



EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

An Evaluation Tool Kit

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EARLY CHILDHOOD
MENTAL HEALTH CONSULTATION:
An Evaluation Tool Kit

*For states, communities, agencies, and programs
investing in early childhood mental health consultation
and committed to quality data*

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Purpose of the Tool Kit

The purpose of this tool kit is to increase the capacity for high-quality evaluation of early childhood mental health consultation (ECMHC) in community based settings. For states, communities, programs, and grant funded projects that are developing or have developed early childhood mental health consultation programs and want to assess their impact, this tool kit provides guidance, tools, and resources that will assist in designing and implementing program evaluations. For researchers, this tool kit also will help guide their work in research design and evaluation, determining evidence of effective practices, and decision-making related to tools and approaches to partnering with program staff. And for policy makers seeking to encourage strong program evaluations of funded projects, it should provide a template for crafting request for proposals for outside evaluators. The text and materials that follow focus on:

1. Defining early childhood mental health consultation services;
2. Designing and incorporating evaluation for early childhood mental health consultation services, identifying measures, and determining outcomes; and
3. Using evaluation data to report service outcomes and to help build the evidence base related to early childhood mental health consultation services.

The tool kit addresses early childhood mental health consultation and essential features of evaluating these services with attention to:

- The evidence base: Current issues and questions
- Early childhood mental health consultation: Defining characteristics and core features
- High quality evaluation: Components of evaluation
- Evaluation tools: Measuring process and outcomes
- Using the data: Integrating evaluation into program improvement and communicating outcomes

Each section includes case study illustrations from early childhood mental health consultation services and program evaluation efforts in the state of Maryland and a **Key Questions Checklist** reviewing key points raised in the text.

The Evidence Base: Current Issues and Questions

There is a growing concern about the prevalence of young children who are manifesting problematic behavior severe enough to warrant their removal from their preschool programs. While much of this concern was initially fueled by anecdotal evidence from parents and early care and education providers, Gilliam (2005) released the first data documenting the extent of this problem nationwide. Surprisingly, most states were expelling preschool-aged children at rates that exceeded their school-aged populations. One hopeful statistic was that access to mental health consultation was found to be associated with lower rates of preschool expulsion (Gilliam & Shahar, 2006). State-funded pre-kindergarten programs that reported on-site access to a psychologist or social worker expelled 5.7 children per 1,000; occasional access to a mental health consultant was associated with a somewhat higher expulsion rate; and the programs that lacked access to mental health consultation expelled children at the highest rates (10.8 per 1,000).

These findings contributed to a collaborative endeavor by the National Technical Assistance Center for Children’s Mental Health at Georgetown University, the Research and Training Center on Family Support and Children’s Mental Health at Portland State University, and the Louis de la Parte Florida Mental Health Institute at the University of South Florida to convene a group of experts in evaluating the effectiveness of mental health consultation in child care settings. This meeting was held in Tampa (2005) and led to a joint effort to conduct a systematic review of the literature (Brennan, Bradley, Allen, Perry, & Tsega, 2005). Motivated by a desire to assess the level of evidence for the effectiveness of early childhood mental health consultation, Brennan, Perry and their collaborators (Brennan et al 2007; Perry et al 2007) completed an extensive review of the literature with the following **research questions** in mind.

1. How effective is mental health consultation in promoting social and emotional development of young children and in reducing difficult or troubling child behavior?
2. What are the effects of mental health consultation on families receiving services?
3. How effective is mental health consultation in building staff capacity to manage problem behaviors and promote social and emotional development in children with special needs?
4. What effects on the early childhood program are seen when a mental health consultant spends time working with teachers, children, and families?

Based on the review of 30 studies, Brennan and her colleagues concluded that there is growing evidence to suggest that mental health consultation is effective in building behavior and classroom management skills of early care and education providers; increasing their use of developmentally appropriate practices and expectations; and reducing staff stress and turnover. In addition, there are also data to suggest that mental health consultation reduces the levels of problematic behavior in young children (Green et al, 2006; Perry et al, in press).

While there is preliminary evidence to suggest that mental health consultation approaches are effective, gaps in the knowledge base remain. These gaps are fueled by a lack of consensus about:

- The essential components of mental health consultation;
- The skills, competencies and credentials of effective consultants;
- How consultants should get training and what kinds of ongoing supervisory and staff development support are needed;
- The level of intensity of the intervention (i.e., frequency, duration) that is needed to effect change in outcomes; and
- Which outcomes should be targeted and how these should be measured.

Brennan et al, 2005

These findings underscore the need for more focused and diligent design and evaluation of early childhood mental health consultation services. It is essential that programs offering or developing consultation services incorporate high quality evaluation of their programs and provide detailed descriptive information about their intervention model and data-driven outcomes. These evaluation efforts can help address gaps in the knowledge base as well as link both shorter-term outcomes achieved through mental health consultation to longitudinal data and school readiness skills and expectations.

As states and communities expand their capacity to meet the mental health needs of young children and their caregivers, the need for accurate, data-driven information about effective strategies to deliver mental health consultation is growing. There are many unanswered questions about the key components of effective consultation and the best tools to evaluate the impact of consultation on child and family, staff and program outcomes. There is a need for systematic studies that compare variations in key elements of the consultation (i.e., qualifications of the consultant; frequency and intensity of the consultation; modality through which the consultation is delivered) so that these relationships may be explored. There is also a need for studies that isolate the effects of mental health consultation from other aspects of more comprehensive interventions. Ideally, these would be randomized controlled trials. There is also a need for longitudinal data to be collected, preferably linking the shorter-term outcomes achieved through mental health consultation and school readiness skills and expectations.

This tool kit is intended to help position all stakeholders to better address these gaps in our evidence base. Researchers must team with state and local policy makers, program managers, providers and families to contribute to the knowledge base of what works (Perry et al, 2007).

Early Childhood Mental Health Consultation: Defining Characteristics and Core Features

In order to assist programs and communities to be more systematic in evaluating early childhood mental health consultation, this tool kit provides the following definition, including some concrete examples of early childhood mental health consultation activities. The lists of activities are not meant to be a menu of services; instead, they are intended to illustrate a range of options that fit within the definition, clarifying the difference between consultation and direct services.

