Mental Health Consultation in Child Care and Early Childhood Settings

Opportunities to Expand the System of Care for Children with Emotional and Behavioral Challenges in Florida

Submitted to
The Florida Department of Children & Families
Children's Mental Health Program

June 30, 2006

Florida State University
Center for Prevention & Early Intervention Policy
1339 E. Lafayette St. • Tallahassee, FL 32301
850-922-1300 • www.cpeip.fsu.edu
Mental Health Consultation in Child Care and Early Childhood Settings

Opportunities to Expand the System of Care for Children with Emotional and Behavioral Challenges in Florida

Prepared under contract with
The Florida Department of Children & Families,
Mental Health Program Office, Children’s Mental Health

Submitted June 30, 2006

Florida State University
Center for Prevention & Early Intervention Policy
1339 E. Lafayette St. • Tallahassee, FL 32301
850-922-1300 • www.cpeip.fsu.edu
# Table of Contents

Introduction ............................................................................................................. 1

What is Mental Health Consultation ................................................................. 3
  San Francisco ...................................................................................................... 4
  Colorado ............................................................................................................ 6
  Vermont ............................................................................................................. 7
  Ohio .................................................................................................................... 9
  Sarasota ............................................................................................................. 11

Characteristics of Early Childhood Consultation .............................................. 15
  Relationships .................................................................................................. 15
  Screening, Assessment and Observation ......................................................... 15
  Types of Early Childhood Mental Health Consultation ................................... 16
  Staff Qualification Mental Health Consultation ........................................... 16
  Effectiveness ................................................................................................. 17

Policy Considerations ......................................................................................... 18
  New Freedom Commission ............................................................................. 18
  American With Disabilities Act and Individuals with Disabilities Education Act ................................................................................. 18
  Good Start Grow Smart .................................................................................. 18
  Florida’s State Plan for the Prevention of Child Abuse, Abandonment, and Neglect .......................................................... 19

Funding .................................................................................................................. 19
  National Funding Strategies ........................................................................... 20
  Florida Possible Funding Sources .................................................................. 20
  Comments Regarding Funding ..................................................................... 27

Strategies for Implementing Early Childhood Mental Health Consultation in Child Care and Educational Settings .................................................. 29

Summary ............................................................................................................... 30

References .......................................................................................................... 31
Introduction

More children are receiving out-of-home care than ever before in history. In fact, it is now the norm and not the exception for children from the age of three months through age 4 to spend many hours a day in a child care center. Reflecting this trend, one chapter in the seminal work *From Neurons to Neighborhoods* (National Research Council, Institute of Medicine, 2000) is entitled “Growing up in Child Care.” It reports that 44% of infants under the age of one are receiving non-parental child care, with the percentage growing each year of life, such that over 70% of four year olds receive non-parental care. These figures reflect our nation’s movement away from daily parental care even for the youngest in our society, resulting in child care settings being second only to the immediate family in influence on early development. The relationships that develop in child care and preschool environments have a significant impact on the overall development of children during this critical period of growth.

Research has shown that high quality preschool programs improve school readiness and provide children with the social and emotional skills required to be successful in school. The research also shows that the benefits acquired during the years in quality preschool programs result in higher high school graduation rates (Gilliam, 2005). On the other hand, children with serious emotional disturbances have the highest drop out rates of any group of children. Early identification and treatment could possibly help address this problem.

Yet all is not well in child care. Quality child care seems to be an elusive goal during this time when an unprecedented number of families have two parents working—sometimes more than one job each—just to make ends meet. The cost of child care for low-income families can be a substantial portion of their income, placing additional stress on these families. Some children (up to 20%) are spending up to 10 hours a day in child care environments that do not provide even a minimally safe and healthy environment (Institute of Medicine, 2000). They may spend their days without organized activities, wandering around the center with limited stimulation and social supports. Their fears, problems with peers, and accomplishments go unnoticed. Children who struggle with regulating their emotions and behaviors may not receive appropriate supports while their behaviors intensify.

Providing adequate child care is a challenge for any organization. The cost of hiring and training qualified staff, providing the appropriate equipment and materials, preparing and serving healthy meals and snacks, and providing a safe, stable, healthy, and nurturing environment can be very high. Families with adequate financial resources may be able to pay for such care, but low-income families and families in poverty cannot begin to make that type of financial commitment. Subsidized child care helps thousands of families obtain adequate care, but does not necessarily cover the costs of high quality care. The children that need the highest quality care due to their familial and community challenges to help prevent developmental delays and emotional difficulties may be the very children that receive low quality care.
While child care staff are trying to provide the best care they can with limited resources, children are presenting with greater needs and challenges. Children are coming into child care centers carrying with them the psychological pressures associated with neighborhood violence, domestic violence, child abuse and neglect, parental mental illness and substance abuse, and in some cases very early onset of biologically based affective disorders. These are the children that need an enriching preschool experience the most, but they are also the most likely to be expelled from child care. Research shows that these children are likely to have continued learning and behavioral problems and later drop out of school (Gilliam, 2005).

The first study ever conducted on the rate of expulsion in prekindergarten programs was completed as part of the National Prekindergarten Study that released their findings in May 2005 (Gilliam). Their key findings were shocking and are listed below:

1. Prekindergarten students are expelled at a rate more than three times that of their older peers in grades K to 12.

2. Prekindergarten expulsion rates vary by classroom setting. Expulsion rates are lowest in classrooms located in public school settings and Head Start, and highest in faith-affiliated centers and for-profit child care.

3. The likelihood of expulsion decreases significantly with access to classroom-based behavioral consultation.

4. The rates of expulsion in Florida fall in the median, with 4 to 7 expulsions per 1,000 Prekindergarten students.

According to Gilliam (2005) “classroom-based behavioral consultation appears to be a promising method for reducing prekindergarten expulsion.” It appears that the term “behavioral” is used to refer to overall mental health consultation rather than consultation provided using only behavioral management techniques. The report states that, although access to a mental health professional is better than no help at all, the best outcomes were found when there was a regular relationship between the behavioral consultant and the Prekindergarten setting.

Alkon, Ramler, and MacLennan (2003) reported on previous studies in this area and stated that:

- One in every five pre-school age children has some behavioral or emotional problems
- Eight in every 100 children have a diagnosable psychiatric disorder
- Preschooler children with persistent behavior disorders continue to have problems in later childhood
- Interventions with pre-school age children can change the prevalence of behavior problems in later childhood and adolescence

Many professionals believe that the earlier the intervention the better chance there is to significantly improve the child’s behavior. With so many children presenting with significant emotional and behavioral issues in the preschool and child care settings, the need to improve the linkages and responsiveness of the mental health service system is evident. Early childhood mental health consultation has been shown to be an effective response to this need.
What is Mental Health Consultation in Child Care and Early Childhood Settings?

According to the Substance Abuse and Mental Health Administration’s (SAMSHA) publication *Early Childhood Mental Health Consultation*, the definition of early childhood mental health consultation is as follows:

>Mental health consultation in early childhood settings is a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals with other areas of expertise, primarily child care center staff. Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age 6 and their families.

Mental health consultants in child care settings have four general roles and functions, which are described below:

1. To help establish a positive emotionally healthy working environment for the staff at the child care center.
2. To help the staff set up an enriching environment to promote positive mental health for the children and promote social and emotional development.
3. To provide individualized assistance usually working through the child care staff to address the particular needs of a child.
4. To provide individual therapeutic treatment to children and their families if warranted.

The field of mental health consultation is relatively new, with many of the characteristics of the work still evolving. The term is used to describe many different functions, resulting in some confusion when attempting to compare different settings. In general, the differences revolve around the type of services provided (i.e., whether more behavioral-oriented or therapy-oriented); the credentials of professionals providing the service (i.e., whether they are licensed therapists, behaviorists, or early childhood specialists/educators); and the degree to which they work individually with children and families.

This paper provides a brief comparison of five different methods of providing mental health consultation in child care settings to illustrate the various models of rendering the service. The literature consistently references a few programs that are considered exemplary models of mental health consultation in child care settings. These include the Vermont CUPS program, the program in San Francisco and Ohio’s Daycare Plus. These are included in the overviews with two additional programs. One in Colorado that is known to do a good job and one in Florida that demonstrated linkages with the Early Learning Coalitions. This paper focuses on several key components which include: (a) methods to identify need, (b) assessments, (c) type and qualifications of professionals providing consultation, (d) the method or focus of consultation, (e) the number of children served per year, (f) the duration of the service per child, and (g) the cost per child. Information was gathered through a review of the literature and semi-structured interviews with staff from each of the sites. This information is provided below and later summarized in Table 1.
San Francisco

A program frequently mentioned in the literature is the Early Childhood Mental Health Project. This is collaboration between the Jewish Family and Children Services in San Francisco and Day Care Consultants, which is an Infant-Parent Program of the University of California in San Francisco. This collaboration has been serving children and their families for over twenty years. The program has three primary activities around which they structure their work. These are quoted from their report: *The Early Childhood Mental Health Project 2003.*

1. Providing on-site mental health consultation services to child care teachers, including case and program consultation and didactic training.

