REPORT OF THE VIRGINIA DEPARTMENTS OF EDUCATION, BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES, AND SOCIAL SERVICES

Feasibility Study of Developing an Early Childhood Mental Health Consultation Program (HJR 51, 2020)

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**

HOUSE DOCUMENT NO. 3

**COMMONWEALTH OF VIRGINIA
RICHMOND
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COMMONWEALTH of VIRGINIA

December 18, 2020

The Honorable Ralph S. Northam
Governor, Commonwealth of Virginia
Office of the Governor
P.O. Box 1475
Richmond, Virginia 23218

Virginia General Assembly
900 E. Main Street
Pocahontas Building
Richmond, Virginia 23219

Dear Governor Northam and Members of the Virginia General Assembly:

I am pleased to submit the enclosed report that summarizes the findings of a feasibility study of adopting a statewide Early Childhood Mental Health (ECMH) consultation model to prevent suspensions and expulsions of young children attending early care and education programs in Virginia and provides a set of recommendations for developing, implementing, funding, scaling, and evaluating a statewide ECMH consultation program.

Joint Resolution 51 (HJ 51- Sickles/Hanger) directs the Departments of Education, Behavioral Health and Developmental Services, and Social Services to jointly study the feasibility of developing an early childhood mental health consultation program available to all early care and education programs serving children from birth to five years of age. The resolution tasked a workgroup, led by these agencies, to complete five specific tasks:

   i.   identify the appropriate state agency to scale up a statewide ECMH consultation program,
  ii.   study effective models of ECMH consultation,
 iii.   identify funding streams that Virginia could access to support statewide implementation of ECMH consultation,
  iv.   develop a plan for scaling up the ECMH workforce that builds off existing resources, and
   v.   provide recommendations for legislative, regulatory, budgetary, and other actions necessary to implement such a plan.

The legislation requires that an executive summary and report of findings is submitted to the Governor and General Assembly for publication as a House or Senate document by the first day of the 2021 Regular Session of the General Assembly.

If you have any questions or require additional information, please do not hesitate to contact Jenna Conway, Chief School Readiness Officer, by telephone at (804) 225-3717 or by email at Jenna.Conway@governor.virginia.gov.

Sincerely,

James F. Lane, Ed.D.
Superintendent of Public Instruction

JFL/JC/lh

Enclosure

c: The Honorable Atif Qarni,
        Secretary of Education

House Joint Resolution No. 51
Feasibility Study of Developing an
Early Childhood Mental Health
Consultation Program

Report Prepared for the Governor and General Assembly

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Executive Summary

[House Joint Resolution 51](#) (HJ51) was passed by the Virginia General Assembly in the 2020 legislative session. This legislation tasked a workgroup, led by the Virginia Department of Education, the Virginia Department of Social Services, and the Virginia Department of Behavioral Health and Developmental Services, with studying the feasibility of adopting a statewide Early Childhood Mental Health (ECMH) consultation model to prevent suspensions and expulsions of young children attending early care and education programs in Virginia. The resolution outlined five specific tasks for the workgroup to complete:

    i.   identify the appropriate state agency to scale up a statewide ECMH consultation program,

    ii.   study effective models of ECMH consultation,

    iii.   identify funding streams that Virginia could access to support statewide implementation of ECMH consultation,

    iv.   develop a plan for scaling up the ECMH workforce that builds off existing resources, and

    v.   provide recommendations for legislative, regulatory, budgetary, and other actions necessary to implement such a plan.

This report summarizes the study's findings and provides a set of recommendations for developing, implementing, funding, scaling, and evaluating a statewide ECMH consultation program in Virginia.

Suspensions and Expulsions from Early Care and Education Programs

Over the past decade, the alarming use of suspensions and expulsions in early care and education settings has received much attention from researchers, practitioners, and policymakers.[1] In Virginia, nearly 6 children for every 1,000 enrolled are suspended or expelled from public preschool – a rate that is the sixth highest in the nation.[2] This rate increases to 13 children for every 1,000 enrolled when including a variety of early care and education settings, including Head Start, Early Head Start, child care centers, Virginia Preschool Initiative (VPI), day home providers, and early childhood special education (ECSE) programs.[3] The use of suspension and expulsion in preschool, much like in K-12 education, is inequitable.[4] Children with mental health issues and behavior problems, Black children, and boys are at an especially heightened risk of being disciplined through these exclusionary practices in early childhood.[1, 5]

The COVID-19 Pandemic's Negative Impact on Young Children

Critically, Virginia, along with the United States and world, is facing an unprecedented health and economic crisis with the current COVID-19 pandemic. The pandemic is having an outsized impact on low-income families and communities of color.[24, 25] Young children's daily routines, early learning, and social experiences have been upended resulting in significant and serious negative impacts on young children's lives. Given the current context and deep concerns about rising inequities due to the pandemic, Virginia should strongly consider initially prioritizing

access to an ECMH consultation for the most under-resourced communities, early care and education programs, and children.

Early Childhood Mental Health (ECMH) Consultation

States are increasingly investing in ECMH consultation to address children's challenging behaviors, support their mental health well-being, and prevent suspensions and expulsions from group-based early care and education settings. ECMH consultation is an intervention strategy that pairs a mental health professional (i.e., "consultant") with the adults (i.e., caregivers, teachers, and families) who work with infants and young children in the settings where they grow and learn.[26] ECMH consultation improves children's social, emotional, behavioral, and mental health outcomes by building the capacity of the adults who interact with children and their families.[26, 27]

Previous research demonstrates that the use of ECMH consultation is associated with improvements in children's behavior, including decreases in challenging behavior and increases in social skills, communication, and self-control.[28] Further, ECMH consultation is consistently linked with improvements in quality of teacher-child interactions and classroom quality.[29] Of particular relevance to the current study, ECMH consultation is associated with fewer instances of expulsion; some theorize that ECMH consultation, although not created to address implicit bias, may reduce implicit bias among teachers, thus affecting disciplinary decisions, particularly for young boys of color.[37]

ECMH consultation must be of sufficient quality and dosage in order to improve adults' interactions with children and children's social-emotional skills and mental health. Experts in the field, including the Center of Excellence for Infant and Early Childhood Mental Health Consultation, strongly encourage the use of master's level mental health professionals for ECMH consultation. Additionally, research consistently points to the consultative alliance, or the degree to which the consultant and consultee perceive that they are working as partners, as a key factor for promoting the effectiveness of ECMH consultation.[39, 48, 49]

Implementing ECMH Consultation Within the Pyramid Model Framework

In order for an ECMH consultation program to be used effectively and strategically, it should be implemented within a multi-tiered system of support (MTSS). MTSS is a data-driven, problem-solving framework that uses a continuum of evidence-based practices matched to student needs to improve outcomes for all students. The *Pyramid Model for Promoting Young Children's Social Emotional Competence* is a MTSS system designed specifically for early childhood education and care settings. The Pyramid Model is a framework of evidence-based practices provided by teachers, home visitors, coaches, behavior specialists, ECMH consultants, program leaders and others to support young children's social and emotional development and prevent challenging behavior in early childhood settings.[50, 51] The Pyramid Model starts with universal strategies to support all children in the classroom and moves toward more targeted interventions for children with severe and persistent challenging behavior.[54] This tiered model

of support results in strategically utilizing mental health professionals for the children who need it most, while also utilizing other prevention and early intervention options that are available within the early childhood system (e.g., evidence-based professional development opportunities, practice-based coaching, use of a behavior specialist). At all tiers of support, all providers serving children and families must be trained to promote social and emotional development, driven by developmentally appropriate practices including nurturing and supportive interactions and trauma-informed approaches.

Funding and Scaling ECMH Consultation in Group-Based Early Care and Education Settings

States across the nation are increasingly investing in ECMH consultation to address children's challenging behaviors, support their mental health well-being, and prevent suspensions and expulsions from group-based early care and education settings because it is recognized as a cost-effective strategy.[55] Funding ECMH consultation can be challenging, though, due to the prevention-based nature of the service and lack of a dedicated funding source. States use a myriad of approaches and sources to fund their ECMH consultation programs, but the most prevalent funding sources being leveraged are state general funds and federal grants such as the Child Care and Development Block Grant.[56] States also approach scaling ECMH consultation programs in different ways, however, it is common for states to implement an ECMH consultation program in a smaller-scale pilot before expanding to reach statewide capacity.

Summarized Recommendations

The following recommendations were developed by the HJ51 workgroup members, led by the Virginia Department of Education, the Virginia Department of Social Services, and the Virginia Department of Behavioral Health and Developmental Services. To develop these recommendations, workgroup members consulted with national experts, conducted research on effective ECMH consultation programs, reviewed other states' ECMH consultation programs, analyzed the existing set of resources in Virginia to draw from, and held rich discussions through a series of workgroup meetings. Further context and details for these recommendations are provided on pages 26-33 of this report.

1. Recommendations for Developing an ECMH Consultation Program:
   - Begin to build a statewide ECMH consultation program by offering services to providers working in group-based early care and education settings serving children from birth to age 5.
   - Continue investments in the larger infant and early childhood mental health system in Virginia. Additionally, further study how to build and coordinate a comprehensive and connected system of infant and early childhood mental health that includes consultation in other settings (e.g., home visiting, primary care) as well as other mental health services that serve Virginia's infants, toddlers, and preschoolers.
   - Within group-based early care and education settings, situate an ECMH consultation program within the education system and a multi-tiered system of support (i.e., Pyramid Model Framework).

- Coordinate an ECMH consultation program across the infant and early childhood mental health and the early education systems more broadly and within the larger early childhood education workforce (teachers, home visitors, coaches, behavior specialists, program leaders, and ECMH consultants). Draw from services that already exist in Virginia.
- Develop a centralized system to receive requests for services.
- Consider implementing ECMH consultation services using regional networks.
- Ensure that ECMH consultants are sufficiently trained and will offer consultation services that are evidence-based.

2. Recommendations for Building a Qualified Early Childhood Workforce, including ECMH Consultants:
   - Build a comprehensive and diverse workforce within a tiered system of support that includes early childhood teachers, coaches, behavior specialists, home visitors, program leaders, and ECMH consultants.
   - Invest in the development of a skilled and diverse ECMH consultant workforce.
   - Make intentional efforts to recruit and retain ECMH consultants who represent the demographic make-up of the children being served.
   - Further develop coursework and training related to infant and early childhood mental health at universities.
   - Create opportunities for professionals seeking to become an ECMH consultant to obtain relevant work experience.

3. Recommendations for ECMH Consultant Qualifications and Competencies:
   - Require that ECMH consultants meet the following basic qualifications:
     - Hold a master's degree in social work, psychology, school counseling, or related field.[a]
     - Have at least 2-3 years of experience working as a mental health professional with young children and families.
   - Ensure that ECMH consultants display the competencies outlined by the Center of Excellence for Infant and Early Childhood Mental Health Consultation (included in Appendix C). These competencies are very comprehensive and are intended to guide the hiring, training, professional development, and evaluation of ECMH consultants.
   - Explore ways of credentialing ECMH consultants to distinguish them from other, similar workforce roles that do not have the same level of clinical mental health expertise in early childhood.

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[a] Note that some have argued that a bachelor's degree may be substituted with substantial experience and supervision by a licensed mental health professional, although this is not aligned with guidance from the Center of Excellence for Infant and Early Childhood Mental Health Consultation.

4. Recommendations for Building the Infrastructure to Implement a Statewide ECMH Consultation Program:
   - House the contract centrally within the Department of Education and create formalized partnerships with other relevant agencies including the VDBHDS.
   - Develop state-wide infrastructure for coordinating and monitoring ECMH consultation across regions.
   - Create an advisory committee with cross-agency representation to get buy-in and support or use an existing group such as the Early Childhood Mental Health Virginia Advisory Board.
   - Explore the feasibility of developing out to the broader mental health system to create a comprehensive service system for infants, toddlers, preschoolers, and their caregivers beyond early care and education.

5. Recommendations for Funding an ECMH Consultation Program Within a Fully Implemented Pyramid Model System:
   - Fund prevention and promotion efforts at tiers 1 and 2 of the Pyramid Model and partner with organizations doing this work currently.
   - Develop a sustainable funding mechanism for ECMH consultation that utilizes multiple funding sources, including a mix of both federal and state funds.

6. Recommendations for Evaluating the Impact of an ECMH Consultation Program:
   - Require evaluation of the ECMHC model to ensure that the investment is leading to improvements, including the prevention of suspensions and expulsions.
   - Gather and connect data from multiple sources and systems to understand the effectiveness of an ECMH consultation program.
   - Determine categories of data that are being collected and include both implementation and outcome data.
   - Make data available to the public.

Summary and Next Steps

The recommendations presented here are broad and comprehensive. Additional time and study will be required to determine specifics related to funding and statewide implementation of an ECMH consultation model. Consistent with other states who have adopted ECMH consultation models, the General Assembly may wish to begin by funding an initial smaller program, evaluating its success, and then scaling to a comprehensive and statewide model over a few years. In response to the disparate impact of the COVID-19 pandemic on disadvantaged children and families, the General Assembly may wish to prioritize access to an ECMH consultation program for the most under-resourced children attending early care and education programs.

Background and Introduction

Overview of House Joint Resolution 51

[House Joint Resolution 51](#) (HJ51) was passed by the Virginia General Assembly in the 2020 legislative session. HJ51 initiated a feasibility study of developing an Early Childhood Mental Health (ECMH) consultation program available to all early care and education programs serving children from birth to five years of age in Virginia. The resolution specified that the feasibility study be conducted jointly between the Virginia Department of Education (VDOE), the Virginia Department of Social Services (VDSS), and the Virginia Department of Behavioral Health and Developmental Services (VDBHDS), and included the convening of a workgroup composed of national, state, and local experts and stakeholders. A total of 55 people engaged in the workgroup. Workgroup members gathered for three whole-group meetings and one smaller, content-specific sub-group meeting. Throughout the study's process, workgroup members were invited and encouraged to provide ideas and information, engage in discussion, and provide feedback on the report and recommendations. A more detailed description of the study process and list of workgroup members are provided in Appendix A.