Definition

Early Childhood Mental Health Consultation (ECMHC)

ECMHC includes culturally sensitive and primarily indirect services for children birth through six in group care and early education settings. Services include capacity building for staff and family members, directly observing children and the caregiving environment, and designing interventions that involve changes in the behaviors of caregivers. ECMH consultants collaborate with administrators, staff, family members, and caregivers who intervene directly with children in group care, early education, and/or home settings. ECMHC is intended to promote social and emotional development in children and transform children's challenging behaviors. Outcomes may be measured by the impact on children, parents, staff and programs. Consultation is offered by persons with formal preparation in children's mental health and experience working with young children and their families.

This definition is derived from the seminal work of Cohen and Kaufmann (2001, revised 2005) and has been revised to reflect the increasing knowledge and research base for early childhood mental health consultation. According to Cohen and Kaufmann, early childhood mental health consultation 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, primarily child care center staff or parents with other areas of expertise or knowledge of the child. 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. Cohen

and Kaufmann have also described two sub-types of consultation: child or family-centered and programmatic consultation (described below). The accompanying lists of activities appear under the relevant sub-type of consultation and indicate the collaborative focus on capacity building for staff, family, or program.

Child or Family-Centered Consultation:

The primary goal of child or family-centered consultation is to address the factors that contribute to an individual child's (and/or family's) difficulties in functioning well in the early childhood setting. This type of early childhood mental health consultation is **typically provided to staff and families** and is often initiated by concerns about an individual child's problematic behavior.

Examples of child-centered consultation services for staff:

- Conduct individual child observations
- Design and implement program practices responsive to the identified needs of an individual child
- Support staff with individual child behavior and classroom management
- Provide one-on-one modeling or coaching for individual child support
- Provide crisis intervention services for staff regarding a child's behavior
- Advise and assist staff in linking to community resources and services
- Provide support for reflective practices

Examples of family-centered consultation services for families:

- Offer training on behavior management techniques
- Provide one-on-one modeling for individual child support
- Educate parents on children's mental health issues
- Refer parents for community mental health services
- Conduct home visits
- Advocate for parents
- Support parents in helping child

Programmatic Consultation:

Programmatic consultation focuses on improving the overall quality of the program or agency and/or assisting the program to solve a specific issue that affects more than one child, staff member, and/or family. This type of early childhood mental health consultation is **typically provided to program staff and administrators**.

Examples of programmatic consultation services for staff:

- Conduct classroom observations
- Evaluate the center or learning environment
- Suggest strategies for making the environment prosocial
- Support staff with classroom management
- Train staff on behavior management techniques
- Train staff on accessing mental health resources
- Educate staff on children’s mental health issues
- Support staff working with children with challenging behaviors
- Provide support for reflective practices

Examples of programmatic consultation services for programs:

- Promote staff wellness
- Address communication within the program
- Promote team building
- Provide staff support
- Participate in staff meetings
- Train staff on cultural competence
- Address programmatic issues
- Design and implement early childhood mental health best practices within the program
- Consult with the director
- Identify and address program needs
- Advise on program policy

Defining Characteristics

What “It” Is:

The defining characteristics of early childhood mental health consultation are collaborative relationships, building the capacity of the child’s caregivers, and the indirect nature of intervention services. Early childhood mental health consultation is a service provided at an “arms length” from the child; supporting and empowering others to “become therapeutic” and deliver care and interventions in the context of the child’s and caregiver’s everyday activities and caregiving. It includes efforts to seek and obtain coordinated services across systems when necessary.

Collaborative relationships

The consultation process involves two or more individuals with different areas of expertise, such as: the mental health expertise of the consultant, the early care and education expertise of the child care provider, and the parenting expertise of the family or caregiver. Each individual offers a valuable perspective and a unique role when working together on shared goals through a process that requires respect, sensitivity to context, and open communication.

Capacity building

The primary instrument of intervention in consultation is capacity building; that is, assisting staff and caregivers to develop attitudes and skills that will help them function

more effectively. With new perspective, skills, and strategies, caregivers can address and solve current problems as well as future concerns that might arise in supporting the social and emotional health of young children.

Indirect nature of intervention services

A consultant's intervention is indirect, working with and through staff and caregivers. By working in collaboration with staff and caregivers and building their capacity to problem solve and change practices, the consultant influences the experience of and outcomes for an individual child, family, staff member, and program.

System navigation

An early childhood mental health consultant sometimes helps to link and bridge systems and services on behalf of a child, family, and program. Often children and their families are receiving services from several different private and public providers and agencies, such as Part C and pre-school special education of IDEA, community mental health, and public or private maternal and child health. Similar to a case manager, a mental health consultant can assist the child and family in integrating their services through a team approach: identifying community resources; advocating for the type, frequency, and intensity of services that meet the child and family needs; and facilitating planning and communication among families, caregivers, and service providers so that services are well coordinated.

Culturally sensitive approach

Because many aspects of early childhood practices are influenced by the culture of the child and family, mental health consultants must be attuned to these nuances as they work with staff and families. Care must be taken to be attentive and responsive to cultural differences between staff and families as well as among staff members; designing services and interventions that are culturally and linguistically appropriate.

What “It” Isn’t:

The defining characteristics of early childhood mental health consultation also help to define what early childhood mental health consultation is *not*. Early childhood mental health consultation is not the mental health expert acting alone as the sole expert or primary source of direct intervention for the child and family. The consultant does not “fix” the problem or the child’s behavior in lieu of those who provide regular care for the child. And, although a mental health expert or professional may provide valuable direct services as part of their relationship or contract with an early care or education program, these services are different from consultation. Direct service or therapeutic interventions would include those services delivered personally by a mental health professional to a child, family, or staff member in accordance with clinical or professional practice standards. In some communities, particularly those in rural areas, the scarcity of service providers who are available as early childhood mental health consultants and therapists requires that the same individuals provide both consultation and direct services. If the model being used is a combination of consultation and direct services, it is important to design an evaluation that can separately document the effects of each of these components.

What “It” Isn’t—Direct Service Intervention**Examples for children:**

- Conduct formal child mental health diagnostic evaluations
- Provide direct therapeutic services
- Provide therapeutic play groups
- Provide one on one, individual child support
- Provide case management

Examples for families:

- Provide crisis intervention services for families
- Conduct family support groups
- Provide direct individual or family therapy services

Examples for staff:

- Provide direct individual therapy services
- Offer employee assistance counseling related to personal issues and job performance

Core Features

Because 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 young children, there are specific core features that help define early childhood mental health consultation. These include the consultant’s qualifications, the consultative stance, integration into the early care and education program and relationship building, intensity and duration of services, and supervision of the early childhood mental health consultant.