2. Providing clinical and assessment services to children and families, such as on-site therapeutic groups, neurodevelopment assessment, and on-site or at-home dyadic child-parent psychotherapy.

3. Providing intensive training and supervision for mental health professionals in the provision of consultation and individual/group treatment of young children, their families, and teachers.

The program started twenty years ago, with funding from a small private foundation, to address the emotional and behavioral needs of children in child care settings. They targeted the centers that served children from low-income families, pioneering the concept of mental health consultation in early childhood settings.

In the beginning of the program, referrals came to the consultants from the child care centers, resulting from specific problems that the centers were having with one or more children. The referrals came directly to the consultants and they responded to the calls. The consultants always have been licensed therapists with the responsibility to complete a mental health assessment with the child. The assessment also includes an informal ecological analysis of the environment to determine its potential impact on social and emotional development and behavioral challenges.

The therapists do not use any particular assessment instrument, working from the premise that each individual child’s behavior has particular meaning to that child. The therapist works with the teacher to try and determine the meaning of a particular set of behaviors. In behavioral terms, this type of approach is known as a functional assessment. However, it is not accurate to assume that the therapeutic interventions are all taken from the behavioral management field. In addition to trying to understand the child, the consultant may also have to try to understand the emotions and perspective of the teacher. In some instances, teachers have become very frustrated by the time the referral is made and the consultant comes on-site. The consultant must pay close attention to the relationship between the child and the teacher. The San Francisco project is adamant that families must be involved in all aspects of the intervention from the beginning. During the assessment process, information is obtained from the family as well.

As described above, the consultation process is multifaceted. First, the consultant must establish a relationship with the staff in the center and try to gain their trust. This good professional relationship is central to successful consultation. The cornerstone of mental health consultation is the assumption that the relationship between the child and the teacher is vital for healthy social and emotional development. Therefore, the bulk of the intervention is done through the
consultant working with the teacher to be more effective with the child. This could include making suggestions about classroom environment, classroom schedules, transitions, and the interaction patterns of the children. To be effective, the consultant must understand the demands on the teachers, working with them to develop interventions that can be realistically applied in that particular child care center.

The consultant develops relationships with all the adults in the child’s life, seeking information and ideas from all of them. This helps create an atmosphere of teamwork in which all the adults feel that they are part of the solution. The consultant is careful not to foster the opinion that they are more knowledgeable, or the “savior” who is going to come in and solve all the child’s behavioral problems. The consultant encourages the teachers and the parents to exchange ideas and to be vocal when they think that a particular strategy cannot be implemented given the constraints of the group situation or home environment.

In rare situations, the consultation does not have the desired outcomes and the consultant must provide direct intervention. In San Francisco, the director estimates that this need is apparent in less than 10% of the children served. The direct interventions usually include work both at the school and in the home. As part of the consultation model, families may receive up to 6 to 8 visits to address mental health issues from the family’s perspective. This work focuses on the child and family relationships and behavioral management. This helps to introduce the family to mental health interventions, making the process less threatening. In some cases the family or parents need more intensive treatment and are referred to an outpatient mental health center.

The amount of time that the consultant spends with a particular child is dependent upon the severity of the child’s disorder. The therapist often uses play therapy and group play therapy for direct intervention. The group play therapy is considered very effective (anecdotal evidence—no formal studies) in child care settings with three to five year olds. The group size tends to be about six children with two adults. The consultant/therapist facilitates the group, while one of the teachers serves as the co-facilitator.

As the program has matured, the mental health consultants have formed relationships with the child care centers, providing program-based consultation as well as case-based (for an individual child). The program-oriented consultation takes two basic forms. First, the consultant examines the organizational environment and the relationships with staff. The premise is that staff should also have a positive and healthy working relationship and model that relationship for the children. The consultant works to help the organization develop practices that are conducive to the prevention of social and emotional disorders. In program consultation, the therapist may also make suggestions to the teachers regarding general approaches to enhance social and emotional development.

The program has served thousands of children over the years, and now mental health consultation is available in every child care center in the Bay Area. The program does not list the cost per child, instead calculating the cost at an average of $10,000 per center.

As stated above, funding originally came from a private foundation, but over time more long-term funding was identified. Today there is a centralized funding mechanism that captures financial support from 8 human service agencies and 4 city departments. One part of the funding comes from TANF. Funds are also allocated from the Child Care Development Fund. The total amount for the Bay Area is about $1.5 million. Medicaid, through the Early Periodic Screening
Diagnosis and Treatment (EPSDT) program, also provides funding for individual treatment for the children when their needs exceed basic consultation.

As the program has grown, several more providers began to provide services. This necessitated the development of a central referral and coordination entity. Centers now make referrals to this central point, and providers are assigned by this entity. There are some issues that must be resolved with this system. It could be very difficult for a center to have more than one therapist. Also, some centers have a long-term relationship with a particular provider, and that should be preserved. The organizational details of the centralized mechanism are currently being designed.

Staff are all licensed therapists who are either experienced in early child care settings or have received training in that area. All the supervisory staff have expertise in both areas.

A full formal evaluation has been completed by Yale University on this project (Alkon et al. 2003) showing that directors and teachers view mental health consultation as supportive and effective, improving teacher efficacy and the likelihood the child care center will offer a developmentally appropriate service.

**Colorado – the Child Care Intervention Team**

The Child Care Intervention Team is designed to meet the needs of at-risk children in early care and educational settings and to increase the skills of their parents and the early education staff to interact effectively with these young children. As in San Francisco, the philosophy is that it is more beneficial to the child and teacher if the consultant provides assistance to the teacher and the teacher implements the suggestions rather than the consultant working primarily with the child. The team focuses on children who exhibit signs of emotional, behavioral, mental or developmental problems to develop specific intervention strategies to help them develop age appropriate social and emotional capabilities (Simpson et al., 2001).

The program started as part of a child care resource and referral agency in Colorado Springs, Colorado. A local group, the Alliance for Kids, had conducted a needs assessment that indicated the need for mental health services in the child care centers. The first program model was similar to San Francisco’s program, using licensed therapists. However, the agency found that the therapists were not able to adjust to the hectic group environment of the child care centers. Based upon this experience, they decided to cross train early childhood professionals in the mental health area and provide consultation and reflective supervision from a licensed clinical social worker on a weekly basis to complement the work of the early childhood professionals.

Referrals for assistance come into the resource and referral agency. The Child Care and Intervention Team first obtain commitment from all parties, including the parents. The usual duration of time for the intervention is about three to six months. The Early Childhood Interventionist observes the child in the child care setting and works with the teacher to design an intervention program. The team uses the *Ages and Stages Questionnaire*, and the *Ages and Stages Questionnaire: Social and Emotional* instruments as screening tools. The *Devereux Early Childhood Assessment* (DECA) instrument and process is used to complete the more comprehensive assessment with the child, teachers and family. The Environmental Rating Scale is used to collect pre and post data. The interventionists do not provide therapy since they are not licensed mental health clinicians. There work is based on positive behavioral supports and social skills instruction (reading books about emotions, creating the child’s own stories, etc.).
They also use the curriculum developed by Dr. Beck Bailey entitled *Conscious discipline* and *Love and logic* by Jim Fay and Foster Cline.

If the child and/or family need additional mental health treatment, the interventionists make referrals to mental health outpatient programs. The number of referrals is estimated to be at about 3% of the population served. The team of the interventionist and the licensed social worker can meet the needs of the majority of children, teachers, and families.

As in San Francisco, the program was originally funded through a start-up grant. In this case the original funding was through Violence Prevention followed by TANF. Unfortunately the TANF funding was terminated. They now have a grant through the quality set aside of the Child Care Development Fund in Colorado. Costs are $1,725 per child for a three to six month intervention.

The JFK Partnership Division at the University of Colorado has evaluated the program’s effectiveness. Pre- and post-tests are used to measure the effectiveness of each individual intervention.

**Vermont – The Children’s Upstream Project (CUPS)**

Vermont received the first Substance Abuse and Mental Health Services Agency (SAMHSA) Comprehensive System of Care grant focused on young children. The state has a long history of working through local interagency planning teams and has a fairly well funded set of services for children. Over the years, much of the funding has come from leveraging Medicaid. Recognizing that it is more efficient to work through existing service delivery structures, the state used grant funds to support existing community-based and agency services for children and families. This included working with the local child care providers.

The CUPS project encouraged local community mental health centers to consult with child care centers about difficult behaviors that children were displaying in the child care centers. The consultants provided training, technical assistance, and consultation to the child care providers and to parents who expressed the need for further assistance. The services, as with the other mental health consultation programs, focused on improving the capacity of the caregivers and improving their relationships with each other and the children. Services included training for child care providers in behavioral management, anger management, positive and effective discipline, stress reduction, and stress management. Referrals came from providers, staff, families, and other agencies (Simpson et al., 2001).