The workgroup was tasked with studying the feasibility of adopting a statewide ECMH consultation model to prevent suspensions and expulsions of young children attending early care and education programs in Virginia. The resolution outlined five specific tasks for the workgroup to complete:
   i. identify the appropriate state agency to scale up a statewide ECMH consultation program,
   ii. study effective models of ECMH consultation,
   iii. identify funding streams that Virginia could access to support statewide implementation of ECMH consultation,
   iv. develop a plan for scaling up the ECMH workforce that builds off existing resources, and
   v. provide recommendations for legislative, regulatory, budgetary, and other actions necessary to implement such a plan.

This report summarizes the study's findings and provides a set of recommendations for developing, implementing, funding, scaling, and evaluating a statewide ECMH consultation program in Virginia.

Problem HJ51 Addresses: Suspensions and Expulsions in Early Care and Education Programs

Over the past decade, the alarming use of suspensions and expulsions in early care and education settings with young children reported to display challenging behaviors has received much attention from researchers, practitioners, and policymakers. Preschool children are expelled from public programs at a rate that is more than three times higher than K-12 students nationally.[1] In Virginia, the difference was even more striking: 10.25 preschoolers were expelled for every 1,000 enrolled, a rate 6.88 times higher than the K-12 student expulsion rate.[1] Out of

the 40 states that had preschool programs at the time of the study, Virginia had the 10th highest preschool expulsion rate. In a more recent report using data from 2018, nearly 6 preschoolers were suspended or expelled for every 1,000 enrolled in public preschool in Virginia, suggesting that rates have decreased somewhat over the past 15 years.[2] However, Virginia had the sixth highest suspension and expulsion rate of all 50 states plus Washington, D.C.[2] The use of expulsion and other types of exclusion are still common and concerning, especially when considering programs beyond state-funded preschool. For example, results from a recent survey of Virginia's early care and education providers indicate that the rate of removal from early care and education settings for children reported to display challenging behavior persists across settings. Across teachers surveyed in Head Start, Early Head Start, child care centers, Virginia Preschool Initiative (VPI), day home providers, and early childhood special education (ECSE) programs, the average removal rate was 13 children for every 1,000 enrolled.[3]

The use of suspension and expulsion in preschool, much like in K-12 education, is inequitable.[4] Children with mental health issues and behavior problems, Black children, and boys are at an especially heightened risk of being disciplined through these exclusionary practices in early childhood.[1,5] A 2014 report from the U.S. Department of Education Office for Civil Rights further demonstrated that Black students experience disproportionately high levels of harsh and exclusionary disciplinary actions.[6] This report found that Black children represent only 18% of preschool enrollment in the United States but 48% of the preschool children suspended more than once. Additionally, although boys represent only 54% of the total preschool enrollment, they represent 82% of preschool children suspended more than once. Higher rates of disciplinary actions for Black students are present even when controlling for levels of teacher-reported disruptive behavior[7] and the seriousness of the misbehavior,[8] indicating that racial bias plays an important role in the discipline gap between Black and White students.[9] This evidence suggests that the school to prison pipeline actually begins as early as preschool.[4]

Suspension, expulsion, or removal from an early care and education setting due to behavioral challenges is concerning for multiple reasons. First, suspensions are not effective at discouraging misbehavior or improving behavior because the underlying cause of the misbehavior is never addressed.[10] In fact, the opposite relationship appears to be the case in which early suspensions beget future suspensions. Second, suspensions and expulsions predict a host of future negative and costly outcomes, including academic failure, grade retention, high school dropout, and incarceration.[11, 12] These links are strong — children who receive suspensions or expulsions are up to ten times more likely to drop out of high school than children who do not.[11] Third, removing a child from an early learning program exacerbates issues by delaying or cutting off much-needed social-emotional and/or mental health services that would help to address the underlying behavioral concern. This removal often results in children with mental health problems not receiving evidence-based treatments for treatable disorders. Finally, removing a child from their early education and care setting increases family stress which further undermines children's healthy social-emotional and behavioral development.[13]

States and school districts are increasingly creating policies to eliminate suspensions and expulsions of our youngest students,[14] but these policy changes are unlikely to shift the classroom dynamics that negatively impact young children, especially young Black children, in U.S. classrooms.[9] Although suspension and expulsion represent the most serious disciplinary consequences, research indicates that before children are suspended and/or expelled, they are subjected to harsh and exclusionary disciplinary practices *in the classroom setting* (i.e., disciplinary practices that remove students from or limit their academic and/or social-emotional learning opportunities such as time out, isolated seating, and/or removal from an activity), causing children to lose the opportunity to fully engage in learning activities. Losing opportunities to engage in learning is particularly detrimental, given the rapid brain development that occurs during this stage of development. Although there is less research on the frequency of these in-classroom disciplinary practices, available evidence suggests that Black children experience these practices disproportionately.[15, 16] Without effective, classroom-based prevention and intervention strategies present within early childhood care and education programs and classrooms, eliminating out-of-classroom consequences may *exacerbate* the *within*-classroom disciplinary issues because teachers are ill-equipped to teach students who in the past they would have sent away. These experiences have long-lasting impacts on children's lives.

Students who experience high levels of harsh and exclusionary disciplinary actions lose valuable instructional time and are at risk for escalating academic problems, grade retention, and school dropout.[17, 18] Young Black students may be impacted to an even greater degree, both because they are more likely to experience out-of-classroom and in-classroom discipline, but also because, over time, they will recognize the discriminatory nature of some actions which may lead them to lose trust in their teachers, lose motivation to learn, and dislike school – pushing them toward negative outcome trajectories including school drop-out, juvenile detention, lower wages, and incarceration.[12, 19] However, these negative trajectories are preventable if they are intentionally addressed before maladaptive behavior and interactions patterns become stable and long-standing.[20, 21, 22]

Young children are in the early developmental stages of learning social and emotional skills. As a result, almost all young children struggle to manage their emotions and behaviors at one time or another. Challenging behavior occurs frequently in early childhood settings, and this is expected developmentally.[23] Young children develop self-regulation through co-regulation with responsive adults in the context of safe and strong relationships. When teachers provide strong and positive connections to their students and high-quality learning experiences are in place, most children learn how to express their emotions, control their behaviors, and make social connections with adults and other children in these settings (i.e., the challenging behavior does not persist). These supports include engaging interactions and relationships with teachers and peers, developmentally appropriate curriculum with a strong emphasis on social-emotional learning, and inclusive, equitable, and antiracist learning environments. Further, efforts to address children's mental health must be grounded in current neuroscience research and an understanding of children's biological and behavioral responses to stress. The first three years of life are the most critical time period for a child's developing brain architecture. This is also a

developmental period during which adults co-regulate with young children as they begin to learn to regulate their own emotions and behaviors. The provision of high-quality supports in the learning environment serves to promote children's social-emotional skills, prevent challenging behaviors, and ultimately reduce the need for intensive intervention, such as ECMH consultation. While these prevention strategies are effective with most children, some children will continue to experience mental health challenges, possibly due to risk factors including witnessing domestic violence, being placed in foster care, or other experienced trauma. In these cases, intervening through more intensive interventions such as ECMH consultation is a warranted and effective strategy. Intervening early can effectively address young children's mental health needs and prevent the need for mental health treatment later in life.

The Negative Impact of the COVID-19 Pandemic on Children's Mental Health

Critically, Virginia, along with the entire United States and world, is facing an unprecedented health and economic crisis with the current COVID-19 pandemic. The pandemic is having an outsized impact on low-income families and communities of color. There are well-documented disparities in the rates of COVID-19 infection, illness, and death among communities of color due to inequities in social determinants of health such as discrimination, crowded housing, and access to health care.[24] Further, low-wage workers are more likely to be laid off from jobs, resulting in greater economic hardship, food insecurity, and evictions.[25] These experiences can no doubt be traumatic for young children and have a significant impact on their mental health well-being. Children are impacted even if they do not directly experience these traumatic events. For instance, the pandemic adds stress to families who may be trying to simultaneously parent and work from home. Additionally, young children's daily routines have been upended and many must engage in remote learning which makes it extremely difficult to form meaningful connections with their teachers and peers. Vulnerable children and children of color are also disproportionately impacted by lower-quality educational opportunities. Given the current context and deep concerns about rising inequities due to the pandemic, Virginia should strongly consider initially prioritizing access to an ECMH consultation for the most under-resourced communities, early care and education programs, and children.

Preventing Suspensions and Expulsions in Early Care and Education Programs: Early Childhood Mental Health (ECMH) Consultation

In 2014, the U.S. Department of Health and Human Services and the U.S. Department of Education issued a joint policy statement on expulsion and suspension policies in early childhood settings. The main goals of the policy statement were to raise awareness about the issue of exclusionary discipline practices in early childhood settings and to provide recommendations and resources around adopting prevention-oriented, evidence-based policies and interventions to decrease use of these practices and to promote children's social-emotional development and mental health well-being. One recommendation included in the policy statement was for states to invest in their early childhood workforce by implementing a statewide Early Childhood Mental Health (ECMH) consultation system.

ECMH consultation is an intervention strategy that pairs a mental health professional (i.e., "consultant") with the adults (i.e., caregivers, teachers, families) who work with infants and young children in the settings where they grow and learn.[26] ECMH consultation is sometimes referred to as infant and early childhood mental health (IECMH) consultation, but for the purposes of this report "ECMH consultation" is used to refer to mental health consultation serving infants, toddlers, and preschoolers. ECMH consultation improves children's social, emotional, behavioral, and mental health outcomes by building the capacity of the adults who interact with children and their families.[26, 27] Importantly, ECMH consultation is not a treatment delivery model. Rather, its goal is for consultants to problem-solve mental health concerns or challenging behaviors with the adults who care for children and to guide adults to interpret and respond to children's challenging behaviors using an early childhood developmental perspective. In this way, ECMH consultation seeks to improve the ongoing, daily interactions between children and their caregivers to support children's optimal development. Working collaboratively with children's caregivers and families, consultants perform a variety of activities such as conducting observations and needs assessments, facilitating workshops and trainings, and modeling best practices. Consultants' work is responsive to the specific context, culture, and needs of the child and their setting. As such, implementation of ECMH consultation may look differently across sites or states.

ECMH consultation can be implemented in a variety of settings (e.g., home visiting, child welfare), however, most of the extant data come from the early care and education system, due to its use as a key strategy for reducing suspensions and expulsions from these settings. Indeed, HJ51 frames a potential statewide ECMH consultation program in Virginia around preventing early childhood suspensions and expulsions. Therefore, for the purposes of this study, ECMH consultation is focused on consultation delivered within the context of group-based early care and education programs serving children birth to age 5 including family day homes, child care centers, Early Head Start and Head Start programs, Virginia Preschool Initiative (VPI), Early Childhood Special Education (ECSE), and private programs. In a survey of early care and education providers in Virginia, 63% of respondents noted that ECMH consultation was a desirable service to help address the needs of children with challenging behavior, the highest among all possible supports listed on the survey.[3]

ECMH consultation is part of a larger system of services under the umbrella of infant and early childhood mental health that support young children's social-emotional and mental-health well-being (See Figure 1). This umbrella of services includes multi-sector ECMH consultation (e.g., consultation occurring within early childhood care and education settings, primary care settings, home visiting); maternal, infant, and early childhood home visiting programs; practice-based coaching; social-emotional screening, mental health assessment, evidence-based treatment, and others. ECMH consultation is not intended to replace any of these existing services. Rather, ECMH consultation should be embedded within this larger system, and a broad array of ECMH services should be supported and coordinated across sectors and settings to maximize benefits for children and families. Virginia should continue building and strengthening its comprehensive system of infant and early childhood mental health to

effectively serve Virginia's infants, toddlers, and preschoolers as well as their caregivers, educators, and families.
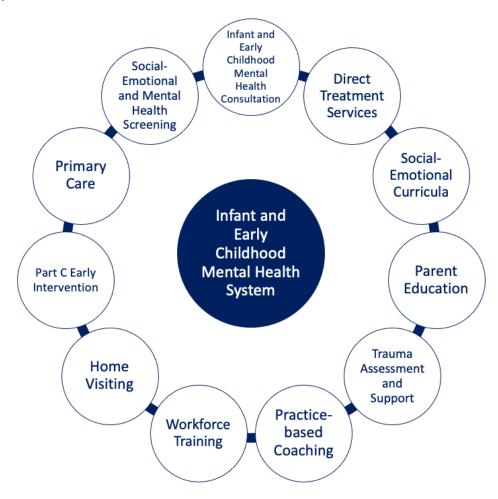

Figure 1: Infant and Early Childhood Mental Health System

Review of Research on ECMH Consultation

This section summarizes the extant research on ECMH consultation in early care and education settings, including its evidence for effectiveness in promoting children's social-emotional development and mental health well-being and reducing early childhood suspensions. Relevant findings related to core components of effective ECMH consultation models are also described.

How effective are ECMH consultation programs at promoting positive outcomes and reducing early childhood suspensions and expulsions?

Previous research demonstrates positive effects of ECMH consultation for children, teachers, and early childhood programs. ECMH consultation is associated with decreases in challenging behavior and increases in positive social and emotional outcomes for young children, including

increases in social skills, communication, and self-control.[28] ECMH consultation is also associated with improvements in quality of teacher-child interactions and classroom quality.[29]

Experimental Evidence

Four rigorous randomized controlled trials (RCTs) have evaluated the effect of ECMH consultation (see Appendix B for a comprehensive summary of these RCTs). Raver and colleagues investigated the effect of the Chicago School Readiness Program (CSRP) and found that classrooms that received ECMH consultation had significant growth in their classroom quality.[30] Namely, the intervention teachers had higher levels of positive climate, teacher sensitivity, and more effective management of children's behavior and lower negative climate in the spring, controlling for fall quality, compared to the control teachers. Two RCTs focused on evaluating the effects of the Early Childhood Consultation Partnership (ECCP), a statewide system of ECMH consultation in Connecticut.[31, 32] Children in classrooms that received ECCP had significant reductions in teacher-reported externalizing behavior problems (e.g. hyperactivity, oppositional behaviors).[31] The more recent evaluation of ECCP indicated that children in classrooms that received ECCP had significant reductions in hyperactivity, restlessness, externalizing behaviors, and total problem behavior, compared with children in the control group.[32] Finally, a recent small RCT further demonstrated positive effects of a specific model of consultation, Learning to Objectively Observe Kids (LOOK).[33] Teachers who received LOOK consultation reported significantly higher efficacy in managing disruptive behavior and use of evidence-based social-emotional teaching strategies, compared to teachers in the control group.[33] In terms of child behavior, LOOK teachers reported significant 1) reductions in target children's negative task engagement and peer disruption and 2) improvements in target children's peer interaction skills and emotion regulation, compared to control group teachers.[33] Thus, causal evidence supports use of ECMH consultation as an effective intervention to improve teacher and child outcomes.