Qualifications

In general, someone who is qualified to provide early childhood mental health consultation would be an individual with formal preparation in children’s mental health and experience working with young children and their families. The core knowledge, skills, and attributes include:

Knowledge	Child development Underlying concepts of social-emotional development Screening, assessment, and clinical indicators Evidence-based strategies for mental health promotion, prevention and intervention Community resources Family systems
Skills	Observation Listening and interviewing Working with families and staff within collaborative relationships Reflection Modeling Cultural competence
Attributes	Warmth Empathy Respect Reflection

Particular knowledge, skills, and attributes may be desirable, depending on unique features of the community or children and families to be served and the specific nature of consultation services.

For example:

- In most communities and early childhood programs, it is desirable for a mental health consultant to demonstrate cultural knowledge or cultural competence in working with various cultural groups; the capacity to “dialogue differences” or act as a bridge between a cultural group and the early care and education setting or other community services; and bi-lingual skills or the capacity to work with interpreters and translators.
- In an early childhood program with concerns related to communication and/or team work that impact program quality, it is desirable for a mental health consultant to demonstrate a capacity to address organizational issues; provide guidance on administrative and supervisory structures; facilitate communication; and promote team building.

Consultative Stance

In their recent book, *Mental Health Consultation in Child Care*, Johnston and Brinamen (2006) capture the principles and practices of the consultative stance essential for the collaborative and capacity building elements of early childhood mental health consultation. They describe the consultative stance as a “way of being” that highlights the mutual responsibilities and “shared endeavor” of the consultant and the staff, caregivers, or family members. By “wondering together”, the consultant assists caregivers in understanding a child’s behavior and participating in changes that may promote, prevent, or intervene in the social emotional development or challenging behavior of young children. The consultative stance helps those involved with the child to explore their understanding of the child and family and consider new information or ideas. Through patience, perspective, and reflective learning, consultants use their relationships with the caregivers to build the capacity of the caregivers so that they can become empathic and responsive to a child in new and effective ways.

Practices Associated with the Consultative Stance

- Observing
- Understanding different perspectives
- Identifying and accepting feelings
- Information gathering
- Acknowledging and valuing the experience of others
- Sharing ideas clearly
- Soliciting ideas from others
- Developing hypotheses in collaboration
- Avoiding the “expert” posture
- Encouraging reflection
- Hearing and representing all voices, including the child
- Building on relationships
- Supporting step-by-step change, enduring set-backs, and holding out hope

(Adapted from Johnston & Brinamen, 2006)

Integration and Relationship Building

Different from qualifications and consultant characteristics, yet related to the consultative stance, is the issue of integration of the consultant or consultant services into an early childhood program. In a survey of Head Start programs in 2003, Green et al, found that programs with a more integrated model of consultation reported higher frequency of early childhood mental health consultation activities; greater use of various funding streams for mental health services; higher rates of utilization of early childhood mental health consultation; improved staff practices and overall program functioning, as well as significant influence on staff response to children's behavior. Factors affecting integration include: availability, approachability, and being perceived as part of the "team". These factors are also highlighted by Donahue, Falk, and Provet's *Mental Health Consultation in Early Childhood* (2000) in which they emphasize the collaborative process.

Practices Associated with Integration of Consultation Services

- Agreement on a shared vision of early childhood mental health and consultation
- Defined roles and responsibilities
- Availability that meets the needs and styles of the staff, families, and program
- Clear, yet flexible, procedures for obtaining consultation services
- Flexibility and responsiveness on the part of the consultant
- Administrative sanction and support for consultation services
- Space and opportunities for one-on-one time, meeting with families, and other physical requirements for consultation services
- Regular opportunities for formal and informal staff development
- Predictable, reliable, and responsive contact
- Cultural and linguistic competence

(Adapted from Donahue et al, 2000 and Green et al, 2003)

Integration of the early childhood mental health consultant and consultation services into the early childhood program can greatly assist the process for building positive collaborative relationships. The ability to build relationships, in fact, is one of the most important characteristics in an early childhood mental health consultant (Johnston & Brinamen, 2006). Green et al (2006) found in a survey of over 800 Head Start staff, directors, and mental health consultants, that mental health consultants who built positive relationships with staff and parents were perceived as most successful in helping to reduce children's behavioral problems and improve their positive social behavior. In fact, the perceived ability to build these relationships was more important to outcomes than the amount of time consultants spent working with the early childhood program, their qualifications, or their knowledge of early childhood mental health best practices. Early childhood mental health consultants who can enter into the consultative relationship with an attitude of mutual respect and sensitivity to cultural values, as well as value and encourage providers to share information and generate solutions, may be better able to build these critically important relationships.

Practices Associated with Building Partnerships and Collaborative Relationships

- Attitude of mutual respect
- Mutual appreciation for knowledge and skills
- Understanding, empathy, and trust
- Spending time together
- Clear communication (listening and dialogue)
- Shared planning and decision making
- Predictable, reliable, and responsive contact
- Cultural and linguistic competence

(Adapted from Cohen & Kaufmann, 2005; Donahue et al, 2000; Johnston & Brinamen, 2006; Green et al, 2003)

Intensity and Duration

While there is limited empirical evidence to draw from in terms of making decisions about how much early childhood mental health consultation is necessary or sufficient for positive outcomes (Brennan, et al, in press), a few studies suggest that the length of time that an early childhood mental health consultant works with a program may be important. Alkon and her colleagues (2003), for example, found that when early childhood mental health consultants provided services to child care programs for a year or more, that staff experienced greater reductions in work-related stress. Further, Green et al (2003) found that early childhood mental health consultants who worked with Head Start programs for extended periods of time were better able to build coaching and mentoring relationships with staff. The required intensity or frequency of services is often difficult to ascertain. In one of the few studies examining this issue, Green et al (2006) found that the hours of early childhood consultation that a program had contracted for was unrelated to early childhood mental health consultation effectiveness. However, frequency of consultation services, as reported by program staff, was related to outcomes. Early childhood mental health consultants who engaged in more frequent and more diverse consultation services were also perceived by staff to be more effective in reducing behavioral problems.

Supervision of Mental Health Consultants

Another key aspect of early childhood mental health consultation that has not been well researched has to do with the support that is provided to the mental health consultant through reflective supervision or other oversight. As a mental health professional, the work of the consultant is by its nature stressful, and supervision and support for the consultant is an important element that is often overlooked. Early childhood mental health consultants need regular supervision with an individual who understands the nature of consultation in early childhood settings, and who can provide expert professional input to help the consultant problem-solve solutions for challenging situations. The nature of early childhood mental health consultation requires a greater breadth of skills and expertise than are traditionally taught in clinical or other mental health training, and ongoing support for this person is an important element of successful early childhood mental health consultation.