Vermont mental health services are divided into 12 regions, which have at least three mental health consultants working in each area. These staff are referred to as CUPS workers. The exact nature of the consultation varies by region, but for the most part addresses the areas outlined earlier in this paper. To initiate the project, CUPS staff provided training to the local child care center staff regarding early childhood mental health services and what assistance the consultants could offer to the centers. After the training, the centers began to refer children to the workers. The workers serve about 525 children per year with the length of service less than one year.

The CUPS project does not use any particular assessment, either for the child or the child care environment. Instead, the staff uses observation to help determine the course of action. Consultants must have a Masters Degree in Human Services, but do not have to be licensed. Vermont chose to build services off their existing community mental health center system, which
does not require staff to be licensed. There are no specific qualifications for supervisors. They have encouraged reflective supervision and have provided training, but it is not required. In order to help the Community Mental Health Centers prepare to provide early childhood mental health services, the state provided extensive training and technical assistance through the grant.

The state wants to embed skills and knowledge regarding early childhood mental health throughout the service delivery system. They believe that the ability to promote social and emotional development of children, identifying needed emotional supports, and addressing mental health issues is not the purview of any one discipline. In line with this philosophy, Vermont’s Early Childhood and Family Mental Health Practice Group is developing a set of competencies for educators, therapists, childcare providers, home health care providers, and child welfare workers to address the skills and knowledge necessary to provide services at four different levels. The levels correspond roughly with educational attainment from the associate degree up through a doctorate. The immediate use of the materials is to determine the competencies necessary to bill administrative Medicaid for consultation. The hope is that a special endorsement or certification will be created in the future (State of Vermont, 2005).

The grant ended in 2005, requiring that the state develop an alternative funding mechanism for the consultation. Direct services for children was already covered in the Medicaid state plan but not the educational and training functions included in early childhood mental health consultation. The mental health staff worked with the Medicaid office and established a service that could be billed using Medicaid administrative match. To continue the project, the Vermont legislature appropriated the state revenue necessary for the state match. Since all children receiving the service are not Medicaid eligible, the state calculated a reduced match ratio to account for the percentage of individuals that were not Medicaid eligible. The state’s rate for the service is $90 per hour. Over the last six months they have provided over 1,537 hours of consultation with an approximate billing of about $138,000. The state has not used TANF dollars to fund any of the services; however, a small amount of Child Development Fund dollars has been used in some regions. As the program has matured, some child care centers now have a full time mental health consultant onsite to provide ongoing support. Most of the costs of this arrangement are covered through Medicaid and the administrative match.

Effectiveness data was collected as part of the overall CUPS project, but does not explicitly address the child care consultation effort. The data showed that parents reported significant levels of stress reduction; the incidence of children entering kindergarten with emotional and social skills to be an active learner increased; behavioral issues decreased and the level was maintained for the year they were tracked; and satisfaction surveys showed a high level of parental satisfaction.

Vermont has recently transferred the CUPS project to the Department of Children and Families, Child Development Division. The staff hope that this will improve integration with the child care community and result in the use of similar assessments and materials.
Ohio – Daycare Plus

The Daycare Plus program is part of a much larger program, the Positive Education Program, and is located in Cuyahoga County, Ohio. The Positive Education Program has a cadre of services for young children, including Early Start home visiting and an early intervention center for children with behavioral problems. The Positive Education Program serves children of all ages.

Daycare Plus started with a grant from the local Community Mental Health Board. In Ohio, the mental health service dollars are allocated to Mental Health Boards that manage these funds. The impetus for the grant was a survey that was sent to the child care centers in the county requesting information on the number of children that were expelled. Of the child care centers responding about 35-40% reported they had asked at least one child to leave the center within the last couple of months. Based upon that knowledge, community leaders thought that it was imperative to begin some type of initiative to address the problem.

In response to the findings and expressed need, the Positive Education Program used a mental health grant to develop a mental health consultation model for the child care centers. The model has two basic components. The first is the assumption that greater gains can be made in the child care center if the consultant and the worker have a long-term working relationship to provide ongoing program-based consultation. The original plan was for a consultant to work with a few child care centers for about two years and then move on to other centers to strengthen their practice. This model did not take into consideration the high rate of turnover of child care staff. The need to be in the child care centers at least intermittently after the first two years became evident.

The second facet of the model is the response team. Whereas the first component’s primary focus is on the overall program, the response team is called in when there is a problem with a particular child. Although the focus may be on the referred child, the response team functions in much the same way as the program consultants in that they direct their attention to the child and the environment, and work through the teacher to address the key issues. Both components assume that the relationship between the child and the teacher is key to promoting social and emotional development, and implement their work in a way that supports that relationship.

The child care centers, parents, and agencies make referrals. In many cases, the focus of the consultation is on the entire program, even if the referral was associated with one particular child. For that level of consultation, the program does not work directly with the parents or obtain permission to work with the child. However, if the consultant works directly with a particular child, they seek parental approval and involve them in the consultation. The consultation is not met to serve as intensive therapy either for the child or for the parent. When therapeutic treatment is necessary, the consultants refer the children and families to the community mental health system. Unfortunately, there are often waiting lists and the consultants must do what is necessary to address the issues while waiting for more intensive services. The program is designed as a prevention strategy; therefore, staff are not permitted to provide direct counseling or therapy, which is considered individual intervention. It is estimated that about 10% of the children need to have more intensive services. The consultants also have wraparound funds at their disposal. They can provide one-on-one care and supervision for a child in the center, provide for environment changes, and purchase materials. This type of flexibility is very helpful when attempting to preserve the child’s ability to remain in the child care center.
The program does not use specific assessments, although they do use *Ages and Stages* as their screening instrument. Currently, the assessments are based upon observations and clinical experience. Staff have been trained in the DECA, but it is not consistently used at this time. If the child needs assessments, they are usually referred to the schools. The demands of the job are extensive. Completing assessment would be very time consuming, and take the consultants away from their primary duties.

When looking at the overall functioning of the childcare center, the consultants may refer to the National Association For the Education of Young Children (naeyc) standards. The Positive Education Program operates under the principles of Re-Education as described by Nicholas Hobbs in *The Troubled and Troubling Child* (1992).

Daycare Plus follows a transdisciplinary approach similar to the one described above in Vermont. Consultants are not required to be licensed mental health professionals, and include professionals with a Masters degree in Family Therapy, Social Work, and Special Education. Although from different backgrounds, as a consultant they are expected to perform the same tasks. Social Workers must understand the child care environment, and special educators must understand the principles of therapeutically informed services.

The current number of staff is five full time and one half time staff consultants. The consultants provide long-term program-based consultation to about five centers at one time as well as serving many children and families through the response team. The total number of children served per year is about 500, with a total budget of $600,000 for a cost per child of $1,200. Most children are seen for about six months.

The funding structure has changed significantly from the first small mental health grant. The county leadership was very pleased with the results of the project and developed an Early Childhood Initiative, which has now grown to the Invest in Children project. Invest in Children is a county-funded consortium of five providers of mental health consultation. The consortium serves as a means to coordinate funding. The total is now over $3 million for mental health consultation and other early childhood programs. The funding sources are county tax dollars, private foundations, and TANF. The program is also evolving into a Special Needs Technical Assistance project that includes medical staff from the county Health Department. This expertise expands the capacity of the already transdisciplinary team. Since Positive Education Program is such a large organization, there are numerous professionals (such as occupational therapists, speech therapists, physical therapists, and psychiatrists) available to provide additional consultation. The program is funded through a prevention program, so it is very important that staff do not provide intensive direct treatment on a long-term basis.

Licensed mental health professionals provide supervision monthly. The consultants meet together once a week to share experiences, obtain guidance from one another, and provide mutual support. Staff are trained on the program components and are mentored for about six weeks by the other consultants before they work independently.

As part of their outcome data, staff track the number of children that they work with who are expelled. The last data set shows that 14 children were expelled but were able to stabilize and function well in their new child care center. A formal evaluation is now underway for the overall Invest in Children project.
Sarasota, Florida – Community Outreach Services

The Community Outreach Services of the Florida Center for Children and Family Development operates an early childhood mental health consultation program. The program has been operating for two years and is funded by the Sarasota County Early Learning Coalition. The Early Learning Coalitions are required to fund Inclusion Specialists in each of their areas as well as operate a “warm line” where child care agencies can call for assistance.

Due to the need for substantial assistance to the child care centers in the area, the Early Learning Coalition provided the Florida Center for Child and Family Development with a grant to provide additional assistance through Inclusion Specialists. They targeted child care centers with a high percentage of subsidized care.