Quasi-Experimental and Correlational Evidence

Correlational and evaluation evidence also points to the promise of ECMH consultation for improving child behavior and teaching quality and reducing teacher stress and expulsions. This research has consistently found that consultation is associated with more positive social and emotional outcomes and fewer instances of challenging behavior for young children.[28, 34, 35, 36]

> **Teaching Practices.** In high quality ECMH consultation, teachers learn new behavior management skills and different approaches to understanding child behavior, including the impact of developmental and contextual factors, and the use of these new teaching skills may result in improved child outcomes.[37] Teachers reported greater understanding of children's behavior and greater empathy for children with behavior problems after receiving ECMH consultation.[38] Further, teachers who engaged in more frequent consultation activities had greater change in their practices, including more positive interactions, less detachment, and less punitiveness.[39] Greater engagement in consultation is linked with improvements in teaching practices, including using more positive practices and less punitive practices.[40]

Teacher Well-being. ECMH consultation is associated with improved teacher well-being, as measured by lower levels of stress and higher job satisfaction. In a sample of 115 teachers receiving ECMH consultation in Arkansas, Connors-Burrow and colleagues[40] found that the amount of time that teachers spent meeting with consultants was associated with lower intention to leave the childcare profession. Olmos and Grimmer found that teacher stress, burnout, and turnover decreased as a result of consultation in the Parent/Provider Effectiveness in Early Learning Environments (PEARL) project in Colorado.[41] Studies have found that use of consultation is associated with higher teacher efficacy, particularly related to efficacy managing challenging child behavior in the classroom.[33, 38]

Exclusionary Discipline. Finally, ECMH consultation has been studied as a potential way to decrease the use of exclusionary discipline, namely expulsion. However, while consultation is often described as a strategy for reducing exclusion, few studies have addressed this empirically, and the vast majority have used correlational designs.[42] In a seminal national study of nearly 4,000 prekindergarten classrooms, Gilliam found that the likelihood that a program expelled a child in the previous year decreased significantly when the program had access to ECMH consultation.[1] In fact, centers with on-site mental health consultants had the lowest rates of expulsion compared to centers with no or limited access to consultation. In a 4-year evaluation of consultation in Maryland, over 79% (n = 114) of the children who were at risk of expulsion from preschool due to challenging behavior remained in their preschool following consultation.[34]

More recently, a study of 124 center-based preschool teachers found that ECMH consultation buffered the relation between teacher depression and expulsion.[43] For teachers who had access to consultation, teacher depression was not significantly related to teacher's use of expulsion. In contrast, for teachers without access to consultation, higher teacher depression significantly predicted expulsion.[43] Some theorize that ECMH consultation, although not created to address implicit bias, may reduce implicit bias among teachers, thus affecting disciplinary decisions, particularly for young boys of color.[37]

Guidance on Core Components for Effective ECMH Consultation Models

The Georgetown University Center for Child and Human Development (GUCCHD) [Center of Excellence for Infant and Early Childhood Mental Health Consultation](#) has developed a widely-used framework to conceptualize effective ECMH consultation programs by conducting an in-depth analysis of six ECMH consultation sites that demonstrated positive evaluation outcomes.[27] This framework, shown in Figure 2, highlights three core components of effective ECMH consultation programs and two "catalysts for success," or process elements, that need to be in place to ensure ECMH consultation is effective at improving children's social-emotional, behavioral, and mental health outcomes. The three core components are solid program infrastructure, highly-qualified consultants, and high-quality services. The two "catalysts for

success" are positive relationships and readiness for ECMH consultation. While the research base is still fairly limited in terms of the available evidence behind these core components,[44] below is a summary of what is currently known for each component.
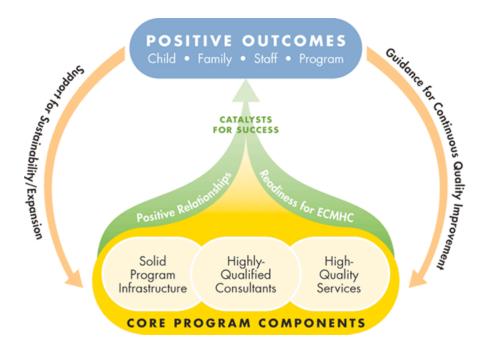

Figure 2: Framework for Effective ECMH Consultation Programs [27]

Solid Program Infrastructure

An effective ECMH consultation program needs to have solid program infrastructure. Program infrastructure includes ten elements:[27]
- program leadership
- a well-defined model and theory of change
- a clear organizational structure that delineates roles and responsibilities
- systems for hiring and training program staff
- ongoing supervision and support for mental health consultants
- strategic partnerships across various sectors
- community outreach and engagement
- communication
- evaluation
- financing

Highly Qualified Consultants

Various organizations, model programs, and researchers have put forth descriptions of consultant qualifications. Experts in the field strongly encourage the use of licensed or license-eligible master's level mental health professionals for ECMH consultation. For example, the

Center of Excellence for Infant and Early Mental Health Consultation recommends the following minimum qualifications:

- Master's degree in social work, psychology, or related field (preferably licensed)
- At least 2-3 years of experience working as a mental health professional
- Possess attributes and skills critical to this work such as a consultative stance, cultural sensitivity, and empathy
- Have specialized knowledge and deep understanding of social, emotional, and relational health

In the scientific literature, most studies report that consultants hold a master's degree or higher.[30, 32, 45]

Effective consultants need to be able to guide consultees in reflective practice, implement problem-solving strategies, and build consultees' capacities to work with young children.[46] Consultants must also demonstrate specific skills including observation, listening, interviewing, administering assessments, as well as work from a strengths-based approach, appreciate cultural differences, and be able to form trusting and respectful relationships with adults.

While hiring consultants who come to the job with a strong skill set is important, the need to provide consultants with ongoing support and training is widely recognized. For example, one approach is to design an intensive pre-service training program that is specific to ECMH consultation in early care and education settings and which consultants must complete before becoming certified to provide ECMH consultation services.[47] It is also recommended that consultants engage in regular, in-service reflective supervision in which the focus is on helping the consultant process their own emotions regarding the work with a supervisor to promote professional growth and prevent burnout.[44]

High-Quality Services

There are many types of services that a consultant might deliver to a consultee. The specific service depends on the nature of the referral for which the consultant's services were requested and the ECMH consultation program model being implemented. Program/classroom consultation involves supporting program staff and teachers to enhance social-emotional and mental health outcomes of the classroom or program more broadly. Child/family consultation is directed at a particular child who is displaying challenging behavior by supporting the skills of the teacher and potentially the child's family.

The positive impact of ECMH consultation to improve teachers' practice and children's mental health and behavioral outcomes is dependent on adequate dosage. The frequency with which consultants engage with teachers in classroom-based activities is positively associated with greater use of positive classroom management strategies and decreased use of practices that are punitive, permissive, and/or detached.[39, 40] When the consultant engaged with program staff in activities more frequently, program staff perceived that the consultation was more helpful and that they felt supported in their work.[48] Research linking the frequency of

consultant-consultee meetings to positive outcomes is more mixed. One study found that the frequency of meetings between a consultant and teacher did not influence the teachers' behaviors, indicating that meetings alone are not likely to lead to desired outcomes,[40] while another study found that more frequent meetings predicted greater improvement in the quality of teacher-child interactions.[39]

Positive Relationships

Research consistently points to the consultative alliance as a key factor for promoting the effectiveness of ECMH consultation.[39, 48, 49] Consultative alliance is the degree to which the consultant and consultee perceive that they are working as partners to achieve the goals of the consultation and the level of warmth and positive emotionality present in their interactions. When ECMH consultants perceive a stronger consultative alliance with teachers, teachers report having more positive relationships with targeted children and that those children demonstrated more adaptive attachment behaviors.[49] Consultative alliance quality is related to more positive teacher-child interactions, classroom expectations, and social-emotional content and less negativity in the classroom.[49]

Implementing ECMH Consultation Within a Tiered System of Supports in Educational Settings

In order for an ECMH consultation program to be used effectively and strategically, it should be implemented within a multi-tiered system of support (MTSS). MTSS is a data-driven, problem-solving framework that uses a continuum of evidence-based practices matched to student needs to improve outcomes for all students. The *Pyramid Model for Promoting Young Children's Social Emotional Competence* is a MTSS system designed specifically for early childhood education and care settings. The Pyramid Model is a framework of evidence-based practices provided by teachers, home visitors, coaches, behavior specialists, ECMH consultants, program leaders and others to support young children's social and emotional development and prevent challenging behavior in early childhood settings.[50, 51] Previous research has consistently found that children in classrooms that implement the Pyramid Model display better social skills and fewer challenging behaviors compared to children in classrooms that do not use the model. For example, a randomized control trial that examined classroom-wide implementation in public preschool classrooms that included 40 preschool classroom teachers and 494 children in Tennessee and Florida found that children in Pyramid Model classrooms were rated by teachers and observers as having high social skills and fewer challenging behaviors.[52] A recent, larger randomized controlled trial that included 92 teachers and 955 children similarly found that children in classrooms with teachers who received Pyramid Model training significantly improved their social skills, compared to children whose teachers did not receive Pyramid Model training.[53]

Twenty-nine states currently use the Pyramid Model state system building efforts through the [Pyramid Model Consortium](#) (PMC) that includes training, technical assistance, and systems-

building for scaling up and sustaining the use of the model. In addition to resources to support state-wide system level implementation, the National Center for Pyramid Model Innovations (NCPMI) disseminates resources and webinars related to implementation for educators, programs, and states. These resources cover topics such as equity and bias, trauma-informed practices, family engagement, coaching, and specific classroom practices to support social and emotional development. Resources related to equity, bias, and anti-racism available through NCPMI are particularly important to utilize, given the focus on reducing racial disparities in exclusionary discipline in early childhood education settings.

Figure 3 displays the Pyramid Model tiers of support. Each tier is described below, along with the relevant workforce that supports implementation of the Pyramid Model. The Pyramid Model starts with universal strategies to support all children in the classroom and moves toward more targeted interventions for children with severe and persistent challenging behavior.[54]

Figure 3: Pyramid Model Tiers of Support

An effective early childhood education workforce is foundational to the Pyramid Model (base of pyramid, indicated in yellow). This workforce includes lead teachers, assistant teachers, and leaders (e.g., program directors, principals, and coordinators), home visitors, coaches, behavior specialists, and ECMH consultants. It is paramount that all individuals in the broad early childhood education workforce understand the importance of children's social and emotional skill development.

Universal promotion strategies (tier 1), indicated in blue, are implemented with all children, before using targeted or intensive interventions. Promotion strategies focus on promoting young children's positive skills, rather than preventing challenging behavior or intervening once challenging behavior arises. These practices include evidence-based strategies for providers to create high-quality, inclusive environments and form nurturing and responsive relationships with children. Equity and bias training for educators to improve cultural competency to promote classroom environments that are inclusive, anti-racist, and support all learners is included at tier 1. At the middle level of the Pyramid Model is Secondary Prevention (tier 2), indicated in green in Figure 3, which includes practices to promote social and emotional skills and reduce challenging behaviors. Practices at the secondary level include explicitly teaching social and emotional skills, such as expressing emotions and problem solving, to all children. This level also includes more targeted support for children at risk of exhibiting challenging behavior. Finally, at the top of the Pyramid Model is Intensive Intervention (tier 3), indicated in orange in Figure 3. This tier includes practices that provide individualized assessments and support to the small but significant number of children who exhibit persistent challenging behavior that does not improve after universal promotion or secondary prevention.

Individuals working within early education and care settings work across the tiers. Practitioners whose role is to support teachers, leaders, home visitors and others to support children's social emotional well-being and mental health provide targeted and intensive supports, often at tiers 2 and 3. For example, practice-based coaches and technical assistance (TA) providers often support the early childhood workforce to implement the promotion and prevention practices. TA providers deliver professional development trainings on a variety of topics, while practice-based coaches use observations, feedback, and support to increase educators' use of evidence-based practices and improve classroom quality that support children's development and well-being. This practice-based coaching is paramount to ensuring that practices are effectively incorporated into teachers' classroom practice.[52] Behavior specialists assist educators to develop and implement individualized behavior support plans that meet children's specific needs. ECMH consultants have clinical expertise needed for children who present with significant mental health concerns. Within school settings, counselors and school psychologists are also part of the workforce that support students across the tiers of the Pyramid Model.

This tiered model of support results in strategically utilizing mental health professionals for the children who need it most, while also utilizing other professionals and professional development options that are available within the overall early childhood system. At all tiers of support, all providers serving children and families must be trained to promote social and emotional development, driven by developmentally appropriate practices including nurturing and supportive interactions and trauma-informed approaches.

Funding and Scaling ECMH Consultation in Group-Based Early Care and Education Settings

States across the nation are increasingly investing in ECMH consultation to address children's challenging behaviors, support their mental health well-being, and prevent suspensions and expulsions from group-based early care and education settings. ECMH consultation is growing in popularity in part because it is recognized as a cost-effective strategy for addressing children's challenging behaviors.[55] Mental health issues are extremely costly to treat via therapeutic services or dyadic parent-child treatment programs, particularly as children get older, so it is advantageous for states to invest in services that reach children early and prevent social-emotional and mental health issues from becoming more severe. Early childhood is an ideal time to provide ECMH consultation since young children's brains are rapidly developing and are particularly sensitive to the quality of the surrounding environment. Further, ECMH consultation delivered in group-based early care and education settings has enormous potential to impact a wide population of children since consultation with a program or classroom benefits multiple children.

While ECMH consultation programs are increasing in number, states have approached building ECMH consultation programs differently depending on various factors, including the set of existing resources the state is able to build upon as well as new opportunities that arise. Two important considerations states face when building an ECMH consultation program are funding and scaling.

Funding

Funding ECMH consultation can be challenging due to the prevention-based nature of the service and lack of a dedicated funding source. ECMH consultation is different from other mental health services because it does not require a diagnosis and is therefore not widely billable. States use a myriad of approaches and sources to fund their ECMH consultation programs, but the most prevalent funding sources being leveraged are state general funds and federal grants such as the Child Care and Development Block Grant.[56] One strategy that has been successful is braiding and blending existing funding sources.