IN MARYLAND

Maryland's State and Community Context

The state of Maryland has been actively engaged in promoting the school readiness of their youngest citizens for more than a decade. One outcome of this work was the publication of a five-year action agenda by an interagency team representing state and local government agencies, advocates, and other stakeholders (Leadership in Action Program, 2002). Through this collaborative process, an initiative to test the effectiveness of mental health consultation provided to child care was designed and funded by the Child Care Administration (now the Office of Child Care in the Maryland State Department of Education). Based upon the promising evaluation results achieved by a mental health consultation project launched in Anne Arundel County several years earlier (Perry, Dunne, McFadden & Campbell, in press), two jurisdictions were selected to expand the availability of early childhood mental health (ECMH) consultation services—Baltimore City and the five-county region of the Eastern Shore. These “pilot sites” were provided an initial two-year grant of \$200,000 per year using federal Child Care Development Fund Quality Expansion dollars; a one-year extension was funded in both locations at a somewhat reduced level. The two pilot sites funded over a three-year period in Maryland to assess the effectiveness of mental health consultation were **The Early Intervention Project (EIP)** in Baltimore City and **Project Right Steps (PRS)** on the Eastern Shore. An external program evaluation conducted by the Center for Child and Human Development at Georgetown University (GUCCHD) was also funded to ensure that data on the pilot sites’ implementation and impact would be collected and analyzed.

ECMH Consultation Model Defining Characteristics

Both of Maryland’s funded sites implemented an early childhood consultation model that included:

- On-site consultation to child care programs,
- Individualized consultation for children who were at risk for expulsion from their child care programs, and
- Consultation to child care staff seeking classroom-wide behavior management strategies and other programmatic features.

The sites also had unique features that, by site, included:

The Early Intervention Project

- A primarily programmatic consultation approach with a 3- to 6-month commitment to providing one-half day per week onsite work with staff on issues related to problematic behaviors with an identified group of child care programs in low-income neighborhoods.

Project Right Steps

- A primarily child and family centered consultation approach using a protocol for a “typical case” and drafted guidelines for the type and intensity of the consultation and
- Home visits as an option for working with families.

IN MARYLAND

Maryland Programs' ECMH Consultation Core Features

- Services delivered by interventionists who were knowledgeable about early childhood development:
 - Bachelor's level early interventionists with expertise in child development to supplement the work of a part-time developmental pediatrician (EIP)
 - Bachelor's level specialists who had backgrounds in early childhood and related fields supported by a licensed clinical psychologist (PRS)
- Technical assistance, consultation and peer mentoring from established mental health consultation models

Common Program Activities

Aspects of the mental health consultation services offered by **EIP** and **PRS** are very similar.

Specialists provided:

- On-site observations of children and child care staff
- Modeling of appropriate child/staff interactions
- Written feedback on observations and effective intervention strategies
- Summaries/syntheses of effective practices for addressing specific presenting problems (e.g., biting)
- Telephone consultation with child care directors, family members, other service providers involved with the child/family
- Referrals for community-based services and supports
- Training on related topics (e.g. behavior management strategies)

Both pilot sites engaged in additional activities to support the evaluation, including:

- Scoring assessment data on cases
- Data input and data base management
- Meetings with the program evaluator and other staff meetings
- Regular reporting to the Office of Child Care

Section 2: Key Questions Checklist

Programs and communities that are planning and investing in early childhood mental health consultation services must ask the right questions to inform decisions to design and evaluate early childhood mental health consultation. These same questions are also relevant to **Section 3**.

What is our definition of early childhood mental health consultation?

- ✓ What services or activities are included in our definition, design or model?
- ✓ What services or activities are NOT in our model?
- ✓ How are referrals going to be made/received?
- ✓ Will we be providing both child/family as well as staff/program focused consultation? How will this be determined?
- ✓ What are the intensity and duration of these services or activities?
- ✓ How long will consultation be provided?
- ✓ Who will receive these services and how will they be delivered?
- ✓ How will we determine if the consultants are following our model of early childhood mental health consultation?

How will we describe and measure the influence of each or all of these services or activities?

What are the qualifications (knowledge, skills, attributes) of our early childhood mental health consultants?

- ✓ Are there formal educational or experiential credentials we are seeking? What counts as mental health training?
- ✓ What supervision does the early childhood mental health consultant receive and how does it influence the consultant and/or services?

How will we describe and measure the influence of each or all of the consultant's qualifications or qualities and supervision?

What are the features of the relationships and interaction between the early childhood mental health consultant and children, parents, staff, and administrators?

- ✓ How will consultants establish their initial relationships with the early childhood programs?
- ✓ Will there be a written agreement of what the expectations and responsibilities for the consultant are? Are there parallel expectations and responsibilities on the part of the early childhood program?
- ✓ What strategies are in place to integrate early childhood mental health consultation into the early childhood program?
- ✓ How will the consultant be available to staff and families and how often will the consultant be on-site?
- ✓ How will we describe and measure the influence of each or all of these relationships and interactions?

High Quality Evaluation: Components and Key Strategies

Program evaluation refers to systematic efforts to collect and use program information for multiple purposes, such as program improvement, accountability, program management, and program development. Evaluation should help to inform and improve programs as they develop, and not focus only on whether the programs “worked” or “didn’t work” (Gilliam & Leiter, 2003). Good evaluation requires carefully thinking through the questions that need to be answered, the type of program being evaluated, and how information will be generated and used. There are two facets of most program evaluations: data collected to assess the implementation of the program (**process or formative evaluation**) and data collected to assess the impact of the implementation of the program (**outcome or summative evaluation**).

Components of Evaluation

There are several components of evaluation that are important for conducting effective evaluations, both process and outcome evaluations. These components include meeting with stakeholders (including families, funders, program administrators, managers, and providers), determining the evaluation strategy, determining the program theory of change, developing a logic model, writing a program description, developing evaluation questions, creating a data collection plan, gaining access to the data, developing a plan for managing the data, writing a data analysis plan, and determining a strategy for disseminating and implementing findings.