Unlike some programs that rely only on referrals, the Community Outreach Service was proactive. They sent all the child care centers, with which they planned to concentrate, a request that the child care center administer the Ages and Stages screening instrument. If there was concern after the screening, the Inclusion Specialists then completed another screening. For children 0 to 3 they use the Developmental Assessment for Young Children (DAYC) and for children three and above they use the Development Indicators for the Assessment of Learning (DIAL). Instruments specifically used to measure behavioral and emotional issues are the Temperament and Atypical Behavior Scale (TABS), the Short Sensory Profile, and the Ages and Stages Questionnaires: Social and Emotional (ASQ-SE).

Parents agree to allow their children to be screened for developmental issues at the time they enroll in the child care center. If the program is going to further assess a particular child, they call and discuss it with the parents. Usually the parents agree. Depending on the age of the child and the results of the more in-depth screening, the Inclusion Specialist may suggest to the parent that the child be referred to either Early Steps or to the school system for further testing.

The program is funded for two functions: to screen and assess children to determine special needs and make referrals if appropriate, and to provide targeted interventions in the child care centers. Although the intervention includes a plan of care for the child, the Inclusion Specialists usually work with the entire child care environment, observing the environment’s daily routine and relationships. The interventions are implemented by working with the teachers to help them better manage the child care situation and improve relationships with the child. The Inclusion Specialists do not just focus on emotional and behavioral issues, but instead are concerned with the overall functioning of the child. The specialist often finds that what is perceived, as a behavioral problem may be the result of frustration due to delayed language or fine motor skills.

Recently, the program has begun to receive numerous requests for help with behavioral problems. They use classroom interventions designed to appropriately manage behavior. The curriculum and materials used is Positive Beginnings: Supporting Young Children with Challenging Behavior (Hanline et al. 2004) which helps teach the child to better regulate and identify their emotions. They also use many of their own approaches that they have developed over time, stress natural consequences to behaviors, and teach alternative behaviors.

The program staff are finding that more and more children are being referred for behavioral problems and that in-classroom interventions are insufficient for these children. They have
found that about 3 children out of about 60 a month require more intensive treatment. The staff are frustrated because services for this population are in very short supply.

The staff consists of about five Inclusion Specialists and their supervisor (who has other duties as well). The staff primarily have Masters Degrees in Education. The supervisor has a Doctorate in Education with an emphasis in early intervention and early childhood special education. Recently, another staff person was hired with a mental health background. The supervisor would like to develop staff with multiple sets of expertise and would like eventually to have them function in a transdisciplinary manner. As with Daycare Plus in Ohio, the Florida Center has professionals available in many specialty areas (such as occupational therapy, physical therapy, and speech therapy) to consult with the Inclusion Specialists. The staff have a formal supervisory meeting once a month.

The program collects data on several outcomes and reports these to the funding source on a quarterly basis. Although called outcomes, the measures are process-oriented (such as the number of children served, number of children screened, number of children referred, etc.). The program also collects data from the child care centers regarding the helpfulness of the intervention. The child care staff tend to rate them as helpful or very helpful.

The program is looking for additional funding to address the needs of the children with more severe emotional and behavioral problems. The classroom-based interventions are very helpful for most children, but—as has been consistently reported by the other sites—there is a group of children that need professional mental health treatment. Making referrals to other programs is the only option they have, though it is not satisfactory. Parents often do not feel comfortable taking their young child to a mental health center and often simply cannot make the arrangements to do so. Therapeutic interventions as an extension of the Inclusion Specialists work would be an asset.

The following tables summarize and compare these five programs.
Table 1. Mental Health Consultation in Child Care and Early Childhood Settings

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Need Identification</th>
<th>Assessment</th>
<th>Type of Professional Providing Consultation</th>
<th>Focus of Consultation</th>
<th>Children Served Per Year</th>
<th>Duration of Services Per Child (months)</th>
<th>Cost Per Child</th>
<th>Funding Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Francisco</td>
<td>Referrals are made by the child care center, or the consultant identifies the child.</td>
<td>Functional assessments are completed with the family and child care staff. Analysis is also done of the physical classroom, materials, interactions, relationships, etc.</td>
<td>Licensed therapist with experience or training in early childhood education or group care environments</td>
<td>Consultation includes both individual case consultation and program consultation. Direct intervention is provided to the family to a limited extent. Direct intervention is provided at the center for a small percentage of the children.</td>
<td>All children in the Bay Area can receive services through the overall initiative</td>
<td>Based upon individual need. Family intervention is limited to about three sessions.</td>
<td>Cost per facility only, $10,000</td>
<td>Several funding streams at a centralized level. Includes money from 8 state agencies and 4 city programs. Includes TANF and Child Care Development Funds.</td>
</tr>
<tr>
<td>Colorado – Child Care Intervention Team</td>
<td>Referrals are made to the child care resource and referral center. Trained early childhood interventionists do screenings and assessments.</td>
<td>Assessments used are the DECA and the Environmental Rating Scale.</td>
<td>Trained early childhood interventionist with weekly supervision from a licensed social worker</td>
<td>Focus is on both the individual child and the child care environment. Interventions are more behavioral and skill development based.</td>
<td>Exact number not known but they serve hundreds of children</td>
<td>Three to six months</td>
<td>$1,725</td>
<td>Child Care Development Fund-Quality set aside. Funds are provided to the resource and referral center.</td>
</tr>
<tr>
<td>Vermont – CUPS</td>
<td>Referrals are made by the early childhood settings and parents</td>
<td>Observation of the environment and the child in the environment</td>
<td>Professionals with Master Degree in Human Services</td>
<td>Provides for both child/family consultation and program consultation</td>
<td>525</td>
<td>Under a year</td>
<td>$90 per hour of consultation</td>
<td>Originally a SAMHSA grant, now Medicaid Administration and Medicaid Fee for Service</td>
</tr>
<tr>
<td>Ohio – Daycare Plus</td>
<td>Referrals are made by the child care centers, parents and other agencies such as child welfare</td>
<td>Ages and Stages Questionnaire – Social and Emotional for further screening and observation</td>
<td>Masters Degree in Human Services</td>
<td>This program is funded through prevention. Provides both child/family consultation and program consultation but does not provide therapy</td>
<td>About 500</td>
<td>About six months</td>
<td>$1,200</td>
<td>County tax dollars, private foundations and TANF</td>
</tr>
</tbody>
</table>
### Table 2. Effectiveness Measures

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Evaluations, Effective Measures, Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>San Francisco</strong></td>
<td>Measure the number of children who have been stabilized in the child care environment (not expelled). Also formal evaluation by Yale University.</td>
</tr>
<tr>
<td><strong>Colorado – Child Care Intervention Team</strong></td>
<td>Pre and Post Tests are used to measure the effectiveness of each child served. Formal evaluation completed by the JFK Partnership Division at the University of Colorado.</td>
</tr>
<tr>
<td><strong>Vermont – CUPS</strong></td>
<td>Outcome data was collected during the course of the SAMHSA grant. Currently no effectiveness data is being collected</td>
</tr>
<tr>
<td><strong>Ohio – Daycare Plus</strong></td>
<td>Number of children diverted from expulsion. A formal evaluation in now underway of the whole Invest in Children Project.</td>
</tr>
<tr>
<td><strong>Sarasota – Community Outreach Services</strong></td>
<td>Collect basic data on number of children served, number of children screened and assessed, number of children referred etc.</td>
</tr>
</tbody>
</table>
Characteristics of Early Childhood Mental Health Consultation

Based upon the literature reviewed and the conversations with the staff from the five sites listed above, it appears that there are basic components of early childhood mental health consultation in child centers that should be further discussed. Some of the sites provided as examples had similar features, though none of them operated the same. All had different funding sources and expectations for their program. Some focused more on mental health therapeutic approaches while others were more educational in nature. Donahue, Falk, and Provet’s book entitled Mental Health Consultation in Early Childhood (2000) provides an excellent resource on the subject. Below is a brief discussion about the major components of the consultation.

Relationships

Relationships are the cornerstone of all interventions in emotional and social development. The consultant must be able to establish positive relationships with the teachers. In some circumstances, the consultant may be asked to help with relationship and organizational issues between staff members. Although Donahue, et al. stress that this role is important, none of the five programs interviewed mentioned it as a primary role. They all, however, did mention that relationships with the director and the teachers were paramount to success. The consultant must be comfortable working in the “messy” environment of a child care center. Often, consultants get involved in the activities and other functions to develop a relationship with the children and to gain the trust of the teachers. The primary role of the consultant is to enhance the relationship between the teachers and the children. Trust between the teachers and the consultant must be in place for the consultant to be successful helping the teachers reach their goals with the children.

Screening, Assessments and Observations

The early childhood environment, often due to problem behaviors or by the parents when children have been asked to leave an early childhood setting, usually generates referrals. Referrals are either made to a central point of coordination or to a particular program. In San Francisco they have centralized their referrals. In Vermont they go to the community mental health centers directly. In some instances the literature states that consultants are assigned full-time in the centers. Vermont reports that this is the case in their state in some situations. When the consultants are onsite full-time, they are able to work closely with the children and identify those in need of assistance.