Scaling

States also approach scaling ECMH consultation programs in different ways. It is common for ECMH consultation programs to first be implemented in a smaller-scale pilot before expanding to reach statewide capacity. Further, states often implement ECMH consultation programs by contracting with local agencies, organized across regions, that are responsible for managing the delivery of consultation services in their region. The way in which ECMH programs are funded and scaled can also depend on the state's ECMH consultation model.

Examples from Other States

To demonstrate the variability in how states approach funding and scaling ECMH programs in group-based early care and education settings, three states are profiled below. Some background information on Arkansas' and Louisiana's models are provided to contextualize each state's funding and scaling approach. Arizona's funding strategy is then briefly described.

Arkansas
Project PLAY, Arkansas' ECMH consultation program, matches ECMH consultants with providers in licensed child care programs throughout the state. The goals of Project PLAY are to build the capacity of child care centers and teachers to prevent and manage children's challenging behavior, to develop children's social and emotional skills, and to reduce suspensions and expulsions from child care programs. In 2016, Project PLAY began a partnership with Arkansas' new BehaviorHelp system, a single-point-of-entry system for early care and education providers who need assistance in addressing children's challenging behaviors. Project PLAY ECMH consultants are accessed by submitting a request through BehaviorHelp's online system. Arkansas uses the Pyramid Model tiered framework of support to determine the appropriate level of support for each request. At tier 1, BehaviorHelp specialists may provide information or resources to a child care provider. At tier 2, technical assistance, including a classroom visit and professional development, is provided by Arkansas State University. If a request reaches tier 3 criteria (e.g., very severe behaviors, history of trauma, etc.), intensive services are provided by Project PLAY ECMH consultants.[47]

Project PLAY is administered by the Arkansas Department of Human Services' Division of Child Care and Early Childhood Education (DHS/DCCECE) and has a leadership team housed at the University of Arkansas for Medical Sciences (UAMS). Funding for Project PLAY and the larger BehaviorHelp system primarily comes from Child Care and Development Block Grant (CCDBG) quality improvement funds. Arkansas' Project PLAY includes 11 ECMH consultants who are licensed or licensed-eligible mental health professionals who hold a DHS/DCCECE certification as an Early Childhood Mental Health Consultant to Child Care. These ECMH consultants are primarily staffed through partnerships with six community mental health centers throughout the state. In FY 18-19, Project PLAY provided 115 cases of ECMH consultation services to 87 child care centers in 56 cities within 35 counties of the state.[57] Project PLAY was launched in 2011, after the state first funded some pilot initiatives to enhance the collaboration between community mental health centers and early childhood programs.

Louisiana
Louisiana has multiple ECMH consultation programs that serve providers across different settings (e.g., home visiting, primary care, Part C Early Intervention, child care). The TIKES program is Louisiana's ECMH consultation program serving teachers and children in child care settings. The goals of TIKES are to promote the healthy social-emotional development of young children, increase teachers' skills and knowledge to effectively support social-emotional development of young children, and support children exhibiting challenging behaviors and/or

mental health or developmental concerns. TIKES is run through the state's Quality Rating and Improvement System (QRIS). Consultation services are available to all centers that accept state funding, though priority is given to child care centers that are rated by the QRIS as unsatisfactory or approaching proficiency.[58]

The Louisiana Department of Education (LDOE) funds the TIKES program using Child Care and Development Block Grant quality funds. LDOE contracts with Tulane University which then sub-contracts with local nonprofit agencies across the state. The nonprofit agencies hire the TIKES ECMH consultants who provide services to the child care centers that fall within the consultants' geographic regions. TIKES has about 12 ECMH consultants working across the state. A mid-year snapshot of FY 16-17 indicated that TIKES ECMH consultants provided 1,040 consultation visits, serving 864 child care centers, and conducted 64 trainings.[59] Louisiana conducted a one-year pilot of the TIKES program in 2006 before scaling statewide in 2007.

Other Funding Example: Arizona
Arizona's ECMH consultation program, Smart Support, receives funding from First Things First, a state early childhood agency that was created from a voter-approved tax on tobacco products. Smart Support is available to licensed child care centers, regulated family child care providers, and home visiting teams in regions that have approved use of the state's revenues from tobacco tax for these services.[60]

Funding Considerations for Virginia

A number of potential sources have been identified to fund an ECMH consultation program in Virginia. Similar to Arkansas and Louisiana, the Child Care and Development Block Grant quality dollars could be used to fund ECMH consultation. Virginia may also want to reallocate some Temporary Assistance for Needy Families (TANF) funds to go toward the Child Care and Development Fund for the purpose of funding ECMH consultation. States are able to reallocate up to 30% of their TANF funds to their Child Care and Development Funds. Virginia could also explore using state Children's Health Insurance Program (S-CHIP) dollars to fund ECMH consultation services. A CHIP Health Services Initiative (HSI) is a flexible funding tool that uses CHIP administrative dollars, authorized through a CHIP state plan amendment (SPA), to support projects and programs focused on improving the health of low-income children, including but not limited to Medicaid and CHIP-eligible children.[61] Although no state is currently using an HSI specifically to fund an ECMH consultation program, HSIs have been used for similar projects and activities supporting children's social and emotional health, including behavioral health workforce training and capacity building. Through an HSI, Virginia could leverage state general funds to draw down federal funds at the enhanced CHIP matching rate of 65 percent (approximately $1.85 federal match for every state dollar invested). The General Assembly would need to allocate funds to comprise the state share, and the Commonwealth would need to provide assurances to the Centers for Medicare and Medicaid Services (CMS) that Virginia would not supplant or match CHIP federal funds with other federal funds.

Importantly, funding an ECMH consultation program in all early care and education settings in Virginia will require the blending/braiding of federal and state funding to ensure all early care and education programs, including Virginia Preschool Initiative and Head Start programs, are able to receive consultation services. For the most part, Arkansas and Louisiana restrict access to their ECMH consultation programs to child care centers, which is why they are able to primarily use federal funds to fund their programs.

Existing Services and Resources in Virginia Related to ECMH Consultation in Group-Based Early Care and Education Settings

Coaching and Consultation

Several services exist in Virginia that provide coaching or consultation to providers and teachers in early care and education settings. The goal of these services is to promote high-quality learning environments that are foundational to young children's healthy development, including their social-emotional development (see Table 1 for summary).

The Virginia Infant & Toddler Specialist Network (VA ITSN) strives to increase the knowledge level and skills of those who care for infants and toddlers, whether in family homes or in centers. Currently, 21 Infant and Toddler Specialists from nine regional offices located across the state offer the following services to child care providers who care for infants and toddlers 0-36 months: intensive on-site technical assistance and coaching, targeted technical assistance, follow-up to trainings, and trainings on a wide variety of topics. Additionally, Child Development Resources (CDR), the entity responsible for implementing the VA ITSN, offers services to infant and toddler providers across the state that include professional development supports (e.g., technical assistance and incentives), targeted technical assistance, follow-up trainings, among others. In 2018, the VA ITSN added Infant Toddler Mental Health (ITMH) program to strengthen the Network's services to increase the use of strategies and practices to promote the social-emotional development of infants and toddlers in child care. Currently, 9 ITMH consultants hired by CDR offer the following promotion, prevention, and intervention services across the state to infant and toddler child care providers: on-site technical assistance and coaching, trainings on social-emotional topics that include screening of infants and toddlers, and the development of individual plans for infants and toddlers with challenging behaviors. Training, coaching, and resources for parents whose children are enrolled in child care programs participating in the Network's services are also provided. The ITMH program as part of the VA ITSN is the closest existing service to a potential statewide ECMH consultation program, though the services are limited to center-based programs and family day homes that serve children birth to age 3.

Over the course of 2018-2020 and in partnership with the VDOE Office of Early Childhood, the Advancing Effective Interactions and Instruction (AEII) initiative at the University of Virginia's Center for Advanced Study of Teaching and Learning (UVA CASTL) began implementing quality improvement efforts in the state-funded PreK program, Virginia Preschool Initiative (VPI). These

efforts, described in [A Plan to Ensure High-Quality Instruction in all Virginia Preschool Initiative Classrooms](#), involve assessing the quality of teacher-child interactions using the Classroom Assessment Scoring System (CLASS®) tool, supporting teachers' use of evidence-based curriculum, and supporting VPI leaders to provide teachers with high-quality, individualized professional development. In 2020-2021, these supports are being extended to Early Childhood Special Education (ECSE) and Title 1 classrooms as well. Additionally, in 2020-2021, the AEII initiative is providing a variety of supports specifically geared toward supporting children's social-emotional development and promoting equity, inclusion, and anti-bias practices in the classroom, in response to the impact the COVID-19 pandemic is having on young children and their families. These supports include virtual coaching for approximately 90 high-needs classrooms and a [Resource Hub](#) that disseminates free resources, developed or vetted by AEII staff, focused on supporting children's social-emotional development and early learning experiences that promote equity, inclusion, and anti-racism.

Finally, the federally funded Head Start and Early Head Start programs provide comprehensive services for low-income families that are family-centered, promote child development, and support families to move towards self-sufficiency. All grantees, including in Virginia, must adhere to the Head Start Program Performance Standards (HSPPS) which are federal guidelines that outline how each program should operate. Included in the HSPPS is a focus on ensuring children's [mental health and social-emotional well-being](#), by securing "mental health consultation services on a schedule of sufficient and consistent frequency to ensure a mental health consultant is available to partner with staff and families in a timely and effective manner." There is not a specific program or model that every Head Start grantee must implement; services are determined at the local level and are based on the needs of families in that locality. Some Head Start/Early Head Start programs have a mental health consultant on staff, while others, typically smaller programs, partner with community agencies when mental health concerns are identified.

In summary, a variety of coaching or consultation supports currently exist for early care and education settings in Virginia. Some of these services specifically focus on mental health, namely the ITMH program and mental health supports in Head Start/Early Head Start. None of the current services are offered fully at scale in all group-based early care and education programs serving children birth to five, though they are important resources for Virginia to draw from to develop an ECMH consultation program.

Table 1: Existing Coaching or Consultation Services in Group-Based Early Care and Education Settings

Service Organization	Ages Served	Setting	Scale
Virginia [Infant & Toddler Specialist Network (VA ITSN)](#)	Birth – Three	Center-based care; Family day homes	21 specialists, across 9 regions

Service Organization	Ages Served	Setting	Scale
Infant Toddler Mental Health (ITMH) Program *This service falls under the VA ITSN	Birth – Three	Center-based care; Family day homes	9 ITMH consultants, across 8 regions
Advancing Effective Interactions and Instruction (AEII) Initiative	Varies but primarily four – five	VPI, ECSE, and Title 1 classrooms	Virtual coaching to about 90 teachers (majority VPI) Resources are publicly available
Mental Health Support in Head Start/Early Head Start	Birth – Five	Head Start and Early Head Start classrooms	All grantees, but specifics of services differ by locality

State Leadership Teams and Initiatives

As previously mentioned, the Pyramid Model Consortium (PMC) provides training and technical assistance to states, communities, and programs to promote the dissemination, sustainability, scale-up and high fidelity use of the Pyramid Model. Virginia has a Pyramid Model State Leadership Team which is made up of agencies using the Pyramid Model in Virginia. Over the past eight years, some professional development, coaching, and training related to the Pyramid Model has occurred, though there has not yet been a successful state-wide initiative to coordinate Pyramid Model implementation at the state-level. The Pyramid Model State Leadership Team was funded through Project SEED, but has been on hold due to a lack of funding. The Pyramid Model has been implemented at a localized, community level in Virginia, including in Fairfax and several Head Start centers.

Early Childhood Mental Health Virginia (ECMHVA) Initiative is a statewide initiative focused on the development, implementation, and sustainability of a comprehensive and coordinated early childhood system of care for infant and early childhood mental health serving children birth through age five and their families/caregivers and providers. ECMHVA Initiative maintains partnerships with the following organizations and initiatives: Virginia Association for Infant Mental Health, Partnership for People with Disabilities at Virginia Commonwealth University, and Project SEED. ECMHVA Initiative has an advisory board that is made up of representatives from infant and early childhood systems in Virginia at the state and local levels whose programs focus on children, birth to age five, as well as mental health clinicians and families. The ECMH VA State Coordinator (VCU Partnership for People with Disabilities) is responsible for overseeing the ECMHVA Initiative including the development and implementation of a Virginia

ECMH Strategic Plan, facilitating regular meetings of the ECMHVA Advisory Board and administering the Virginia Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®. Funding for the ECMH Virginia Initiative is currently made available through the support of the Department of Behavioral Health & Developmental Services, Office of Child & Family Services including the Infant & Toddler Connection of Virginia and Early Impact Virginia. The ECMH Virginia Initiative partners with the Virginia Association for Infant Mental Health to implement the Virginia Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®.

Systems of Professional Endorsement in Mental Health

Virginia has several mechanisms for granting professional endorsements for those working in the early childhood and mental health fields. The Virginia Association for Infant Mental Health, in collaboration with the Early Childhood Mental Health Virginia (ECMHVA) Initiative within the Partnership for People with Disabilities at Virginia Commonwealth University, administers the Virginia Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®. This Endorsement® recognizes individuals who have attained the professional qualifications, competencies and early childhood experience to specialize in the promotion/practice of infant mental health. The Infant Mental Health Endorsement® has four categories that each align with professions supporting young children within a multi-tiered system of support (promotion, prevention, intervention and leadership). Each category of Endorsement® verifies the early childhood professional has the identified competencies related to knowledge and application of relationship-focused infant mental health principles and practices as required and documented through their education, in-service training, reflective supervision and work experience in settings serving young children. The Infant Mental Health Specialist (Category III) and the Infant Mental Health Mentor-Clinical (Category IV) align with the recommended qualifications for Virginia's Early Childhood Mental Health Consultants (Master's degree or higher mental health professionals). The Infant Mental Health Endorsement® is currently available for professionals working with children from birth to age 3 and plans to expand to an Early Childhood Mental Health Endorsement® (birth through age 5) are underway.

Additionally, the Virginia Department of Health Professions offers a Qualified Mental Health Professional (QMHP) credential which designates that an individual is professionally qualified, by education and experience, to provide mental health services. Within the QMHP credential, individuals are qualified to work with either adults (i.e., QMHP-A) or children (i.e., QMHP-C). The QMHP-C designation spans children and adolescents up to age 22. An additional designation could be developed for early childhood (i.e., QMHP-EC), in collaboration with the Department of Health Professions, to indicate expertise in providing early childhood mental health services.