Meet with Stakeholders

One of the earliest considerations when undertaking an evaluation of early childhood mental health consultation is to assess the motivation for undertaking the evaluation. In some cases, the evaluation is a required element of a funded project—a condition of receiving outside money from a federal, state or philanthropic source. In other cases, an existing program may be seeking to identify the impact of their program in order to make improvements, seek additional funding to expand or sustain their efforts, or add to the literature on what leads to effective practice in this field. Families, who are served by programs for young children, bring powerful perspectives and resources to program evaluation. In addition to their very personal interest, experience and wish to benefit from an early childhood mental health consultation (ECMHC) program, families have a deep investment in effective services and improved service delivery systems. Engaging families in program evaluation

brings an essential voice to the process and many potential benefits that influence all aspects of the evaluation plan. (See **Appendix D—On-line Resources**: Jivanjee et al, 2003; Turnbull et al, 1998; and Markey et al 1998 for guidance on involving families in evaluation). The impetus for the evaluation will impact decision making throughout the evaluation, including the identified target audience, the evaluation questions, the selected tools, and the measured outcomes.

IN MARYLAND

In Anne Arundel County Maryland...

Stakeholders were concerned about a growing number of young children who were being expelled from their early childhood programs because of challenging behaviors. As part a comprehensive early childhood system initiative, they developed an ECMHC project (known as the BEST project), and hired an external evaluation consultant to work with the community program. Collaboratively, the community team developed a logic model that identified one of the key outcomes as a reduction in the number of children who were expelled from their child care programs. They also sought reductions in children’s problem behaviors in addition to increases in their social skills as intermediate outcomes from the BEST project. The evaluation was motivated by the Local Management Board’s desire to demonstrate effectiveness to the state agency which was funding the early childhood systems project.

Shared ownership is key to program and evaluation success. Representatives from all interested parties must be included in all aspects of the evaluation, and it is important to make sure that everyone has at least one of his/her key issues addressed in the evaluation. When determining which stakeholders to include in the evaluation process, families of young children with challenging behaviors, child care providers and the mental health consultant should be included in the planning process. Also consider including other stakeholders who have the authority to:

- Implement data collection plans,
- Grant access to data, and
- Make changes in the program based on evaluation information.

Cultural Sensitivity: When involving stakeholders, seek individuals who have a relationship with and understanding of all culturally diverse populations who will be involved in the evaluation. Families and community members from diverse populations will be better prepared to formulate relevant questions, identify key issues and variables, and use or develop methodology that will fit diverse populations. This is a great opportunity for the evaluation team to discuss important elements regarding the participants’ cultural background, such as, values, tradition, religion, family structure, community, and protocols. Rapport and trust between the evaluation team and the participants’ community can begin during this stage.

Discuss Appropriate Evaluation Strategy

As previously mentioned, there are two general types of evaluation: **process evaluation** and **outcome evaluation**. A process evaluation is conducted when the evaluation team hopes to assess how a program is implemented. In contrast, outcome evaluations are used when an evaluation team hopes to evaluate a program's success in reaching its goals (Chen, 2005; Gilliam & Leiter, 2003). Often program evaluations will combine both process and outcome evaluation questions.

Process evaluations may be as simple as determining whether the intervention was implemented as intended and whether it is serving the intended groups. However, process evaluations may be very comprehensive by conducting a systematic assessment of the implementation of all major components of a program plan (Chen, 2005; Gilliam & Leiter, 2003). A good process evaluation will capture the array of activities that are actually being implemented and it will collect data on the intensity/frequency of these activities.

For example:

- In some cases, it may be of interest/importance to be able to quantify the amount of time the mental health consultant spends focusing on an individual child, family, staff member, or program issues in order to better assess outcomes or impacts.

In conducting **outcome evaluations**, Gilliam & Leiter (2003) point out that there is an important distinction between evaluating outcomes and impacts—a distinction that is often obscured. They define program outcomes as the many things that may change for participants in an intervention or “the degree to which participants are able to achieve the conditions that the program seeks to facilitate” (p. 9). In contrast, when one seeks to evaluate impacts, there is a more specific task to achieve: the evaluator must measure these outcomes using tools and strategies that will gather evidence that the cause of these changes in outcomes can be attributed to the intervention. Impact evaluation implicitly requires a comparison group, at a minimum, and a randomized design if true causation is to be evaluated. Studies with a randomized design are considered to be the gold standard for determining program impact.

When determining whether to evaluate outcomes or impacts, it is important to address ethical considerations of implementing control groups for a randomized design. It may be unethical to provide the intervention to one group and not to the other or to provide an intervention that is thought to be less effective to one group while the other group receives an effective intervention.

Determine Program Theory of Change

As programs design an evaluation plan for early childhood mental health consultation, it is important to think about the connections between what specific services and activities are going to be delivered and the desired outcomes, and to articulate the “theory” or set of assumptions about how and why a particular set of strategies will lead to the desired outcomes.

For example:

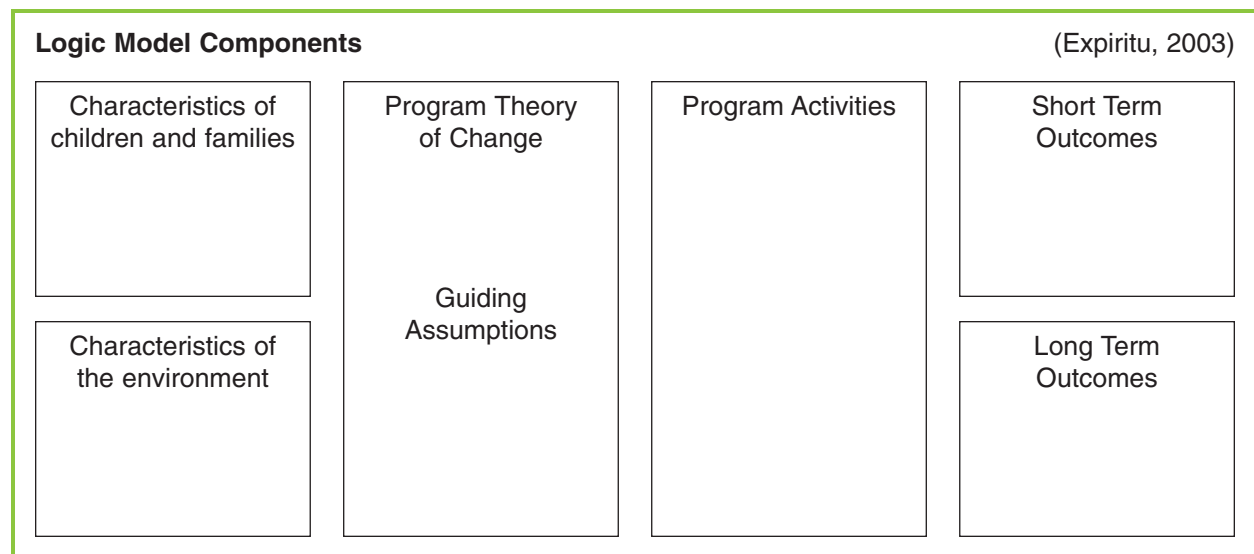
- For program-focused consultation models, the theory of change for child-level outcomes would depend on: the effects consultation would have on changing teachers' behaviors, classroom

management strategies and routines. These “pathways” through which the effects of the intervention would manifest are the theory of change.