Assessments always include observing the classroom environment. The observations include areas such as: (a) the number of children in the room; (b) the ratio of adults to children; (c) the physical setup of the room; (d) the balance between active and quiet periods, structured and free play; (e) the transitions from one activity to another, (f) the teachers’ styles of interacting with the children; and (g) the relationships between the teachers. When observing the environment, the consultant tries to understand how the children are responding to the classroom situation. The observations are usually done without formal instruments and are based upon the consultant’s experience with young children and early childhood settings (Donahue, et al., 2000)

A similar process is followed when observing individual children. The consultant tries to determine how the child is functioning in this environment. Formal screening and assessment instruments may be used at this point. The consultant must be careful not to focus on just the
problem areas, but to look for strengths as well. When there are behavioral issues, the consultants frequently try to determine what function the behavior has for the child.

Types of Early Childhood Mental Health Consultation

Generally, consultation can be described in one of two ways. One approach focuses on a particular child and family, and is referred to as child-based, child-focused or child-centered consultation. The other approach addresses the general program issues that impact the mental health of staff, children, or families and is called program consultation (Cohen and Kaufman, 2000). In child-centered consultation, the early childhood environment usually has identified children that they have concerns about. The consultant works with the teacher and family to complete an assessment and develop a plan to address the factors that contribute to the child’s problems. The consultant usually works with the teacher to respond to the child’s needs and the teacher is the professional who implements the interventions. Occasionally the consultant will work directly with a child but this is not the norm. As the site reports indicate only 3 to 10% of the children need that level of intervention.

The focus of program consultation focuses on improving the overall program. The consultants help the teachers to change their schedules, activities, interactions, or classroom setups. Through these efforts, they help establish an environment that better supports social and emotional development. Often components of both types of consultation are applied in a program. The sites that are discussed above all included some aspects of both approaches.

Staff Qualifications

Cohen and Kaufman (2000) reported that a roundtable discussion supported by the federal Center for Mental Health Services recommended that mental health consultants be licensed as mental health professionals. Of the five sites reviewed above, only one required their consultants to be licensed mental health professionals. Berson (2003) found that the consultants came from a wide variety of disciplines. The Wayne State University recognizes this trend and provides for an interdisciplinary training model for infant mental health. Their programs offer master’s and post-master’s degrees to professionals from the fields of social work, psychology, early childhood education, special education, and nursing to study theories about development and to develop skills in the practice of infant mental health (Weatherston, 2005). The consultants must have expertise in early childhood development and classroom management. If they are going to work in the homes with families, they must understand family systems. The expertise of the consultants also can limit the amount of consultation. For example, many of the sites stated that, after a certain point, the family and child had to be referred on to a more intensive setting, especially if a licensed mental health professional was not on staff. It should be noted though, that the San Francisco site, with trained therapists, also referred children out to more intensive programs after a certain number of sessions.

The U.S. Public Health Service (2000) stated that there was a severe shortage of professionals with expertise in both child development and mental health who are truly prepared to provide consultation in these settings. Programs have found that it is difficult to hire staff that have the expertise necessary to provide the consultation. Staff training—and fairly extensive—is required to equip staff to function in this role. Few professionals come with a thorough knowledge of child development, mental health therapeutic skills with young children, and knowledge of educational practices in the early childhood arena. According to the staff interviewed, it is often
better to focus on the potential staff person’s characteristics, such as their ability to form positive relationships, their respect for others, and their commitment to children and families. It was frequently mentioned that direct experience in working with young children and their families was a must. Working in an early childhood site was also seen as very beneficial.

The literature is now beginning to mention transdisciplinary teams as a way to provide services in early childhood settings, a concept that was also brought up by staff that were interviewed. This model is based upon the premise of levels of shared roles. These are described as role extension, role enrichment, role expansion, role exchange, role release, and role support. This continuum is based on training and experience. Using early childhood mental health consultation as an example, the shifting in roles would allow the special educator to become more involved in providing mental health interventions and would expand the mental health professional’s role as an educational consultant (Woodruff and Shelton, 2006).

Given the problems in defining the professional degrees necessary for early childhood mental health consultation, this concept is appealing. Costa (2006) warns that role modifications should not be taken lightly and requires extensive cross-training and supervision. He has developed a grid that describes (by professional discipline and functions that the professional must perform) the level of training necessary to render a service. For example, he states that non-mental health professionals must have extensive training to conduct infant-parent psychotherapy and must be supervised by licensed staff. He does suggest that, with a moderate level of training, non-mental health professionals could also provide supportive counseling under the supervision of a mental health professional. Here, though, state licensure laws must be taken into consideration.

Different strategies are emerging as the programs struggle with how best to provide the service. One option that seems to be appropriate is to train staff using the transdisciplinary process ensuring that mental health experts are on the team, but only allow actual therapy to be conducted by licensed staff. This would promote a team approach but would ensure that the psychotherapy services such as the infant and parent dyad would require trained licensed staff.

**Effectiveness**

With the programs that were interviewed and those reported in the literature, there doesn’t seem to be an emphasis on collecting outcome data. Satisfaction surveys are conducted, but less program data is available on individual changes with the children. Brennan (2003) provides an overview of the effectiveness of mental health consultation. The highlights of that discussion are listed below.

1. Tyminiski (2001) concluded that child-centered consultation was effective because it reduced the number of months that children were delayed in social and emotional development from 20 months to 9 months in just 8 months.

2. Fong and Wu (2002) found that there were differential project outcomes by gender, with girls becoming less shy and more assertive, and boys learning to manage aggression, impulsiveness, and disruptive behavior. All the children were rated as more able to stay on task, learn, and tolerate frustration based upon pre- and post-test scores.

3. The Cuyahoga County Early Childhood Initiative (Daycare Plus) reported in 2001 that the project was able to retain 259 children who were identified for expulsion in their child care settings.
4. Project SUCCEED, a Head Start setting in Oregon, conducted a study with six comparison classrooms and found that only the intervention classroom improved in attachment and did not have an increase in behavioral issues. Reports of teacher stress were reduced in the intervention classroom but not in the comparison classrooms.

Brennan (2003) concludes that these investigations indicate that mental health consultation is effective, especially when delivered by practitioners who are well-integrated into the natural settings and who involve parents in a meaningful manner. The child-centered approach and the program consultation model have been shown to have favorable outcomes.

Policy Considerations

When determining whether a service should be provided, policy makers must evaluate the service in light of their overall goals and mission. It is important to examine the alignment with policy directions at all levels, federal, state, and local. Early childhood mental health services and consultation are thoroughly supported in the federal and state policies discussed below.

New Freedom Commission

In 2002, President Bush created the New Freedom Commission on Mental Health, which released a report in July of 2003. The report called for a transformation of the system by integrating mental health services throughout the systems of care in the community and by focusing on developing resiliency in children. Concerning the mental health of young children, the report places emphasis (Goal 4.1) on the early detection and intervention that should occur in low-stigma settings, such as primary health care facilities and schools. Early childhood mental health consultation is an excellent means to address this goal.

Americans with Disabilities Act (ADA) and Individuals with Disabilities Education Act (IDEA)

The ADA provides broad protections to children with disabilities and prohibits discrimination on this basis. This federal law applies to very young children as well as older students. If enforced, ADA would protect children from being asked to leave federally subsidized child care centers, and theoretically any other early childhood center as well.

IDEA mandates that school systems provide for children with disabilities a free, appropriate public education, that emphasizes special education and related services designed to meet their individual needs. The states must not engage in discriminating actions such as segregating students simply because they have disabilities. The law is applicable to infants, toddlers, preschool students, and to students ages 6 to 21 (Brennan, 2003). Unfortunately young children with emotional and behavioral disorders are often not considered in need of special educational services unless they have a significant developmental delay or cognitive limitations.

Good Start Grow Smart

President Bush’s plan for education reform is based upon the need to prepare children to read and succeed in school with improved Head Start and early childhood development programs. Head Start programs are required to have available mental health consultation on a regular basis.
The policies under Good Start Grow Smart are designed to help States and local communities strengthen early learning for young children to ensure that young children are equipped with the skills they need to start school ready to learn. Dr. Jane Knitzer from the National Center for Poverty has continually asserted that Early Childhood Mental Health Consultation is an excellent strategy to promote school readiness (Knitzer J, and Lefkowitz, J, 2005).


The plan’s vision is simple but compelling. Florida’s highest priority is that children are raised in healthy, safe, stable and nurturing family environments. Since over 60% of children are in out-of-home child care during several hours of the day, achieving this goal requires that the child care environments are also safe, stable and nurturing environments. This reality is acknowledged throughout several goals and activities in the plan. These are listed below:

Goal 1 Objective 1.7: By June 30, 2010 the percent of kindergarten children ready to learn will be increased from the 2003-2004 statewide level of 84% to 95%.