Recommendations

Based upon the information gathered and summarized in this report, the following recommendations were developed by the HJ51 workgroup members, led by the Virginia Department of Education (VDOE), the Virginia Department of Social Services (VDSS), and the Virginia Department of Behavioral Health and Developmental Services (VDBHDS). To develop these recommendations, workgroup members consulted with national experts, conducted research on effective ECMH consultation programs, reviewed other states' ECMH consultation programs, analyzed the existing set of resources in Virginia to draw from, and held rich discussions through a series of workgroup meetings. A full description of the study process and complete list of workgroup members is provided in Appendix A.

1. **Recommendations for Developing an ECMH Consultation Program:**

- **Begin to build a statewide ECMH consultation program by offering services to providers working in group-based early care and education settings serving children from birth to age 5** (e.g., family day homes, child care centers, Early Head Start and Head Start, Virginia Preschool Initiative, Early Childhood Special Education, and private programs).
   - In response to the disparate impact of the COVID-19 pandemic on disadvantaged children and families, prioritize access to an ECMH consultation program for the most under-resourced children attending publicly-funded early care and education programs.

- **Continue investments in the larger infant and early childhood mental health system in Virginia**, acknowledging that ECMH consultation within group-based early care and education settings is only one service within the larger field of ECMH consultation and within infant and early childhood mental health more broadly.
   - Further study how to build and coordinate a comprehensive and connected system of infant and early childhood mental health that includes consultation in other settings (e.g., home visiting, primary care) as well as other mental health services that serve Virginia's infants, toddlers, and preschoolers.

- **Within group-based early care and education settings, situate an ECMH consultation program within the education system and a multi-tiered system of support. Within early childhood, the Pyramid Model Framework** describes a three-tier system of support to promote young children's social-emotional development and prevent challenging behaviors in early childhood settings.
   - Strategically use ECMH consultants for cases that require clinically trained mental health consultants (e.g., trauma, attachment issues, grief and loss, COVID-19, etc). For cases that do not require clinically trained mental health consultants, provide the appropriate support through the use of evidence-based practices supported by practice-based coaches, behavior specialists, and other professionals. Implementing the full Pyramid Model will require significant

investments in supports and services at all tiers through a comprehensive workforce that includes teachers, home visitors, coaches, behavior specialists, program leaders, and ECMH consultants.

- **Coordinate an ECMH consultation program across the infant and early childhood mental health and the early education systems more broadly. Draw from services that already exist in Virginia.** For example:
  - Tiers 1 and 2 of the Pyramid Model (universal promotion and targeted practices) should be coordinated with the quality improvement advances being made through the VDOE Office of Early Childhood. A broader recommendation would be to expand the expectation that teachers are supported to use a vetted evidence-based curriculum that is aligned with early learning and development standards; use assessments designed to help educators individualize instruction to meet the needs of all children; and receive frequent feedback on the effectiveness of teacher-child interactions, based on the Classroom Assessment Scoring System (CLASS$^{®}$) tool to all publicly-funded birth to five educators. All teachers would also be required to participate in professional development that is 1) individualized based on classroom data (e.g., CLASS$^{®}$ scores or children's assessment data); 2) focused on standards, curriculum and/or improving teacher-child interactions; and 3) delivered with fidelity with the necessary leadership and organizational support, which is currently provided through the [Advancing Effective Interactions & Instruction (AEII) initiative](), in partnership with UVA-CASTL. The Teaching Pyramid Observation Tool (TPOT) for preschool classrooms and the Teaching Pyramid Infant-Toddler Observation Scale (TPITOS) for infant and toddler classrooms are additional potential measures of Pyramid Model practices and classroom quality.
  - Connect to and consider expanding the Virginia Infant & Toddler Specialist Network.
  - Consider using the Virginia Cross-Sector Professional Development Team (VCPD) to coordinate professional development providers at tiers 1 and 2 of the Pyramid Model. For example, VCPD could serve as a central hub for training on the Pyramid Model, practice-based coaching, adult learning, etc. Ensure that professional development covers topics including trauma, adverse childhood experiences (ACEs), brain states, and the development of children's self-regulation.
  - As tiers 1 and 2 are being built out, focus efforts on supporting geographic areas or programs that have fewer resources available to them.

- **Develop a centralized system to receive requests for services.** As part of this system, develop a mechanism for gathering information to determine the level of support that is most appropriate (i.e., triaging to tier 1, 2, or 3 of the Pyramid Model).

- **Consider implementing ECMH consultation services using regional networks** such that ECMH consultants would serve particular regions of the state. There are several

different regional systems already in place in Virginia that an ECMH consultation program could follow. For instance, the Virginia Infant & Toddler Specialist Network, Smart Beginnings, and the Virginia Mental Health Access Program (VMAP) are all implemented using a regional approach, though the specific regions differ.

- **Ensure that ECMH consultants are sufficiently trained and will offer consultation services that are evidence-based to support and improve the social-emotional and mental health well-being of children from birth to age 5.** ECMH consultation must be of sufficient quality and dosage in order to improve adults' interactions with children and children's social-emotional skills and mental health (see recommendations #2 and #3 below).

2. **Recommendations for Building a Qualified Early Childhood Workforce, including ECMH Consultants:**

- **Build a comprehensive and diverse workforce within a tiered system of support that includes early childhood teachers, coaches, and ECMH consultants.** Within tiers 1 and 2 of the system, provide teachers with evidence-based professional development, including practice-based coaching. Coaches providing these services to adults in group-based early childhood education (ECE) settings should have a bachelor's degree in a related field, experience in early childhood settings, knowledge of social-emotional development and mental health well-being, and an understanding of developmentally appropriate practices.

- **Invest in the development of a skilled and diverse early childhood mental health consultant workforce.** There is currently a dearth of early childhood mental health clinicians in Virginia. Substantial investments from the state are needed to reduce barriers to entry and to promote retention once in the workforce, particularly for minorities and first-generation college graduates. For instance:
  - Consider creating a stipend program that uses federal funding with a state match to cover higher education tuition costs in exchange for 1-2 years of work.
  - Consider offering financial incentives to consultants who remain in the early childhood mental health field for a certain number of years.
  - Consider offering scholarships to mental health consultants to support costs associated with the Virginia Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® and required Reflective Supervision for Endorsement® targeted to the clinical categories of Endorsement® (Infant Mental Health Specialist and Infant Mental Health Mentor-Clinical). This Endorsement® ensures Virginia ECMH Consultants have both the mental health and infant/early childhood expertise required as well as Reflective Supervision that is highly recommended in the field of infant and early childhood mental health and by the Center of Excellence for Infant and Early Childhood Mental Health Consultation. The Virginia Infant & Toddler Specialist Network requires Virginia's IMH Endorsement® for their Infant Mental Health

Consultants and funds the cost of both the Endorsement® fees and Reflective Supervision. Other Virginia state agencies provide Endorsement® scholarships for providers within their networks as well (i.e. Early Impact Virginia and the Infant and Toddler Connection of Virginia).

- **Make intentional efforts to recruit and retain ECMH consultants who represent the demographic make-up of the children being served.** For example, consider building partnerships between an ECMH consultation program and Historically Black Colleges and Universities (HBCUs).

- **Further develop coursework and training related to infant and early childhood mental health at universities.** As an example, Virginia Commonwealth University (VCU) is in the beginning stages of developing a certification in infant and early childhood mental health that would be added onto a bachelor's or master's degree.
  - Ensure there is intentional and ongoing training in anti-racism, equity, and inclusion in an effort to reduce racial disparities in children's experience of exclusionary discipline practices.

- **Create opportunities for professionals seeking to become an ECMH consultant to obtain relevant work experience.** As an example, trainees could engage in clinical rotations that would give them experience delivering ECMH consultation in a variety of settings.

3. **Recommendations for ECMH Consultant Qualifications and Competencies:**

- **Require that ECMH consultants meet the following basic qualifications:**
  - Hold a master's degree in social work, psychology, school counseling, or related field.[a]
  - Have at least 2-3 years of experience working as a mental health professional with young children and families.

- **In addition to the basic qualifications outlined above, ECMH consultants should display the competencies outlined by the Center of Excellence for Infant and Early Childhood Mental Health Consultation (included in Appendix C).**
  - Embedded throughout these competencies is the need for ECMH consultants to have specialized knowledge in infant and early childhood development; expertise in developmentally appropriate practices in early childhood settings; skills in cultural competency and addressing bias, inequities, and discrimination; and the ability to develop and foster positive relationships. Consider how these competencies align with existing endorsements in Virginia, such as the Virginia

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[a] Note that some have argued that a bachelor's degree may be substituted with substantial experience and supervision by a licensed mental health professional, although this is not aligned with guidance from the Center of Excellence for Infant and Early Childhood Mental Health Consultation.

Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health®.
- These competencies are very comprehensive and are intended to guide the hiring, training, professional development, and evaluation of ECMH consultants.

- **Explore ways of credentialing ECMH consultants to distinguish them from other, similar workforce roles that do not have the same level of clinical mental health expertise in early childhood.** For instance, Virginia could explore the following possibilities:
  - Use the existing Infant Mental Health endorsement system, which has plans to expand to early childhood, to credential ECMH consultants at the clinical level (category 3 or 4).
  - Work with the Department of Health Professions to expand the Qualified Mental Health Professional (QMHP) designation to include an early-childhood age band. Individuals seeking to become an ECMH consultant could work as a QMHP-trainee while gaining the necessary work experience before gaining a license-eligible QMHP-Early Childhood designation.
  - Create a comprehensive and intensive pre-service training program and related credential that is specific to Virginia's ECMH consultation program in group-based early care and education settings.

4. **Recommendations for Building the Infrastructure to Implement a Statewide ECMH Consultation Program:**

- **House the contract centrally within the Department of Education,** given the focus on delivering ECMH consultation initially in group-based early care and education settings, but create formalized partnerships with other relevant agencies including the VDBHDS.

- **Develop state-wide infrastructure for coordinating and monitoring an ECMH consultation program across regions.** Recommendations for this infrastructure include:
  - Ensure adequate oversight within VDOE for an ECMH consultation program, including developing contracts with providers, service definitions, qualifications, consultant training, and program requirements.
  - Create a state-level central call system for early care and education providers to easily navigate care.
  - Hire staff to coordinate and monitor the implementation of an ECMH program across regions.
  - Build out the state's data-related infrastructure to ensure consistent data collection, uniform measures/outcomes, and reporting across regions.
  - Depending on model and funding decisions, determine whether and how funding should stream down from the state to regional/local agencies or all the way down to early care and education settings.
  - Develop systems for accountability and tracking to make sure dollars are spent on serving the needs of infants and young children.

- Provide consistent training and ongoing professional development approaches for consultants and providers.

- **Create an advisory committee with cross-agency representation to get buy-in and support.** The existing Early Childhood Mental Health Virginia Advisory Board could be used for this purpose, or a new group could consult with this existing group. Members of an advisory committee should include relevant agencies involved and be representative of diverse stakeholders and experiences. This advisory board could also be connected to other critical advisory councils in the state such as the new Early Childhood Advisory Council being formed under the Board of Education. Agencies must be braided together and not exist in silos. Virginia Mental Health Access Program (VMAP) has used this type of formal governance board successfully.

- **Explore the feasibility of developing out to the broader mental health system to create a comprehensive service system for infants, toddlers, preschoolers, and their caregivers beyond early care and education.**

5. **Recommendations for Funding an ECMH Consultation Program Within a Fully Implemented Pyramid Model System:**

- **Fund prevention and promotion efforts that fall at tiers 1 and 2 of the Pyramid Model and partner with organizations doing this work currently.** For an ECMH consultation program to be effective, a robust set of prevention services at tiers 1 and 2 is critical and must be funded appropriately. Partnerships with Virginia Quality, Child Development Resources, the Virginia Cross-Sector Professional Development Team (VCPD), and other active professional development and training organizations could create more integrated systems of prevention and promotion in early care and education, and thus reserve the more costly, clinically trained consultants for children and families who need the highest level of support.
    - Consider using state general funds to increase investments in prevention and promotion services at tiers 1 and 2 of the Pyramid Model.

- **Develop a sustainable funding mechanism for ECMH consultation that utilizes multiple funding sources, including a mix of both federal and state funds, to fund and ensure the longevity of a statewide ECMH consultation model** (i.e., not solely grant based). The following funding sources have been identified as possible mechanisms for funding ECMH consultation in Virginia:
    - Federal Block Grants including:
        - Child Care and Development Block Grant (CCDBG)
        - Title V dollars
    - TANF funds/transfers
        - States can reallocate up to 30% of these funds to their Child Care and Development Fund, under which ECMH consultation can be implemented and supported.

- Health Services Initiative (HSI) under the Children's Health Insurance Program (CHIP) State Plan [61]
  - A CHIP Health Services Initiative (HSI) is a flexible funding tool that uses CHIP administrative dollars, authorized through a CHIP state plan amendment (SPA), to support projects and programs focused on improving the health of low-income children, including but not limited to Medicaid and CHIP-eligible children. Virginia's Department of Medical Assistance Services (DMAS) could submit a CHIP State Plan Amendment (SPA) to fund an ECMH consultation program through a CHIP Health Services Initiative (HSI).
- State General Fund dollars

6. **Recommendations for Evaluating the Impact of an ECMH Consultation Program:**

- **Require evaluation of the ECMH consultation model to ensure that the investment is leading to improved adult-child interactions and children's improved social-emotional development and mental health, including the prevention of suspensions and expulsions.**
  - Set aside an appropriate amount of the operating budget for evaluation and redesign on an ongoing basis.
  - Ensure that data collection is embedded as a core component of the ECMH consultation service provision.
  - Include both periodic, more intensive data collection for a formal evaluation to ensure uptake and impact as well as ongoing data collection that should occur as part of everyday implementation.

- **Gather and connect data from multiple sources and systems to understand the effectiveness of an ECMH consultation program.**
  - Use a multi-informant, multi-method approach to data collection. Data from families, teachers, pediatricians, and other education and mental health providers should be collected. This data can be provided via surveys, observations, record keeping (e.g., consultant service log, log of trainings provided to a teacher or program), interviews etc. Include both quantitative and qualitative data collection.
  - Ensure families have a voice in the evaluation of the system. Build capacity to follow a child/family during ECE transitions in terms of continuity of care.
  - Connect data to early childhood statewide data systems and other ongoing evaluation systems. Examples include VPI, Head Start, and Virginia Infant & Toddler Specialist Network.
  - Consider that data collection systems vary widely across ECE sectors. For example, Head Start and VPI data collection versus what may be collected in a private ECE program or family childcare practice.
  - Coordinate to minimize redundancy of data collection.