Sometimes, researchers initiate a project that builds from a strong theoretical foundation. Starting with a theory about the relationship between two variables allows a researcher to determine what they need to measure to support or refute their assumptions about causal relationships between variables. In program evaluation, it is more often the case that the formal discussion of these links between activities and outcomes happens after the project is funded. Ideally, the theory of change is based on or related to available knowledge and previous research with an evidence base that guides the selection of intervention strategies (Hernandez & Hodges, 2001, Perry et al, 2007).

Develop Logic Model

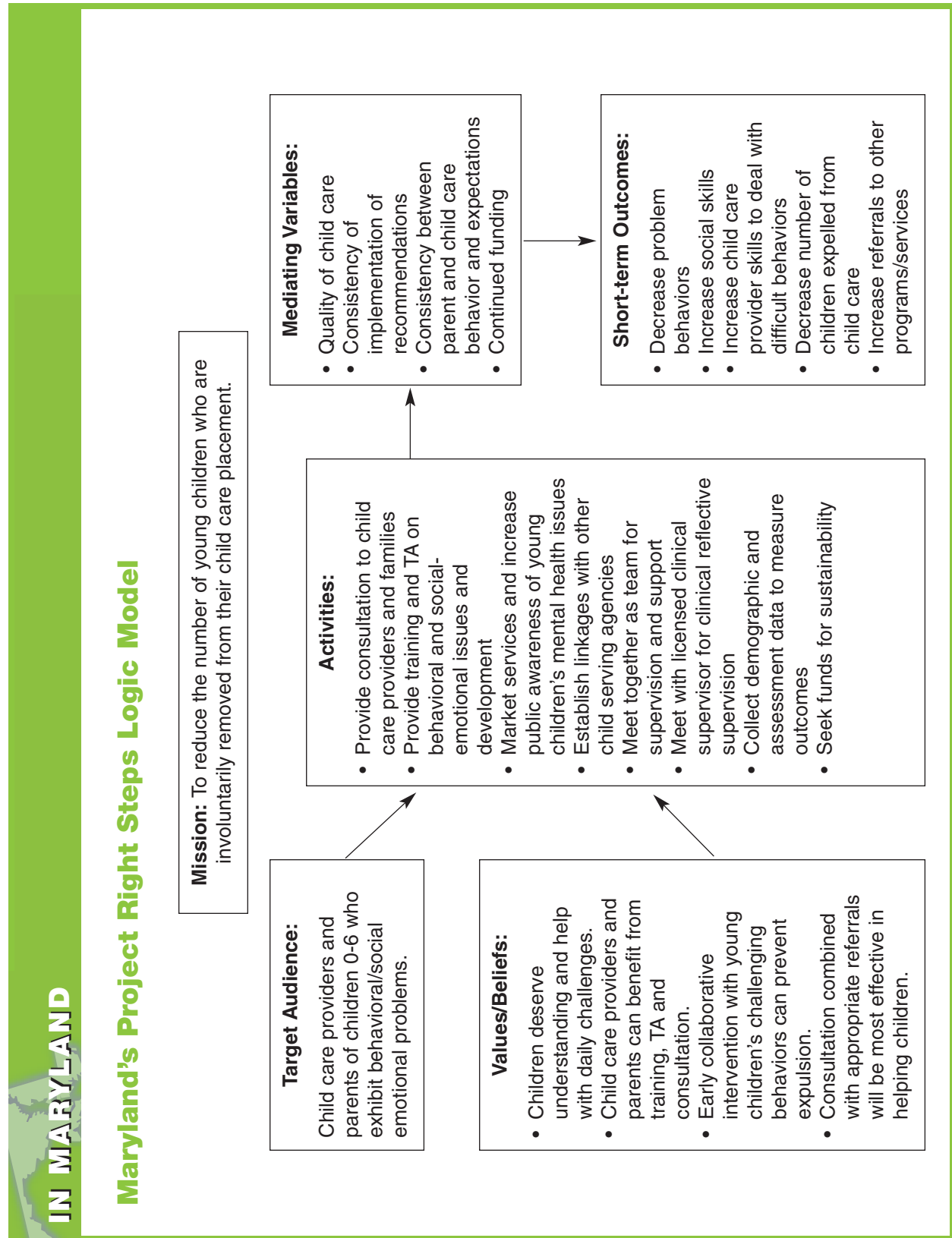
A logic model is one tool that evaluators often use to graphically depict the connections between the problem or need and a set of actions to be undertaken by a state or community (Chinman, Imm & Wandersman, 2004). It offers all interested parties, including families, a way to communicate and understand the evaluation plan. In traveler’s terms, the logic model provides a map, beginning with current conditions (the starting point), linking these to a set of activities designed to address those conditions (the journey), which then are connected to short-term and long-term outcomes (the destination). In its simplest form, components of a logic model include a description of the target population; the program theory of change and guiding assumptions; program activities; and outcomes (Espiritu, 2003; Gilliam & Leiter, 2003; Perry et al, 2007). Program activities are considered the processes, tools, events, technology, and actions that are an intentional part of the program implementation. The outcomes are specific changes in program participants’ behavior, knowledge, skills, status and level of functioning. Short-term outcomes should be attainable within one to three years, while longer-term outcomes should be achievable within a four to six year timeframe (W.K. Kellogg Foundation, 2004). Given the scope of funding for many community-based evaluations, there may not be the opportunity to measure long-term outcomes; but they should still be included in the logic model as they are often of interest to some of the stakeholders.



Combining the theory of change approach and the logic model helps programs design a comprehensive evaluation plan. It enables a program to:

- Identify a problem and generate potential solutions;
- Communicate and build consensus about the ways the intervention will affect outcomes;
- Create a graphic representation of the intervention and evaluation plan;
- Organize the work and implementation;
- Track progress; as well as
- Explore alternative explanations, or mediating variables for observed outcomes.