Goal 1 Objective 1.21: By June 30, 2008, subsidized child care will be available for all children at risk of abuse or neglect as defined by the Agency for Workforce Innovation.

Goal 1 Objective 1.22: By June 30, 2010 subsidized child care will be available to all eligible children

Goal 2 Objective 2.5: By June 30, 2010, children with severe emotional disturbances whose behavioral and mental health needs are met, will improve significantly from a 2003-2004 statewide level of 64.6% to 69.6% and a decrease in school suspensions of two percent from the 2003-2004 levels. Note-Hopefully this includes children under school age as well since expulsion rates are three times higher for that population than for school age children.

Early Childhood Mental Health Services such as Infant Mental Health and Consultation in early childhood settings is one means to help meet these Federal and State Initiatives. Local leaders should be provided with the information about effective interventions for young children so that they can consider including them in their local prevention activities.

Funding

One of the greatest challenges facing mental health consultation in child care is the funding. The literature consistently cites examples of cobbled together funding mechanisms, inconsistent funding, and terminated funding. There is no common source of financial support for this type of service. Because the service includes “consultation,” funding is difficult. Many funding sources will only pay for the direct intervention with the child, or they may only be willing to fund services for children already showing the symptoms of serious emotional disturbance. Below is a list of possible funding sources. Each has potential, but each also has many competing needs that it is intended to cover.
National Funding Strategies

Georgetown University Child Development Center published in March 2001, a full review of all possible funding sources for Early Childhood Mental Health Services and Supports (Wishman, Kates, and Kaufman, 2001). The included a detailed Matrix of the funding options with a discussion on the constraints and opportunities associated with each funding component. Also the National Center for Children in Poverty published, Spending Smarter A Funding Guide for Policymakers and Advocates to Promote Social and Emotional Health and School Readiness (Johnson and Knitzer, 2005) which also provides an excellent overview of funding sources for Early Childhood Consultation in child care and educational settings. That information will not be repeated here. Other states such as California have identified a wide range of funding sources for financing their Early Childhood Mental Health Services with include: Medicaid, State Children’s Health Insurance Program, Title V Maternal and Health Block Grant, Community Mental Health Services Funding, TANF, Foster Care IV-E, Safe and Stable Families/ Family Preservation IV-B, Child Care and Development Fund, Individual with Disabilities Education Act, Part C Infants and Toddlers with Disabilities, and Part B Preschool Special Education. For the purpose of this report these various funding sources were reviewed and those most likely to be viable in Florida are discussed below.

Florida Possible Funding Sources

Medicaid

Medicaid is the primary funding source for children’s mental health services in Florida. Florida is known as a leader in the design of Medicaid compensable services for children five and under. However, these services are now covered under managed care, and anecdotal information raises concerns that the identification of need and the reimbursement for appropriate services are below former levels of care. The coverage is still available, but access may be an issue.

Although not in the Florida state plan, consultation is an allowable service under the Medicaid Rehabilitation Option. For example, it is a covered service in Alabama. However, Medicaid has placed all Florida’s Medicaid Rehabilitation Option services under the managed care system and would not be inclined to develop a new service outside of the capitation rate.

Medicaid Certified School Match Program

Florida has some interesting opportunities to use non-federal school funds as the match to cover Medicaid eligible services. In 1995, the Florida Legislature authorized the Florida Medicaid office to develop a school-based program to allow schools to capture federal Medicaid match for expenditures for specific services. Initially, the program focused on services such as occupational therapy, speech therapy, and nursing services; soon after the inception of the program, behavioral health services were added. These behavioral health services included psychological services, social work, behavioral analysis, counseling, and guidance. Participating school districts could also receive federal match for administrative services, such as outreach, interagency coordination, referral, service coordination, and monitoring (Berson et al., 2004).

The Medicaid Certified School Match Program requires that the services be provided as Part B services under the Individual with Disabilities Education Act (IDEA, Part B); with the services referenced on the child’s individual education plan. IDEA stresses proactive and effective measures to intervene with behavioral problems and requires positive behavioral intervention on
the individual education plan. Also, this legislation emphasizes that early intervention can be an effective way to address the needs of children who are at risk for behavioral problems. Services include supports provided in the prekindergarten disabilities program. Many of the children with emotional disorders are served as developmentally delayed or as having learning disabilities. School officials tend to avoid labeling young children with a mental health diagnosis.

Unfortunately the match program requires that the child have an ICD-9 diagnosis (Berson et al., 2004).

Although a potential funding source for the schools, only 2.5% of the population covered under Part B of IDEA received services through this program. Berson et al. (2004) reports that the reasons given for the low level of billing are that some school systems believe that the administrative costs outweigh the benefit and that it is not necessary for the schools to bill because community mental health providers provide on-site services and bill Medicaid directly. With the implementation of managed care, schools may find that on-site school-based services will be reduced. The incentives for providers will shift from outreach and maximization of billing to a stricter application of medical necessity criteria and possibly increased use of office-based services rather than providing the services on the schools. Should this occur, school systems might be more interested in expanding services under this provision, especially if the administrative burdens could be reduced.

The highest percentage of children served is the group between the ages of 3 and 7, making up 29% of the population billed. Also, the most frequently billed diagnosis is developmental delay (Berson et al., 2004). This data shows that, for the schools that are participating in the program, there seems to be an emphasis on the younger population. The majority of services were assessments performed by psychologists, yet over the last few years a wider array of services has been provided, including counseling, group therapy, and behavioral analysis by certified behavior analysts. It appears that some school systems are providing early childhood mental health services for their four and five year olds and that some of the components of mental health consultation could be provided through the schools using the certified Medicaid match program. Many details would have to be addressed, such as ensuring that the definition of the services meets the Medicaid requirements for reimbursement, diagnosis, training of school personnel, and encouraging the use of the certification of match program. Early intervention with this population could help the child learn to manage their behaviors during their early years in school and possibly avoid some of the negative consequences of their behavior problems over their years in school.

Local Funding Revenue Maximization Act

Additionally, the Florida legislature passed in 2003 Section 409.017 of the Florida Statutes, entitled Local Funding Revenue Maximization Act. This legislation is intended to allow other units of government (for example, counties and children’s councils) to use their funds to obtain additional federal match for prevention and local child development programs. To date, this provision has not been widely used. However, Medicaid is in the processing of developing a Targeted Case Management program for children considered high risk that will be funded through this mechanism. One limitation with this opportunity is the Medicaid requirement for state-wideness, which requires that any service provided in one geographical area of a state must be available in all areas. Targeted Case Management is an exception to that rule and can be provided to a specific population in limited parts of the state without a Medicaid Waiver.
As stated earlier in this paper, the most difficult challenges of early childhood mental health consultation is to find ways to fund non-direct education and training to childcare staff and family. Direct services should be covered under the traditional Medicaid plan for eligible children in need of services. As part of their SAMSHA grant sustainability strategies, Vermont developed a mechanism to provide the program consultation component through the use of the Medicaid Administrative match of 50%. The program is defined as “consultation and education with the family and community-based groups to improve circumstances and environments for young children and their families. The consultation and education (for example, training) should aim to assist parents and community groups to use health care resources effectively and efficiently as they gain knowledge, attitudes, and skill to enhance early identification, intervention, screening and referral for mental health Medicaid services for young children and their families” (Vermont Training Document, 2006). Through the use of this funding mechanism, Vermont has been able to expand the number of consultants available in early childhood settings beyond what was available under the SAMSHA grant.

Local certification of match possibly could be used to develop such a service. The advantages are that the administrative component of Medicaid does not have the state-wideness criteria. These types of administrative services also are not included in managed care programs, eliminating any concerns about duplication of services and payment. Many counties and Children’s Boards are anxious to better utilize the Local Funding Revenue Utilization Act.

Temporary Assistance for Needy Families (TANF)

Two distinct populations are eligible to receive TANF funding: families receiving cash assistance and those that are considered TANF Diversion Families. The State of Florida receives about $481 million in TANF dollars, with $210 million going to Workforce Innovation. Of the latter amount, $111 million is allocated to the School Readiness program (Early Learning Coalitions). $228 million is appropriated to the Department of Children and Families (DCF); about $6 million of this is available in the Community Prevention Initiative, with another $22 million allocated to the office of Substance Abuse and Mental Health (SAMH) (conversation with DCF budget staff, 2006). The Community Prevention Initiative and the funds allocated to SAMH are possible funding sources for Early Childhood Mental Health consultation. It should be noted that DCF does not have discretion to increase funding in any one particular area. The Florida Legislature appropriates the funds and specifies the areas in which they will be used.

Community Prevention Initiative.

