff connected to the program.
- When support is needed around therapeutic transitions for children and families, or referrals to early intervention, developmental preschool or other therapeutic services seem warranted.
- If a program is experiencing high levels of staff stress, turnover, low morale, and/or ongoing strained or conflicted relationships between adults.
- If a provider has a high percentage of children in foster care, families involved with child welfare, and/or children with trauma histories.
- When training is needed on topics such as: trauma-informed care, emotional regulation for children and adults, supporting providers and children with COVID-related stress responses, etc.
- If a provider hasn't been able to make desired changes or program improvements despite supportive coaching, you suspect there may be underlying factors affecting progress, and/or you would like to partner with a consultant to support a provider who has been challenging for you to work with.

If any of these circumstances apply to child care providers on your caseload, please consider reaching out to partner with your regional mental health consultant (MHC). MHCs are available to consider these cases with you, regardless of whether the provider signs up for ongoing consultation.

APPENDIX E: INTERIM REPORT IECMHC NEEDS ASSESSMENT SURVEY DATA

Early Achievers 2020 Provider Survey Data

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

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

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

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

By Region

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

By Provider Type

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

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

By Region

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

By Provider Type

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

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

By Region

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

By Provider Type

	Family Child Care		Child Care Center		School Age Only Program	
Yes, we screen all of our children	37%	229	58%	194	13%	3
Yes, we screen when we have a concern	21%	128	17%	58	26%	6
We've been trained, but haven't used these tools yet	17%	104	9%	30	17%	4
No, we need more training or information	26%	159	15%	50	43%	10
Total		620		332		23

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

By Region

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

By Provider Type

	Family Child Care		Child Care Center		School Age Only Program	
Yes	34%	212	63%	214	52%	12
No	66%	419	37%	128	48%	11
Total		631		342		23

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

By Region

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

By Provider Type

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

APPENDIX F: LITERATURE REVIEW

Background

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

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

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

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

Outcomes

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

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

Gaps in the Literature Base / Emerging Evidence

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

Race and Infant and Early Childhood Mental Health Consultation

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

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

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

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

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

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

Evaluating Workforce Development: Dosage, Processes and Equity

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

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

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

Organizational Capacity

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

Conclusion

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

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

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