The Maryland logic model for early childhood mental health consultation that follows further illustrates these key points. For a more generic logic model, see Appendix A. This logic model describes the possible resources, activities, theories of change, and outcomes for mental health consultation focused on four levels of intervention: child, family, staff, and program. This generic logic model requires careful study and can help guide thinking and decision making for states, communities, programs, and agencies in the process of designing their own logic models.



Write a Program Description

Since ECMHC is a complex process—and typically not a “manualized intervention”—embedded within a community context of existing programs, services, and settings, there needs to be a lot of upfront work to conceptualize what is being implemented in each community. Ideally, the evaluator will be at the table as the ECMHC project is being conceptualized and facilitate the planning process, making sure that all voices—especially families—are heard and have influence on the program description.

During this process, it is important to develop a clear definition of the target population for the intervention and a well-defined model of the ECMHC approach(es) to be implemented. In order to write a clear program description of intended ECMHC service, it is important to consider:

- What age(s) of children will be targeted?
- Will their families receive ECMHC, or simply give their permission for services in the child care setting?
- Will the early childhood program staff be the primary recipients of the ECMHC, or will the children be observed, screened, or referred?
- Who will be able to access the ECMHC services, or will a group (e.g., licensed child care centers) be the focus? What is the path through which ECMHC services are accessed?

When developing the program description, consider the elements of the program that will be necessary for ECMHC to be successfully implemented. For instance, the evaluation team should consider:

- In order to be effective, what kind of training would the mental health consultant need to have?
- What kinds of skills and competencies would the mental health consultant need?
- How does the relationship between the mental health consultant and the early childhood caregiver affect changes in the caregivers’ skills and knowledge?
- What is the extent of the “goodness of fit” in the philosophy of the mental health consultant and the early childhood program staff?
- Is there reflective supervision available to the mental health consultants?
- Does the early childhood program staff have good administrative support available to follow-through on the recommendations made by the mental health consultants?

These questions can also be used as process evaluation questions to determine the degree to which the ECMHC program was implemented as intended. These questions relate to those in the **Key Questions Checklist in Section 2**.

Develop Evaluation Questions and Determine Evaluation Measures

One important use of a good logic model and/or theory of change is to help stakeholders—funders, providers, and families—articulate the primary evaluative questions they want to have answered. It will also guide the selection of specific outcomes, their measures and the expected relationship between different variables of interest. Primary questions will be driven in part by the funders, the policy climate, the model, and what can be measured accurately using reliable and valid tools. But a good evaluation should also address questions that are meaningful and useful to the early childhood program, administrators, early care and education providers, and families of young children directly involved in the early childhood program and to the consultants providing service. Having families involved in determining evaluation questions and measures can help evaluators “ask the right questions”, or those that are most important to service consumers. In addition, families can share cultural perspectives and linguistic features that influence how evaluation questions are crafted and the process for data collection (Hepburn, 2004). When generating a “long list” of possible evaluation questions that can then be prioritized based on a logic model, it is important to consider several key factors.

- What questions **MUST** you answer (to meet reporting or other requirements)?
- What questions would you **LIKE** to answer and **WHY** (how will you use the information)?
- Expected effects—what is realistic? Match this with who the target of the intervention is and the intensity (i.e., measuring changes in child-level behavioral outcomes for a short-term intervention focused on staff may not yield strong effects).
- What information can you readily collect? What reliable tools are available to collect these data?

Outcomes can be measured to be of interest to different audiences. Some are most relevant to policy-makers, such as cost effectiveness data, personnel qualifications related to effective services, and school readiness. Others are helpful to program staff, such as reductions in job stress, increase in professional-efficacy, gains in behavior management skills. Families may be especially interested in building their children’s social skills, in developmental gains made by their children, and in their own parenting-efficacy. Some outcomes are of interest to everyone, including averting expulsion from early childhood programs.

While there are many questions to be answered, the field of ECMHC is limited by a lack of tools that validly and reliably measure many of the constructs that are of great importance. For example, mutually respectful relationships between the mental health consultant and the early care and education provider are considered essential components of effective ECMHC, yet there are few standardized instruments that measure the quality and complexity of these dynamic relationships and how they change over time. There is also a lack of tools that systematically measure the transfer of knowledge between the consultant and the early childhood educator related to how they foster social and emotional development in young children.

Since we are limited by the instruments we have available, it is important to identify those aspects of early childhood practice that can change as a result of consultation and are likely related to child, family, staff and program outcomes. It is also important to identify aspects of the early childhood setting that will interfere with even the most effective consultation yielding positive results.

For example:

- A very skilled mental health consultant faced with a highly resistant early childhood provider, in a classroom with few developmentally appropriate resources, and only six weeks of intervention, will be unlikely to affect positive changes in child behavioral outcomes. In these cases it is critical to document these intervening variables (i.e., staff attitudes, environmental characteristics, and limited “dose”) in addition to monitoring child behavior outcomes.

An ongoing challenge in assessing the true “impact” of ECMHC relates to our limited ability to measure and account for all the other things that may be contributing to the outcomes we see (Gilliam & Leiter, 2003; Perry et al, 2007). These external factors exist at the macro-level—such as statewide efforts to improve children’s readiness for kindergarten through preschool teacher-training, increased expectations for basic knowledge about social, emotional development in young children for child care providers, or the proliferation of child-rearing advice in the mass media and through the internet. They may also be occurring in the specific classrooms and communities that have ECMHC available.

For example:

- In Anne Arundel county the BEST project was one of a number of initiatives that county leaders put into place to improve school readiness.

Without a carefully controlled scientific experiment, evaluators can rarely isolate the true effects of ECMHC on the outcomes of interest. However this does not diminish the importance of measuring outcomes; rather it challenges evaluators to design studies that collect data on these important contextual variables and use more sophisticated analytic methods for assessing impact.

Examples of evaluation questions:

- Is the duration of mental health consultation services associated with teacher turnover, center quality, or teachers’ self-efficacy? (Alkon, Ramler, & MacLennan, 2003, p.92)
- Do families served by ECMHC show an increase in their sense of empowerment, their efficacy as parents, and their ability to act on their children’s needs? (Olmos & Grimmer, 2005)
- Will children in classrooms with ECMHC learn new social skills and demonstrate less problematic behavior in those classrooms and at home? (Hennigan, Upshur, & Wenz-Gross, 2004)

These examples drawn from actual evaluation studies suggest that in spite of limited tools, interesting and important questions can be answered and that these findings can influence program improvement and policy development.

Create a Data Collection Plan

Review research question(s) and determine:

- What information is needed to answer the questions?
- What information is already collected somewhere and how can you get it?
- What new information will need to be collected?