- Leverage the Virginia Longitudinal Data System (VLDS). Distinguish between what needs to live in the state system/longitudinal and what is needed for a more intensive evaluation. Understand the limits of what can and should be included in the state data system but consider how the state data system can be used to understand longitudinal associations.
- Consider the use of universal screening tools. For example, The Virginia Kindergarten Readiness Program (VKRP) includes a short, 22-item universal teacher reported screening tool that includes items assessing children's self-regulation, social skills, and mental health (see Appendix D). The Ages and Stages Developmental Questionnaire and the Ages and Stages Social Emotional Questionnaire are other potential screening tools.

- **Determine categories of data that are being collected and include both implementation and outcome data.**
  - Collect implementation and service delivery data to ensure that ECMH consultation is being delivered with the minimum quality and dosage necessary for positive impact. This data collection includes assessment of who was referred, who provided the service, who received services, the amount of services received, etc.
  - Collect outcome data to determine the positive effect of ECMH consultation on adult-child interactions and child development and health. This data collection includes suspensions and expulsions, use of other exclusionary discipline practices (office referrals, use of time-out, early pick up, being sent to another classroom or to the director/principal's office, loss of recess, isolated seating, removal from an activity, being asked to remain silent when talking is otherwise allowed), quality of adult-child interactions, child social-emotional and behavior skills, child mental health, etc.

- **Make data available to the public.**
  - When appropriate, tailor presentations and reports so that information is relevant to the diversity of stakeholders.

Summary and Next Steps

In summary, [House Joint Resolution 51](#) (HJ51) was passed by the Virginia General Assembly in the 2020 legislative session. This legislation tasked a workgroup, led by the Virginia Department of Education, Department of Social Services, and Department of Behavioral Health and Developmental Services, to study the feasibility of adopting a statewide Early Childhood Mental Health (ECMH) consultation model to prevent suspensions and expulsions of young children attending early care and education programs in Virginia. This report summarizes the study's findings and provides recommendations for developing, implementing, scaling, and evaluating a statewide ECMH consultation program in Virginia.

In Virginia, far too many young and vulnerable children are being suspended and expelled from the early care and education settings that should be supporting their learning and development. Children with mental health issues and behavior problems, Black children, and boys disproportionately experience these exclusionary practices in early childhood.[1,5] Research indicates that racial bias plays an important role in the discipline gap between Black and White students.[9]

States are increasingly investing in ECMH consultation to support children's social-emotional and behavioral development, support their mental health well-being, and prevent young children from being suspended and expelled from group-based early care and education settings. ECMH consultation improves children's social, emotional, behavioral, and mental health outcomes by building the capacity of the adults who interact with children and their families and can be a cost-effective strategy for preventing serious mental health concerns from occurring in the future.[55]

Critically, Virginia, along with the United States and world, is facing an unprecedented health and economic crisis with the current COVID-19 pandemic. The pandemic is having an outsized impact on low-income families and communities of color.[24, 25] Young children's daily routines, early learning, and social experiences have been upended resulting in significant and serious negative impacts on young children's lives. Given the current context and deep concerns about rising inequities due to the pandemic, Virginia should strongly consider initially prioritizing access to an ECMH consultation for the most under-resourced communities, early care and education programs, and children.

The recommendations presented here are broad and comprehensive. Additional time and study will be required to determine specifics related to funding and statewide implementation of an ECMH consultation model. Consistent with other states who have adopted ECMH consultation models, the General Assembly may wish to begin by funding an initial smaller program, evaluating its success, and then scaling to a comprehensive and statewide model over a few years. In response to the disparate impact of the COVID-19 pandemic on disadvantaged children and families, the General Assembly may wish to prioritize access to an ECMH consultation program for the most under-resourced children attending early care and education programs.

Appendix A.
Description of Study Process and Workgroup Members

To study the feasibility of developing a statewide ECMH consultation model in Virginia, VDOE, VDSS, and VDBHDS convened a workgroup composed of national, state, and local experts. The HJ51 resolution indicated that workgroup members should include stakeholders from the Early Childhood Mental Health Virginia Advisory Board, the Virginia Association for Infant Mental Health, Voices for Virginia's Children, the Center of Excellence for Infant and Early Childhood Mental Health Consultation, the National Center for Children in Poverty, Zero to Three, Head Start, Early Impact Virginia, and other state and national experts that the Departments deem appropriate.

In July 2020, Jenna Conway, Virginia's Chief School Readiness Officer, invited stakeholders to participate in the ECMH consultation workgroup. Stakeholders were invited to participate in the ECMH consultation workgroup based on having background and expertise relevant to achieve the goals of HJ51. The workgroup included stakeholders from the VDOE, VDSS, VDBHDS, all of the organizations listed above, and additional groups identified by VDOE, VDSS, and VDBHDS.

The HJ51 study and report was led by a core team. Core team members are listed below:
- Jenna Conway, Erin Carroll, Tamilah Richardson (Department of Education)
- Bethany Imbody, Tatanishia Armstrong, Sharon Lindsay (Department of Social Services)
- Nina Marino, Katharine Hunter (Department of Behavioral Health and Developmental Services)
- Bonnie Grifa (Partnership for People with Disabilities, Virginia Commonwealth University)
- Ashley Everette Airington, Emily Griffey (Voices for Virginia's Children)
- Amanda Williford, Ann Partee, Kelsey Clayback (University of Virginia)

National experts providing guidance and information include:
- Sheila Smith (National Center for Children in Poverty)
- Neal Horen (Georgetown University Center for Child and Human Development; Center of Excellence for Infant and Early Childhood Mental Health Consultation)
- Rob Corso (Pyramid Model Consortium)
- Lindsay Usry (Zero to Three)

Table A-1: Complete List of HJ51 Feasibility Study Workgroup Members

Name	Professional Affiliation
Mark Allan, PhD Erin Carroll Jenna Conway Dawn Hendricks, PhD Taundwa Jeffries Arlene Kasper Mickie McInnis Kris Myers Tamilah Richardson, EdD	Virginia Department of Education (VDOE)
Katharine Hunter, MSW Nina Marino, LCSW	Virginia Department of Behavioral Health and Developmental Services (VDBHDS)
Tatanishia Armstrong, EdS Bethany Imbody Sharon Lindsay, MSW	Virginia Department of Social Services (VDSS)
Amy Bornhoft Janina Reyes Linda Tazi Dawn Wimbush	Virginia Infant & Toddler Specialist Network
Patrice Beard Pam Booker, IMH-E Bonnie Grifa Cori Hill, MEd	Partnership for People with Disabilities | Virginia Commonwealth University
Bergen Nelson, MD, MS Aradhana Bela Sood, MD, MSHA	Virginia Commonwealth University
Alison Standring	Virginia Association of Community Service Boards/Rappahannock Area Community Services Board/Infant & Toddler Connection of the Rappahannock Area
Laurel Aparicio, MPA	Early Impact Virginia
Debbie Coleman, LCSE, IMH-E	Virginia Association for Mental Health
Bethany Geldmaker, PhD, PNP	Virginia Department of Health

Name	Professional Affiliation
Kim Hulcher	Virginia Child Care Association
Alyssa Ward, PhD, LCP	Virginia Department of Medical Assistance Services
Kelsey Clayback, MEd Ann Partee, PhD Amanda Williford, PhD	University of Virginia, Center for Advanced Study of Teaching and Learning
Alyson Williams, EdD	Virginia Early Childhood Foundation
Ashley Everette Airington Emily Griffey	Voices for Virginia's Children
Jane Glasgow, PhD	Minus 9 to 5 | Eastern Virginia Medical School
Mary Margaret Gleason, MD	Children's Hospital of the The King's Daughters, Eastern Virginia Medical School
Diana Bermudez, PhD, LPC	Amare Counseling and Education
Anilla del Fabbro, MD	Carilion Clinic Psychiatry & Behavioral Medicine
Mark Gardner, MSW, LCSW	Nurture Child and Family, PLLC
Jeannie Harper, MSW, LSW Kathy Ryan, PhD, LCSW	Greater Richmond SCAN (Stop Child Abuse Now)
Joyce Jones	Hopewell City Public Schools
Vanessa Lane	Grafton Integrated Health Network
Carol Lieske	Main Street Child Development Center
Tammy Mann, PhD	The Campagna Center
Judith Martens, LCSW, IMH-E	Reflective Supervision and Training
Sandra Triveri, LPC	Infant and Early Childhood Mental Health Therapist
Rob Corso, PhD	Pyramid Model Consortium
Neal Horen, PhD	Georgetown University Center for Child and Human Development; Center of Excellence for

Name	Professional Affiliation
	Infant and Early Childhood Mental Health Consultation
Tammy Petrowicz	Region III Head Start Early Childhood Systems Specialist
Sheila Smith, PhD	National Center for Children in Poverty
Beth Tolley	Alliance Against Seclusion and Restraint
Lindsay Usry	Zero to Three

Stakeholders participated in a series of three workgroup meetings in fall 2020 and engaged in one of five sub-groups aligned to their area of expertise (e.g., Funding; ECMH Consultation Models/Services; Data/Evaluation/Outcomes; Infrastructure/State Lead/State Role; and Workforce Development).

The large workgroup meetings were held on August 25, September 30, and October 27. The primary agenda items for each meeting is provided in Table A-2.

Table A-2: Agenda of HJ51 Full Workgroup Meetings

Meetings	Primary Agenda Items
Workgroup Meeting 1: August 25, 2020	• Purpose of HJ51 • Presentation from Sheila Smith, PhD – National Center for Children in Poverty • Presentation from Neal Horen, PhD – Center of Excellence for Infant and Early Childhood Mental Health Consultation
Workgroup Meeting 2: September 30, 2020	• Presentation from Lindsay Usry – Zero to Three • Presentation from Rob Corso, PhD – Pyramid Model Consortium
Workgroup Meeting 3: October 27, 2020	• Shared recommendations coming out of sub-group meetings and provided opportunity for workgroup members to provide feedback

Additionally, workgroup members participated in one of five sub-groups based on their interest in expertise. Each sub-group met once to discuss recommendations specific to that group's focus. Sub-group meetings were held on the following dates.

- Infrastructure/State Lead/State Role: October 14, 2020
- Workforce Development: October 14, 2020
- Funding: October 19, 2020
- Data/Evaluation/Outcomes: October 19, 2020
- ECMH Consultation Models/Services: October 21, 2020

Appendix B.
Comprehensive Summary of Experimental Research on ECMHC

Experimental Evidence

Raver and colleagues investigated the effect of the Chicago School Readiness Program (CSRP), which included intensive, on-site ECMH consultation from licensed social workers.[30] CSRP teachers also received training in classroom management through the Incredible Years program. A total of 90 Head Start teachers participated and were randomized to the ECMHC group or a control group. Control group teachers were given a teacher's aide, who was in the classroom for the same amount of time as the ECMH consultation to rule out that positive effects were simply a function of having extra hands in the classroom. Classrooms that received ECMHC had significant growth in their classroom quality. Namely, intervention teachers had higher levels of positive climate, teacher sensitivity, and more effective management of children's behavior and lower negative climate in the spring, controlling for fall quality, compared to control teachers.

Two RCTs focused on evaluating the effects of the Early Childhood Consultation Partnership (ECCP), a statewide system of early childhood mental health consultation in Connecticut.[31, 32] The ECCP system includes ECMHC available to staff, upon request. Consultation lasts 8 weeks, with 4 to 6 hours of classroom-based consultation per week provided by a supervised masters-level consultant and a week-12 follow-up visit. The 2007 evaluation of ECCP included 144 children and 67 teachers, most of whom (82%) taught at community-based care settings. Children in classrooms that received ECCP had significant reductions in teacher-reported externalizing behavior problems (e.g. hyperactivity, oppositional behaviors), but no change in teacher-reported social skills or internalizing behavior problems (e.g., shyness, withdrawn behaviors, anxiety, etc.). Contrary to hypotheses, no significant differences were found between ECCP and control teachers on classroom quality, teacher beliefs, or teacher stress.[31] The more recent evaluation of ECCP included 176 children and 88 teachers, who were randomly assigned to receive ECMHC or to a control group. Results indicated that children in classrooms that received ECCP had significant reductions in hyperactivity, restlessness, externalizing behaviors, and total problem behavior, compared with children in the control group.[32] Again, contrary to hypotheses, this RCT did not find evidence that ECMHC improved classroom quality or reduced the likelihood of target children being expelled.

Finally, a recent small RCT further demonstrated positive effects of a specific model of consultation, Learning to Objectively Observe Kids (LOOK).[33] LOOK is referred to as a hybrid consultation model that integrates practice-based coaching to increase teacher capacity for implementing evidence-based social–emotional teaching strategies through an online, video-

based feedback process with consultants that deepens self-reflection and self-analysis of teaching practice. This pilot RCT included 45 Head Start teachers and 143 target children who were identified as having elevated levels of challenging behavior at the beginning of the year. In terms of teaching practices, teachers who received LOOK consultation reported significantly higher efficacy in managing disruptive behavior and use of evidence-based social-emotional teaching strategies, compared to teachers in the control group.[33] These strategies included praise, incentivizing positive behavior, being proactive, and teaching children specific social skills. In terms of child behavior, LOOK teachers reported significant 1) reductions in target children's negative task engagement and peer disruption and 2) improvements in target children's peer interaction skills and emotion regulation, compared to control group teachers.[33] Overall, causal evidence suggests that ECMHC can be effective in improving teacher and child outcomes, particularly for improving child behavior.

Appendix C.
Center of Excellence for Infant and Early Childhood
Mental Health Consultation Competencies

1. Role of the ECMH Consultant

Understands and can convey how IECMHC is a mental health specialization that is distinct from other activities in which mental health professionals may engage. Demonstrates an ability to strengthen families' and ECE staff's capacity to support the social, emotional, and relational health of children and families in a range of settings. Partners with families and ECE staff in working to prevent mental health problems from developing or increasing in intensity and/or in responding effectively to existing mental health concerns.