The Center for Study of Social Policy developed a handbook entitled Protecting children by strengthening families-A Guidebook for Early Childhood Programs (2004). They focused on early care and educational programs because they believe that child care centers represent the only systematic way to reach a large number of very young children. Just as for older children, the best way to address the needs of children and families is by integrating the services into programs and services where the families naturally go. With over 60% of our preschool, toddler and infant population in out-of-home child care settings; these environments are the best avenue for addressing the issues of children and families. The high quality child care settings develop partnerships with the parents to ensure the safety and development of children. According to the Center for the Study of Social Policy, these settings provide “an unparalleled opportunity for parents to share intimate concerns and hopes for their children.” This notion of linking child abuse prevention with child care centers is a new idea, and most states and centers have not seen the potential. This type of prevention program focuses on building protective factors for the
families and resiliency in the children. A study completed as part of the development of the Guidebook includes mental health consultation as one of the components in exemplary programs designed to help prevent abuse and neglect.

The Community Prevention Initiative is funded through TANF dollars. In Florida, protective supervision, foster care, and adoption services are now managed through community programs known as Community Based Care lead agencies (CBCs). These organizations are under contract with DCF to provide child welfare services. Since these programs are imbedded within the community, one of their primary goals is to prevent child abuse and neglect. Community Prevention Initiative dollars now are provided to the CBC lead agencies to develop community-based prevention programs. These lead agencies have some discretion over the use of these funds and may be interested in working with child care centers to develop some high quality mental health consultation to address the prevention of child abuse and neglect.

Substance Abuse and Mental Health TANF funds.

As stated above, the DCF SAMH programs receive about $22 million dollars in TANF funds. The Substance Abuse office receives the majority of the funds, with about $7.5 million being appropriated to the Adult Mental Health program. Because the dollars are in the Adult Mental Health category, services for the child must be directly related to the needs of the parents. Since the goals of the program promote self-sufficiency, children remaining stable in early childhood settings is directly related to the parent’s ability to work successfully.

The TANF funds are allocated to the DCF’s 15 districts. The districts, within the rules governing TANF services, have considerable discretion in how they use these funds. In three parts of the state (District 13, the SunCoast Region, and District 11), districts have decided to contract with Administrative Services Organizations (ASOs) to manage their TANF dollars and operate a network of providers. In these areas, the district and ASO management have shown interest in providing more services to young children and their families. Because these funds are allocated to the SAMH, their natural emphasis is on providing services to adults with mental health or substance abuse disorders. Yet many of these individuals have children in child care settings who are at high risk for developing challenging behaviors. The need to integrate the services and supports for the parents and children is paramount.

As with most SAMH programs, services are rendered through contracts with community providers that bill units of services. There are a few unit of service definitions that would be particularly appropriate for early childhood mental health consultation. These are outlined in the DCF TANF SAMH Policy Handbook (December 2005) and are discussed below:

1. Definition of In-home and On-Site Services: In-home and On-Site Services are therapeutic services and supports that are rendered in non-provider settings, such as nursing homes, adult congregate living facilities, residences, schools, detention centers, commitment settings, foster homes, and other community settings.

Discussion: This service would allow for trained staff to go into the childcare setting and work with children who have been identified as needing special assistance for behavioral and emotional issues. This service is more appropriate for child-focused intervention rather than overall program consultation. Because these funds are appropriated in the TANF Adult Mental Health category, the child’s needs must be tied to the needs of the parent. Therefore, to appropriately use TANF, the parent would need to be TANF
eligible and the service would need to assist the family in stabilizing their situation or maintaining employment. It would be preferable for the interventionists to work with the parent directly as well as with the child care staff.

2. **Definition of Intervention Services:** Intervention Services focus on reducing risk factors generally associated with the progression of substance abuse and mental health problems. Intervention is accomplished through early identification of persons at risk, performing basic individual assessments, and providing supportive services that emphasize short-term counseling and referral. These services are targeted toward individuals and families.

   *Discussion:* The service description is a good match for both types of early childhood mental health consultation, child-focused consultation and program consultation. The issue is how to tie the service back to reducing risk factors associated with substance abuse and mental health in adults. Two arguments could be made. One argument is that early childhood mental health consultation has been shown to increase resiliency in children with multiple risk factors and help prevent later substance abuse and mental health disorders. The second argument focuses on the needs of the parents. Disruptive behavior in children is a stress factor for families that are trying to work and maintain a family and can be even more devastating in families already facing stress associated with low income. These families don’t have the private resources to obtain assistance for their children. Such stress can aggravate substance abuse or mental health conditions with the parents.

3. **Description of Prevention Services:** Prevention Services are those involving strategies that preclude, forestall, or impede the development of substance abuse and mental health problems and include increasing public awareness through information, education and alternative focused activities.

   *Discussion:* This service could possibly be used to provide the program level of consultation. The research is clear that high quality child care and mental health consultation helps increase resiliency in children and is a protective factor for families. Elsewhere in the handbook, it states that when prevention services are used, at least 25% of the population must be receiving cash assistance or at risk of receiving cash assistance. Child care centers that receive subsidies for low income populations would very likely meet that criterion. Additionally, in many areas of the state the Agency for Workforce Innovation has given priority to subsidized child care to families that are working to get off cash assistance. Child care centers that serve this population would likely have children at high risk for emotional and behavioral problems and would be good candidates for both levels of consultation.

4. **Description of Comprehensive Community Service Teams:** This is a new service that was just established by SAMH. These teams provide services in community-based settings to children (and adults) with mental illness to help promote resiliency and facilitate recovery. The services are intended to be short-term and aimed at developing a resiliency plan focusing on the areas of individual and family living.

   *Discussion:* The description in the department’s document is very recovery oriented and reads as if designed for adults. The description above is taken from the department’s document, with emphasis on children’s services. Staff in the contracting section of SAMH thought that this service could be used for early childhood mental health
consultation. It seems that it would be very appropriate for children with the most severe behavioral and emotional disorders. It would be an excellent service to use when working with parents with mental health or substance abuse disorders and very young children showing early indications of delays in emotional and social development.

Substance Abuse and Mental Health General Revenue and Block Grant Funds

The federal Mental Health Block Grant funds usually focus on children with severe emotional disturbances. The use of these funds would be appropriate for the small group of children and their families that need more intensive mental health treatment. The provision of these services in early childhood settings may be an opportunity to better engage the child and family and encourage attendance. Families are very busy and often cannot request leave from their employment to take a child to a mental health clinic. Also, services in the environment where the child is comfortable can be more conducive to the therapeutic process than those rendered in a practitioner’s office. The San Francisco site provided individual and group therapy at a child care center.

One target population for SAMH is children at risk. General revenue funds can be used for this population and are very flexible. Unfortunately, they are in very short supply. Many competing needs must be funded with these dollars. The SAMH office has funded small Infant Mental Health projects in each of the districts, but it is probably not viable for them to use a substantial amount of their funding for the consultation.

Block grant and general revenue funds are allocated to the districts just as the TANF dollars described above. The districts determine what services are needed and what they need to purchase. The district SAMH office then contracts with the individual providers or goes through an Administrative Service Organization to purchase the required services. Services are purchased in accordance with the rules specified in Chapter 65E-14 Community Substance Abuse and Mental Health Services-Financial Rule, which includes a list of allowable services. The same services discussed above under TANF are applicable under general revenue and the block grant. There is continual pressure on the districts to fund a multitude of services, and children’s mental health funds are severely limited. Still, small projects may be possible if the district considers it a critical service.

Child Care and Development Block Grant

This block grant provides for subsidized child care and has a 4% set aside requirement for quality initiatives. These funds are allocated to the Office of Early Learning at the Agency for Workforce Innovation, which administers the state’s child care subsidy program through area Early Learning Coalitions. TANF funds for child care are transferred to the Agency for Workforce Innovation and are also managed by the Office of Early Learning and the area coalitions. There are 31 Local Early Learning Coalitions throughout the state. With the exception of just over a million dollars, all the funds for child care services and quality improvement are allocated to the 31 Early Learning Coalitions. The coalitions are also responsible for quality initiatives having the largest proportion of the 25 million dollars in quality initiative funds in their budgets.

Throughout the literature, there are references to the use of the 4% set aside for quality initiatives as a funding source for mental health consultation in early child care settings. The research has shown that the presence of mental health and behavioral experts has increased the quality of the
programs. The Early Learning Coalitions also have flexibility in how they can spend their funds and are required to have an Inclusion Specialist available in each geographical area. As reported earlier in this paper, Sarasota’s Early Learning Coalition has identified early childhood mental health consultation as a priority and has provided the Florida Center with a grant to provide this service.

The local coalitions may use dollars earmarked for quality initiatives to purchase Early Childhood Mental Health Consultation in the child care centers. The coalitions tend to make decisions about the use of their dollars early in the fiscal year, but may have some dollars unencumbered during the course of the year.