1A. Distinguishes ECMH consultation from other related endeavors

> 1A.1. Demonstrates an understanding of IECMHC as an indirect service that helps to build the reflective capacities and relational health of families, ECE staff, and others who care for or provide services to young children. Grasps and can convey the difference between IECMHC and modes of intervention that involve direct mental health treatment for children and/or families.

> 1A.2. Understands and can convey the distinction between the role of the IECMH consultant and that of other professionals who support the development of ECE staff and family capacities (e.g., professional development coaches, health service managers, health care consultants, home visitors, early interventionists, therapists, disability coordinators).

> 1A.3. Embraces the idea that IECMHC focuses on promoting mental health and social and emotional development using a wide-ranging knowledge base that draws from numerous fields of study. (See Section 2. Foundational Knowledge for further explication.)

1B. Exhibits an ability to work in natural settings

> 1B.1. Demonstrates an ability to work in natural settings, including homes and early care and education environments.

> 1B.2. Considers the influence of setting and organizational functioning on providers, families, children, and service provision.

> 1B.3. Suggests and/or supports interventions that reflect the particular setting in which IECMHC is delivered, which may include programmatic and/or child- and family-specific activities.

1B.4. Offers consultation that reflects and respects the philosophy and model of the program in which IECMHC takes place and the community and cultural context in which that program resides and/or functions.

1C. Understands and engages in the consultative process

1C.1. Demonstrates an organized approach to the stages of the consultative process (e.g., entering the new environment, establishing mutual expectations for the work, gathering information from and the perspectives of all involved, facilitating the establishment of goals, supporting and assessing progress, righting the course of consultation when necessary, transitioning, ending).

1C.2. Demonstrates an ability to support the emotional well-being and relational health of infants and young children, and the adults who care for them, and promotes a shared and accurate understanding of child, family, and provider needs.

1C.3. Maintains accurate and timely records, provides professional documentation, and engages in substantive data collection in accordance with a program's or setting's requirements.

1C.4. Recognizes when additional mental health and/or other services are warranted, and is able to make appropriate and effective referrals across multiple systems.

1D. Embraces the consultative stance and reflective practice

1D.1. Can articulate the elements of the "consultative stance," and demonstrates the demeanor and skills embodied by this stance.

1D.2. Demonstrates the ability to engage in a flexible and varied "use of self" based on the unique needs of a setting, its context, and the relationships involved (i.e., in a range of situations, is able to serve as an observer, listener, facilitator, problem-solver, and/or educator).

1D.3. Recognizes and maintains appropriate professional boundaries and role as defined by discipline (e.g., psychology, social work, counseling) and scope of practice.

1E. Deepens knowledge and skills through active participation in supervision or consultation

1E.1. Actively participates in clinical consultation and/or reflective supervision that is characterized by a focus on interpersonal and systems issues and on child and family dynamics. Willingly engages in supervision that includes analysis of the dynamic interactions between participants (e.g., family members, teachers, administrators,

service providers, consultants, institutions). Engages in explorations of the possible challenges to developmentally supportive activities.

1E.2. Participates in regular administrative supervision that includes discussion of job-related responsibilities, work quality, documentation, data collection, etc.

1F. Adheres to Ethics and Standards of Professional Conduct

1F.1. Adheres to the ethics and standards of professional conduct (e.g., the National Association of Social Workers' Code of Ethics), and, if licensed, adheres to the requirements for maintenance of licensure.

1F.2. Discusses confidentiality and the limits of confidentiality with ECE staff and families at the start of services, and, as circumstances indicate, revisits these topics during the course of consultative work.

1F.3. Carries out the mandate to report suspected child abuse and neglect, and supports others in their responsibilities as mandated reporters.

1F.4. Seeks continuing education experiences to enhance knowledge and skills, and stays apprised of new research, scholarship, and promising practices in IECMHC.

1G. Collaborates respectfully with other agencies

1G.1. Establishes and maintains partnerships with relevant child- and family- serving agencies within the community (e.g., those involving Early Head Start, Head Start, child care, family support, early intervention, mental health treatment, child welfare) in order to collaborate on behalf of children and families.

2. Foundational Knowledge

Draws from a broad and diverse knowledge base to understand children, families, and ECE staff and how they relate to one another. Turns to a variety of disciplines and theories to inform the direction of consultation.

2A. Understands the multidisciplinary body of knowledge that informs consultation

2A.1. Appreciates and embraces multidisciplinary approaches to working with young children, families, non-familial caregivers, and ECE staff, drawing on areas of study that include professional consultation, psychology, social work, health, behavior, early education, ECMH, family and/or systemic functioning, and organizational psychology.

2A.2. Understands that a child's physical environment, experience of attachment, social relationships, culture, life circumstances (e.g., poverty and domestic violence), temperament, and developmental capacities all impact behavior and social and

emotional well-being. Uses this knowledge to support change in one or more of these realms to improve child outcomes.

2A.3. Understands mental health concepts and psychological processes related to adults and adult functioning (e.g., parallel process [how the relationship between an IECMH consultant and the staff or caregivers impacts the relationships between the staff or caregivers and the children and families], the ways in which experiences from a caregiver's past and present can distort how a child's behavior is interpreted, experiences of or responses to trauma).

2A.4. Understands the impact of trauma (including historical trauma and family violence) on child and family development, and can educate others about trauma-informed approaches as needed.

2A.5. Understands how the attitudes and behaviors of primary caregivers influence young children, and works to ensure that parents and caregivers understand the potential of their influence.

2A.6. Understands the root causes of the disparities that exist in expulsion rates and disciplinary practices. Understands how discrimination negatively impacts the social and emotional well-being of young children and their families.

2A.7. Has a broad knowledge base of social and emotional curricula, screening tools, frameworks, and resources.

2A.8. Understands adult learning theory (i.e., concepts related to how adults learn best) as it relates to families and staff.

2A.9. Understands basic principles of organizational or systems psychology as they relate to the programs in which consultation takes place.

2A.10. Recognizes and respects non-dominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within diverse families and communities.

2B. Understands the nature of and influences on development

2B.1. Understands the importance of the development of self-regulation, social relationships, communication, representational thinking, and executive function abilities for school readiness.

2B.2. Understands the interplay of genes and experiences on development—that both the child's constitutional nature (including temperament) and aspects of the environment (e.g., the functioning of parents and other caregivers, the presence of risk and protective factors) play a role in determining the course of development.

2B.3. Understands that development is a transactional phenomenon, within which young children experience attachment relationships with primary caregivers that play a critical foundational role in development. Understands the potential negative impact of parental history, multiple separations, relational disruptions, parental depression, and loss.

2B.4. Understands the potentially positive and protective role of siblings, peers, and group interactions on early development and emotional well-being.

2B.5. Understands typical and atypical growth and development of young children. Has an in-depth knowledge of the general sequence of developmental milestones in all domains, including those connected to cognitive and social and emotional development, communication, sensory-motor processing, self- regulation, physical development, and play.

2B.6. Recognizes risk factors associated with trauma in regard to environmental, situational, and interpersonal contexts, and understands the role of protective factors in ameliorating impacts on the developing child and caregiver relationships.

2B.7. Understands the many ways in which current and historical inequities (racism, homophobia, sexism, able-ism, and other forms of institutional oppression) can negatively impact adult-child relationships and children's development.

2C. Understands the importance of power of culture

2C.1. Understands and supports cultural variations in development, child-rearing practices, and caregiver expectations.

2C.2. Recognizes the biological, psychological, social, and spiritual context of culture and its influence on values, beliefs, child-rearing practices, child development, and social and emotional health and well-being.

2D. Understands the importance of self-awareness and nature of reflective practice

2D.1. Understands the importance of examining personal values, beliefs, biases, and experiences to ensure that misinterpretation or judgment is not imposed on others' intentions and actions.

2D.2. Understands the impact of unconscious bias in interpersonal interactions.

2D.3. Understands the importance of assisting others in reflecting on and examining their own values, beliefs, assumptions, and experiences; supporting them in regulating

their emotions; and helping them accurately perceive the meaning of others' behavior (specifically, the behavior of children, families, and co-workers).

2D.4. Recognizes the value of remaining curious and attentive to visceral and emotional responses to consultees and families, and the importance of understanding these reactions as personal information to be processed and explored.

2D.5. Embraces the importance of seeking to understand the perspectives and experiences of others in the context of consultation.

2D.6. Understands the importance of clinical supervision, consultation, and reflective supervision, and values them as critical components that support the provision of effective consultation.

2E. Understands the functioning of and relationships between families, caregivers, ECMH consultants, and systems

2E.1. Understands the value of support networks. Recognizes barriers and challenges to service acquisition for families, especially those who are isolated or face discriminatory practices due to race or immigration status.

2E.2. Understands parallel process (i.e., that the relationship between an ECMH consultant and the staff or caregivers impacts the relationships between the staff or caregivers and the children and families).

2E.3. Understands that the quality of relationships among adults (between staff members and/or between staff members and families) influences children's experiences in their classrooms and homes.

2E.4. Understands the importance of self-care and the value of offering information to families and staff on the connection between self-care and the ability to build successful relationships with others.

2E.5. Understands a program's methods for screening and assessment, and is aware of the ways in which those systems are used to identify young children who exhibit challenges in the social and emotional domain.

2E.6. Understands that program-level challenges exist within the context of larger systems.

2E.7. Understands the role of the consultant within the context of multiple systems, and considers how interventions in one system may impact others.

3. Equity and Cultural Sensitivity

Describes and demonstrates how culture (beliefs, values, attitudes, biases, and experiences), equity, and environment shape relationships and behaviors, and how they influence settings and communities in important and meaningful ways.

3A. Demonstrates an awareness of diversity, cultural variation, and normative differences in family structure

> 3A.1. Understands how culture (beliefs, values, linguistic expression, styles of communication, behavioral norms, and attitudes) shapes relationships, family structures, behaviors, and development.

> 3A.2. Can define and demonstrate cultural sensitivity (including an understanding of issues related to linguistic diversity), and is able to describe its relevance to IECMHC. Appreciates culture as a source of resilience.

> 3A.3. Demonstrates an appreciation of the unique values and beliefs of each family and each family's structure, and can work effectively with children and families from a range of cultural backgrounds.

> 3A.4. Demonstrates the skills to identify and address implicit bias in practice. Identifies and can effectively discuss program, local, state, or other system policies that disproportionately disadvantage one group of children or families (including expulsion and suspension policies and language access).

> 3A.5 Can identify specific strategies to address inequities in practice and in systems. Can support others to recognize and address inequities.

> 3A.6. Demonstrates the ability to explore and negotiate cultural differences, to value and adapt to the diverse cultural contexts of programs and communities served, and to work effectively with individuals, groups, organizations, and systems that vary in cultures, perspectives, and priorities.

3B. Demonstrates the capacity for self-awareness

> 3B.1. Explores personal background, attributes, knowledge, and skills in a way that enhances the effectiveness of consultation in diverse communities.

> 3B.2. Demonstrates the capacity for self-awareness in regard to cultural issues (i.e., the ability to recognize how culturally influenced experiences shape personal and professional behavior and attitudes, including those connected to how interactions with others unfold and are perceived).

3B.3. Demonstrates the capacity to recognize and address personal biases (including potentially implicit bias).

3B.4. Demonstrates the ability to recognize personal limitations in knowledge of particular cultures, and seeks to gain a greater understanding.

3C. Promotes cultural responsiveness in practices, policies, and procedures

3C.1. Supports ECE staff in speaking with families in their preferred language and in using culturally responsive professional interpreters when same-language communication is not an option.

3C.2. Works with programs to promote cultural sensitivity so that language and culture are respected, families are provided with culturally and linguistically appropriate materials, and staff are offered training opportunities focused on increased cultural responsiveness.

3C.3. Supports the capacity of others to work cross-culturally with the goal of positively influencing practice, policymaking, administrative functioning, and service delivery. Works to systematically involve families, key stakeholders, and communities in these efforts.

3C.4. Demonstrates the capacity to help ECE staff recognize and assess their own implicit biases. Assists others to explore how biases may inadvertently influence perceptions and behavior.

4. Reflective Practice

Thinks about and questions personal influences and actions before, during, and/or after consultative interactions. Considers the influences on and the perspectives of others (e.g., child, family, staff) in the context of consultation (i.e., "What must this experience have been like for the child, staff member, or parent?"). Promotes reflective practice with consultees, using this experience-based learning to support consultees' professional growth and development.

4A. Uses self-reflection to enhance consultation

4A.1. Understands, can describe, and values the importance and benefits of reflective practice.

4A.2. Regularly reflects on personally held values, beliefs, biases, and assumptions as they influence interactions, relationships, and the directions that consultation may take.

4A.3. Reflects on personal biases and can recognize when biases may negatively impact effective consultation. Works to explore personal implicit biases, and takes steps to make objective decisions.

4A.4. Reflects on culture, values, and beliefs and on the personally experienced impact of racism, classism, sexism, able-ism, homophobia, xenophobia, and/or other systems of oppression in order to provide diversity-informed and culturally attuned services.

4A.5. Uses self-reflection to maintain awareness of thoughts, emotions, and visceral reactions that regularly inform and can enhance the quality of consultative work.

4A.6. Reflects on and explores a wide variety of approaches to working with staff, families, and children, and understands that there is no one correct strategy (nor any "quick fixes") in regard to possibilities for change and growth.

4B. Assists others in reflecting

4B.1. Encourages staff and families to become aware of behaviors that stir up strong feelings and reactions, and assists them in identifying the origins of those responses so that they can respond to families, caregivers, and/or children compassionately and effectively.

4B.2. Supports staff and families in understanding how their values, beliefs, experiences, and feelings—along with factors connected to specific settings—have a role in influencing children's behavior.

4B.3. Seeks to engender curiosity through carefully timed, nonjudgmental inquiry. Uses listening, patience, and reflection to encourage others to explore possibilities for approaching challenges and supporting growth and well-being.

4B.4. Collaborates with others to explore how they can regulate their emotions, engage in self-care, reduce stress, strengthen coping mechanisms and resilience, and aim for life balance even in the face of difficult circumstances.

4B.5. Provides individual and group opportunities for staff to engage in reflection in regard to personal values, experiences, ethics, and biases when they are working in a supportive role with families.

4B.6. Assists others in reflecting on the strengths and limitations of the setting in which they work or live (e.g., an agency, classroom, program, or home) and to explore how that setting impacts possibilities for and approaches to supporting children, families, and/or staff.