Children’s Services Councils and Juvenile Welfare Boards

Section 125.901 of the Florida Statutes, known as the Children’s Services Statute, allows the development of independent county-based special districts to enhance services for children. These special districts (known as Children’s Services Councils) have the authority to levy up to (1/2) mill in taxes to fund services for children. Some of these councils are responsible for the management of multimillions of dollars. The use of these funds is very flexible and would be an excellent source of funding for mental health consultation in child care settings. Also, these funds are eligible for match for Medicaid services through the local match initiatives as discussed above.

The Dade County Children’s Service Council and the Early Learning Coalition of Miami-Dade Monroe have recently funded just such a project in Miami. The purpose of the project is to provide child-family-program consultation to programs serving teen parents and their children. The consultation will build the capacity of staff, families, programs, and systems to support social-emotional development, and prevent, identify, and treat mental health challenges among children of teen parents. It is estimated that the project will serve about 100 children, 100 parents, and 50 child care workers in 5 centers.

The targeted population is children from birth to age four who have specific needs that may include failure to thrive, developmental delays, attachment concerns, or the need of additional social-emotional support. The teen parents may have multiple needs that include former or current foster care placements, repeated moves from home to home, or placement in exceptional student education classes.

Substance Abuse and Mental Health Services Administration Comprehensive Service System Grants

SAMHSA is currently funding several grants for early childhood mental health. Vermont used the SAMHSA grant to start their early childhood mental health project. Sarasota County has an early childhood mental health grant and will use some of these funds to pay for non-Medicaid compensable direct intervention services. Unfortunately, these grants are very limited.

Title IV-B and IV-E

These funds are appropriated to DCF districts and then contracted with local CBC organizations for the provision of services to children in the Florida child protection system. In Florida, the Safe and Stable Families/Family Preservation Title IV-B services are used to fund children who are not eligible for Foster Care IV-E or other funding sources. These dollars tend to be used to
the full extent of the federal and state appropriation and would probably not be a good source of funds at this time in Florida for early childhood mental health consultation.

Recently, Florida applied for a Foster Care Title IV-E Waiver to allow for additional flexibility in the use of these funds. The Waiver is scheduled to be implemented in October of 2006 and will give the CBCs much more flexibility in how they spend their dollars. Currently IV-E dollars cannot be used for treatment and are available for children in out of home placements only. As the CBCs become more successful in keeping the children safely with their families, the access to IV-E is reduced. With the Waiver, the funds can be used for foster care diversion, treatment, and other supports. The Medicaid Child Welfare Prepaid Mental Health Program will be responsible for providing all the medically necessary mental health services to the children enrolled in the Florida child welfare information system HomeSafeNet. This includes children in protective supervision and foster care. Since the Medicaid mental health services will be closely coordinated with the CBCs, the lead agencies will have some latitude to use the IV-E dollars for other purposes. Providing early childhood mental health consultation is one service that could be purchased and that would support their goals of reducing abuse and neglect, strengthening families, and providing for safety and emotional well-being. The individual CBC lead agencies would have to be approached about purchasing these services.

**United Way and Local Charitable Foundations**

Nationally, some projects have been able to secure funding from United Way or other local charitable foundations to get started. Although these funds may not be available for the long-term, they provide the opportunity to demonstrate the positive aspects of the service and provide the base upon which to seek other funds. Non-profit agencies frequently receive grants to start similar services. United Way has local offices throughout the state that make annual decisions about what services to fund. They usually have ongoing relationships with established community providers. However, they may entertain new ideas if presented by established organizations. Many charitable foundations are very interested in prevention and funding services for young children. Florida State University currently has a Knight Foundation Grant to provide mentoring in early childhood settings. Children’s Home Society just received a grant from the Kellogg Foundation to improve child welfare services for young children in foster care. This grant includes mental health interventions as well as specialized case management services. Many foundations serve just their local communities, but are easier to access than large national programs.

**Comments Regarding Funding**

As the Funding Section shows there is not a dedicated funding source for Early Childhood Consultation in child care and educational settings. Each state in the examples provided, have pulled together different funding mechanisms to provide different levels of the service. TANF is the only funding source flexible enough to fund both the program consultation and the child/family based consultation as well as treatment. States have creatively identified different funding sources dependent upon the child/families eligibility and the constraints of the funding sources. In San Francisco those funding sources have been combined into pooled funding and then allocated to the various programs. It is doubtful that Florida will be able to identify and set aside large amounts of funding for this initiative without a budget request and appropriations from the Legislature. Short of accomplishing that goal, funding for Early Childhood Consultation will have to be pieced together in each district and in some cases, counties, of
Florida. Although difficult, this is not an impossible task. It will require state leadership to inform local community stakeholders of the opportunities that the service offers and assistance to the local areas regarding how best to weave together the various funding sources.
Strategies for Implementing Early Childhood Mental Health Consultation in Child Care and Educational Settings

1. In 2000 Florida developed the *Florida’s Strategic Plan for Infant Mental Health*, through funding from the Florida Developmental Disabilities Council and published by Florida State University, Center for Prevention and Early Intervention (Florida State University 2001). This plan contemplated 8 Goals that addressed prevention, early intervention and treatment. Although mentioned, the plan did not have an emphasis on Early Childhood Mental Health Consultation in early childhood settings. Much has been learned in the field of early childhood and infant mental health since the completion of the plan. Leaders from the various state agencies and community stakeholders need to re-assess their goals in this area and receive additional information regarding the benefits of integration of early childhood mental health into early childhood settings. One way to accomplish this and provide public education and awareness on this consultation is through an update of the strategic plan and develop additional detail on how to incorporate these ideas into the service delivery system.

2. Identification of possible funding sources and models of service alone will not result in increased provision of early childhood mental health consultation. Local leaders and agencies must understand the service, its benefits, how to develop it, how to operate it, and how to fund it. This work will have to be done primarily at the local level since that is where the need and the funds reside.

3. Technical assistance and training programs should be available to help communities determine the need for mental health consultation in early childhood settings, to design a program that is responsive to the local communities particular needs, locate funding sources and implement the program. There may be many communities that already have some funds available to provide some level of intervention.

4. Florida should pay close attention to the strategies used in Vermont, to strengthen the existing service system in the area of early childhood mental health services. The Florida model of early childhood mental health should be imbedded in and designed to enhance the current system of care for young children. The model should address the multiple needs of children and families in Florida, including, those children at high risk for serious behavioral and emotional problems due to parental issues with substance abuse and mental health, biological vulnerabilities within the child, and the negative impact of child abuse and neglect. Services should be coordinated with the Inclusion Specialist with the Early Learning Coalitions, Community Based Care Lead Agencies, and other community initiatives for young children.

5. In order to demonstrate the effectiveness of this Early Childhood Mental Health Consultation, Florida should consider requesting legislative funding to establish a pilot in one or two parts of the state. The pilot should have a community planning component as well as provide for direct services in individual child and family outcome tracking. The focus should be on child care settings that serve high-risk children with high percentages of TANF and Medicaid eligible children.
6. As part of the legislative request, funds should be requested for extensive training of existing providers to render Early Childhood Mental Health Consultation.

7. Further work should be done on each of the possible funding sources to provide detailed guidelines to the local staff on the association of improved children’s social and emotional functioning on secondary prevention of mental health disorders, school readiness and the impact on the parents success in getting and maintaining employment. The guidelines should show how the funding sources can be used to fund early childhood mental health consultation and exactly how to access and use the funds.

8. Additional work should be done as soon as possible with Medicaid to determine the viability of using Medicaid Administrative Match.

Summary

Early Childhood Mental Health Consultation is an effective service that can address multiple federal, state and local goals for children and families. Some states have successfully used this program for many years and their communities have reaped the benefits. The opportunities exist, some without additional state dollars, to expand this opportunity in Florida. There are multiple funding sources that could support this effort, but none that are solely dedicated to this area. Local communities are at the core of the state planning and service provision but they need assistance to understand, conceptualize, and implement multifaceted programs and funding sources. This service is one of several that could help us move toward the vision of safe, stable, and nurturing environments for Florida’s children and families.
References


Baily, B. *Conscious Discipline.* Gryphon House.


Conversation with Brenda Bean, Early Childhood Mental Health Programs Director, Child Development Division, Department for Children and Families, Vermont State Agency for Human Services, on June 27, 2006.

Conversation with Deb Lawrence, Child Care Connections, Denver Colorado, on May 26, 2006.


Conversation with Kim Finch-Kareem, TANF Specialist, Mental Health Program Office, Department of Children and Families, Tallahassee, Fl., on June 20, 2006.

Conversation with Sally Brown, Day Care Plus, Cleveland Ohio on June 27, 2006

Conversation with Dr. Terry Jackel, Project Director, Early Intervention and Outreach, The Florida Center for Child and Family Development, Sarasota Fl. On June 29, 2006.


Florida State University, Center for Prevention and Early Intervention Policy (2001). *Florida’s Strategic Plan for Infant Mental Health.* Funded by the Florida Developmental Disabilities Council, Tallahassee, Florida.