5. **Child- and Family-Focused Consultation**

Collaborates with families and/or ECE staff to understand and respond effectively to a child's or parent's mental health needs, behavioral difficulties, and/or developmental challenges. Partners respectfully with families and ECE staff to understand the context and nature of a particular family's life in order to enhance the child's and family's well-being.

5A. Values and Promotes the Power of Relationships and the Importance of Relationship-Building

> 5A.1. Demonstrates an ability to honor family strengths, perspectives, and expertise, and assists others in valuing and supporting family relationships as the first and primary relationships in a child's life.

> 5A.2. Supports ECE staff in developing trusted and respectful relationships with families.

> 5A.3. Gathers (or supports ECE staff in helping to gather) family- and child- related information in a manner that is nonthreatening, respectful, collaborative, and supportive.

> 5A.4. Facilitates understanding, mutual respect, and direct communication between families and ECE/HV staff and among members of the ECE community.

> 5A.5. Engages warmly and flexibly with ECE staff and families in order to consider the meaning of a particular behavior.

5B. Works collaboratively to understand a child's behavior

> 5B.1. Collaborates with families and ECE staff to develop a working hypothesis about the meaning of a child's behavior, including social and emotional, relational, cultural, and family factors; physical and/or medical issues; environmental factors and setting events (such as a history of exposure to trauma); and/or developmental vulnerabilities that may play a role in that behavior. Recognizes the need to revise that hypothesis, over time, as new information emerges and in the face of conflicting and/or additional information.

> 5B.2. Demonstrates an ability to pay close attention to the relationships and interactions between ECE staff, family members, and the child—and between that child and his or her peers—and to consider how those interactions may impact child and family well-being.

> 5B.3. Considers and encourages others to consider information from families (including information about family history and culture), from ECE staff and from observations and documentation (e.g., health records, anecdotal notes, assessments, reports).

5B.4. Uses a variety of observation strategies, tools, and recording techniques to gain insight into a child's behavior and the relational influences on his or her functioning.

5B.5. Helps families and ECE staff understand all the influences on their view of the child (e.g., cultural, historical, and interpersonal factors; exposure to trauma; programmatic and bureaucratic issues).

5C. Supports and facilitates plan development and implementation

5C.1. Integrates information and, considering both context and available resources, collaborates with ECE staff and families to develop a plan that addresses child, family, and ECE staff needs in a culturally sensitive manner.

5C.2. Assists and supports families and ECE staff so that collaboratively developed plans for children involve interventions that reflect best practice (i.e., are developmentally appropriate and, when possible, evidence-based).

5C.3. Works in collaboration with other service providers to support families and ECE staff (e.g., Part C, Early Intervention).

5D. Supports and facilitates referrals, service provision, and community collaboration

5D.1. Partners with ECE staff and families in order to identify and facilitate appropriate referrals for specific children and families, whether in regard to medical, developmental, mental health, and/or other needs.

5D.2. Works to see that referrals meet the diverse needs of families, with particular consideration given to issues concerning resources, culture, and language.

6. **Classroom- and Home-Focused Consultation**
Collaborates with parents and ECE staff to promote warm and trusting relationships, steady routines, and development-enhancing interactions that positively impact classroom and home climates. Explores how elements of classroom and/or family life can play a powerful role in supporting all children's social and emotional development.

6A. Promotes secure and supportive relationships between children and adults

6A.1. Helps families and ECE staff deepen their understanding of how the quality of adult-child relationships impacts the way that children experience themselves in various settings, learn expectations, and understand how to interact and get along with others.

6A.2. Helps families and ECE staff understand and use the power of positive relationships and adult-child interactions to support growth and development.

6A.3. Offers insight into the role of positive sibling, peer, and group interactions in promoting children's growth and well-being. Supports families and ECE staff in promoting, fostering, and/or engaging in such interactions. Suggests, as needed, a range of strategies that promote successful give-and-take with peers.

6A.4. Supports the development of and addresses impediments to positive relationships between (1) families and ECE staff, (2) ECE team members, and (3) ECE teachers or providers and ECE administrators.

6B. Supports families and staff in understanding the nature of development and possibilities for developmental support

6B.1. Shares information about how young children learn and develop in a way that families and ECE staff can understand, embrace, and use.

6B.2. Fosters families' and ECE staff's abilities to promote and facilitate the development of children's relational capacities and social and emotional mastery, including their capacities for connection, self-regulation, communication, problem-solving, and impulse control.

6C. Supports families and staff in providing or encouraging consistent routines and developmentally appropriate interactions and practices

6C.1. Supports families and ECE staff in initiating, modifying, and/or supporting routines in order to promote safety and consistency.

6C.2. Collaborates with families and ECE staff to promote practices and interactions that are responsive to the needs of individual children and groups of children.

6D. Fosters a deepened understanding of mental health issues and related interventions

6D.1. Assists ECE programs and staff in selecting, suggesting, and/or implementing observation strategies, tools, assessments, and recording techniques to gain insight into the functioning and social and emotional climate of homes or classrooms.

6D.2. Helps families and ECE staff to integrate ideas, activities, and resources that infuse mental health principles into the daily routines and interactions of a particular home or classroom.

7. **Programmatic Consultation**

Maintains a systemic approach and aims for program-wide impact through a focus on multiple issues that affect the overall quality of an ECE setting. Works to enhance programmatic functioning by assisting ECE program administrators and/or staff in considering their setting's

overall social and emotional climate and in solving issues that affect more than one child, staff member, and/or family.

7A. Understands and attends to program design and infrastructure

7A.1. Initiates consultation services with an agreement outlining roles, scope of work, frequency, duration, etc.

7A.2. Establishes a relationship with the program leadership in a manner that supports their ability to champion social and emotional wellness in center functioning; to promote the relational health of children, families, and staff; and to foster children's healthy social and emotional development.

7A.3. Learns about a program's organizational structure, including staff roles and responsibilities and lines of authority. Shares information about the role of the consultant, including its parameters and limitations. Uses established pathways to engage members of the organization as indicated.

7A.4. Becomes familiar with and works within a program's mission and policies, especially those impacting staff development, family engagement, and positive behavioral supports.

7A.5. Pays particular attention to program policies that may disproportionately disadvantage certain groups of children, such as children of color or dual language learners.

7A.6. Facilitates the discovery of gaps between policies and program practices that impact the provision of a healthy social and emotional climate and that are related to child outcomes.

7A.7. Identifies factors (including policies, practices, leadership style, and professional development) that influence the social and emotional climate of a center or program.

7A.8. Evaluates the efficacy of program-level intervention strategies, and revises them as needed.

7A.9. Elicits and explores multiple perspectives in understanding concerns within a program, encourages the development of clear lines of communication between program staff, and represents the perspective of consultees to others across all levels of the institutional hierarchy. Fosters solutions that build collaborative relationships and support common goals.

7A.10. Facilitates effective interventions to address relational difficulties that are negatively impacting the mental health climate of a program. Understands interpersonal

dynamics associated with diversity and inclusion issues (especially in regard to groups experiencing discrimination) and how they may manifest in conflicts, tensions, misunderstandings, and/or opportunities. Understands the context of the community in which a center functions, including factors related to its history, culture, language, values, capacities, etc.

7B. Supports and facilitates program-wide approaches to supporting the mental health of children and families

7B.1. Coordinates with and among external quality enhancement efforts and internal program resources (e.g., instructional coaches, training and technical assistance efforts, program leadership).

7B.2. Shares information about resources and best practices in order to support programmatic decision making and effective implementation of center-wide approaches to healthy social and emotional development.

7B.3. Provides guidance related to resource selection and adaptation in a manner consistent with a specific program's philosophy, needs, and culture.

7C. Engages in group facilitation

7C.1. Facilitates group processes that support staff in working toward and maintaining a focus on established goals. Attends to and manages complex group dynamics.

7C.2. Promotes perspective taking, communication, and/or activities that facilitate mutually respectful relationships, interactions, and teamwork.

7C.3. Offers direction during times of ambiguity, maintaining a focus on both promoting young children's healthy social and emotional development and supporting caregivers' capacities.

7D. Supports and facilitates plans for mental health support during crises or disasters

7D.1. Facilitates or links programs to appropriate resources when developing and implementing plans to prepare for or respond to disasters or crises.

7D.2. Provides guidance related to the manner in which crisis drills are implemented. Considers developmentally appropriate explanations, procedures, advance preparation, and debriefing for staff, families, and children. Anticipates potential negative impacts of crises on individual children, and proactively establishes plans to address concerns.

7D.3. Recognizes the nature and parameters of the consultant's role during crises, and is familiar with available crisis services. Considers the importance of the timing of the consultant's entry or reentry into a center recently impacted by crisis.

8. Systems-Wide Orientation

Works within and across systems, integrating mental health concepts and supports into the cultures and environments where young children spend time. Maintains awareness of the systems within which IECMHC occurs, and considers these contexts when seeking to understand factors that promote or hinder the process of change.

8A. Evaluates the complexity of working within multiple systems

8A.1. Demonstrates the ability to articulate basic concepts of systems theory, and understands how they inform the process of IECMHC.

8A.2. Demonstrates the ability to work concurrently within two or more systems, and understands that changes in response to IECMHC may influence multiple systems.

8A.3. Works within and across systems, integrating mental health concepts and supports into the cultures and environments where young children spend time.

8A.4. Considers the historical and cultural contexts of communities and their member, and recognizes cultural influences on values, perspectives, and actions.

8A.5. Demonstrates awareness of and sensitivity toward existing attitudes and strengths of community members (e.g., community leaders, agencies, service providers).

8B. Bridges services to promote cohesion for young children and families

8B.1. Gains entry into and engages effectively with child-serving centers or programs where consultation services are delivered.

8B.2. Maintains up-to-date information about community resources. Limits unnecessary barriers for families to obtain services by making effective referrals.

8B.3. Establishes relationships with professionals in other early childhood and mental health disciplines, including those providing counseling and treatment services.

8B.4. Encourages networking between ECE settings and programs and other child- and family-serving organizations within a community.

8B.5. Uses and shares current information about standards (i.e., professional, program, and licensing standards), resources, and other child- and family serving systems.

8C. Promotes mental health and social and emotional well-being

8C.1. Promotes healthy social and emotional development through the creation and/or distribution of informational materials and resources that can be disseminated to a range of audiences, using a mix of methods informed by the community.

8C.2. Maintains visibility as a resource for promoting healthy social and emotional development and mental wellness.

Purpose:
The purpose of this instrument is to examine children's well-being and behavior with other children, adults, and materials in a classroom or virtual classroom setting. **This form should only be completed by teachers who interact regularly with the child (in-person or virtually).**

Teacher Instructions:
You will complete one CBRS for each individual child in your class.

Please complete all items on this instrument to the best of your ability by choosing the response number that best indicates how frequently the child exhibits the behavior(s) described in a particular item.

Never	Rarely	Sometimes	Frequently/ usually	Always
1	2	3	4	5

The response numbers for items 1-22 indicate the following:

1) The child **never** exhibits the behavior described by the item.
2) The child **rarely** exhibits the behavior described by the item.
3) The child **sometimes** exhibits the behavior described by the item.
4) The child **frequently or usually** exhibits the behavior described by the item.
5) The child **always** exhibits the behavior described by the item.

Please read items 12, 13, 20, 21 carefully (marked with asterisk). They are worded differently than the

There are three items at the end of the scale that ask you to rate how concerned you are about a child's social-emotional well-being and how often you interact with the child virtually and in-person.

CBRS – July, 2012
Bronson, M. B., Goodson, B. D., Layzer, J. I., & Love, J. M. (1990). Child behavior rating scale. Cambridge, MA: Abt Associates. (Items 1

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	Never	Rarely	Sometimes	Frequently/ Usually	Always
1. Observes rules and follows directions without requiring repeated reminders.	1	2	3	4	5
2. Completes learning tasks involving two or more steps (e.g. cutting and pasting) in organized way.	1	2	3	4	5
3. Completes tasks successfully.	1	2	3	4	5
4. Attempts new challenging tasks.	1	2	3	4	5
5. Concentrates when working on a task; is not easily distracted by surrounding activities.	1	2	3	4	5
6. Responds to instructions and then begins an appropriate task without being reminded.	1	2	3	4	5
7. Takes time to do his/her best on a task.	1	2	3	4	5
8. Finds and organizes materials and works in an appropriate place when activities are initiated.	1	2	3	4	5
9. Sees own errors in a task and corrects them.	1	2	3	4	5
10. Returns to unfinished tasks after interruption.	1	2	3	4	5
11. Willing to share toys or other things with other children when playing; does not fight or argue with playmates in disputes over property.	1	2	3	4	5
12. *Expresses hostility to other children verbally (teasing, threats, taunts, name calling, "I don't like you," etc.).	1	2	3	4	5
13. * Expresses hostility to other children physically (hitting, pinching, kicking, pushing, biting).	1	2	3	4	5
14. Cooperative with playmates when participating in a group play activity; willing to give and take in the group, to listen to or help others.	1	2	3	4	5
15. Takes turns in a game situation with toys, materials, and other things without being told to do so.	1	2	3	4	5
16.Complies with adult directives, giving little or no verbal or physical resistance, even with tasks that he/she dislikes.	1	2	3	4	5

CBRS – July, 2012

Bronson, M. B., Goodson, B. D., Layzer, J. I., & Love, J. M. (1990). Child behavior rating scale. Cambridge, MA: Abt Associates. (Items 1   58

	Never	Rarely	Sometimes	Frequently/ Usually	Always
17. Does not fuss when he/she has to wait briefly to get attention from teacher or another adult; child may be asked once to wait by teacher or adult.	1	2	3	4	5
18. Calms down after becoming upset, frustrated, or angry.	1	2	3	4	5
19. Adapts when plans change; goes with the flow.	1	2	3	4	5
20. *Is withdrawn from people or activities.	1	2	3	4	5
21. *Appears worried or anxious.	1	2	3	4	5
22. Smiles, laughs, and responds positively to other children or adults.	1	2	3	4	5

	Not at all	Slightly	Moderately	Very	Extremely
How concerned are you about this child's social-emotional well-being?	1	2	3	4	5

	Days per week					
How often do you interact with this student in terms of in-person instruction?	0	1	2	3	4	5
How often do you interact with this student in terms of virtual instruction?	0	1	2	3	4	5

COMMENTS:

Endnotes

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