There are several possible sources of data that may be useful in an evaluation of early childhood mental health consultation:

- Administrative Data—This type of data includes computerized or written case files that are currently collected by the program.
- Policy Makers and Program Managers—These interested stakeholders may have important information to share that can be collected through interviews, surveys, or focus groups.
- Parents—Parents who have participated in services provided by the mental health consultant may provide valuable information through interviews, surveys, and focus groups.
- Service Providers—Early childhood care and education service providers may provide valuable information through interviews, surveys, and focus groups.

One of the most important considerations for developing a data collection plan is to avoid duplication of paper work and data collection. Early childhood programs often have a great deal of paperwork to complete with little time to complete it. Program staff may find additional paperwork for the evaluation to be a burden. A careful assessment of what is already being collected from other sources is a good first step, as is working closely with the programs to determine what their information needs are. The best data are collected when everyone has a stake in its quality. Another essential consideration for developing a data collection plan is to make the format and process user and family friendly. Easy to use (time to administer or complete, reading level, etc.) and easy to understand strategies encourage family participation in the data collection process.

Cultural Sensitivity: When developing the data collection plan, it is necessary to consider the languages and culture of all participants. For non-English speakers, materials and interviews should be translated into the participants' language. When translating, it is important to remember that not all languages may share the same meaning for certain terminologies and definitions, so it is important to be culturally sensitive and aware of how questions, terminologies, and translations are framed (Fisher et al., 2002). This is especially true for mental health terms and the perception and meaning of different behaviors among diverse cultural groups. Seeking multiple stakeholders' and community members' opinions on the research methodology and design (especially tools that assess children's behavior) is essential when working with culturally diverse populations.

Gain Access to the Evaluation Participants

When developing the data collection plan, it is important to consider key questions regarding access to evaluation participants.

- Who will you collect information about? Who would you like to invite to participate (children, staff, parents)? How long will it take to collect this information?
- Will you collect data on participants who “drop out” of the program? If not, you risk being accused of presenting data on families that might be more likely to have had a positive outcome. However, collecting this data will require additional resources to try to find/locate parents who are no longer participating in the program.

Having families involved in the design of the evaluation plan, identification of evaluation questions, and selection of measures can also help to inform and support improved retention of and access to program participants. Family input can guide how families are approached and engaged in the ECMHC program and its evaluation. Gaining access to evaluation participants is enhanced if families and other participants (1) understand the goals of the program; (2) understand the purpose and process for evaluating services; (3) determine individualized goals; (4) can easily complete data collection instruments; (5) receive feedback about their own and program progress and outcomes and refine personal goals; and (6) understand how the data will be used to refine the program or to promote program sustainability (Hepburn, 2004).

Informed consent and confidentiality are two important issues in considering the steps to gain access to the data.

Informed Consent:

If child-specific data are being collected and/or an individual child is the focus of early childhood mental health consultation, permission from the child’s parent or guardian must be obtained in writing. If the program evaluation is part of a formal research protocol, this permission form must be reviewed and approved by an Institutional Review Board. When university researchers are involved, they will usually take the lead on this step; but the wording of the consent form should be developed in concert with program staff and participants whenever possible.

Informed consent to participate in a formal research/evaluation protocol must include very specific information on the risks and benefits of participating in the study. It must inform the parents of their right to withdraw from the study at any time, and it should describe the purpose of the study in common-sense language. It must also ensure that all personally identifiable data gathered will be kept confidential and safe.

Confidentiality:

Maintaining the confidentiality of evaluation participants is very important. In small, rural, or close-knit ethnic neighborhoods, the evaluation team must take extra care in ensuring confidentiality of participants. Confidentiality procedures must be addressed in

the recruitment, implementation, and dissemination stages of research. When using multiple informants, take care not to reveal confidential information about the participants to the informants. Finally, when research is conducted through institutional settings, evaluators should be aware that the staff may have less stringent confidentiality policies.

In a formal research study, data must be kept in a secure location and personally identifiable data be kept separate from other data on children's behavioral changes, for example, or teacher attitudes and practices.

Cultural Sensitivity: People of color and those from different cultures may be reluctant to participate in a program evaluation or may be distrustful of researchers for various reasons, including historical mistreatment by research and medical institutions, or fear that the research will be used by child welfare or immigration. The evaluation team should take into consideration the participants' exposure to and familiarity with research. Extra care should be given to explaining participants' rights.

Differences in language proficiency, language preference, and communication styles can result in misrepresentation or misunderstanding of consent information. Informed consent procedures should be conducted in a language understood and preferred by prospective participants. The evaluation team should consider the impact of cultural attitudes, values, and histories related to the roles of family members and community structures regarding the welfare of children when designing informed consent procedures for studies involving children. Consent should be sought without coercion or undue influence. When selecting fair and non-coercive compensation, the researcher should consider cultural, economic, and developmental factors that influence the value and meaning of monetary payments or other compensation alternatives. Informed consent should be readdressed with participants periodically throughout the study, especially longitudinal studies, to determine if participants would like to continue.

Develop a Plan for Managing and Analyzing the Data

It is essential to have a well-organized plan for managing the data prior to beginning data collection. The written plan should address:

- What information will be collected/compiled;
- How and when the data will be collected and compiled;
- Who will ensure that data-sharing agreements and/or proper signed releases are in place;
- Where the centralized data will be stored; and
- Who will take responsibility for ensuring data are recorded, compiled, and reported.

For data collection, it is important for someone to be responsible for data collection activities at each program site and across programs. If direct service providers, such as teachers, are expected to collect the data, then supervisors must support them to ensure that it happens. Consider building in regular data collection checks, such as quarterly reports of key information, to make sure that data are collected. These checks can also help with quality control. All staff involved with handling the data should be informed of confidentiality procedures. It is especially important that if you are relying on people to collect data before and after the consultation (and there is no control group), that procedures to collect that post-intervention data are put into place.

For data analysis, there may need to be a formal relationship with a university-based researcher (or similarly trained person) depending on the skills and expertise of the evaluation team. This person will bring knowledge about the appropriate strategies and approaches to analyze different types of data being collected (e.g., qualitative versus quantitative data) and ways to present the findings that will be valid and meaningful to a broad audience. They will also bring a degree of rigor and credibility to the evaluation that can be helpful in getting the results published and making well-founded claims about the program's effectiveness to decision-makers. Ideally, this relationship with a formally-trained evaluator would be established early on in the process, and data analysis would be one of several tasks that they would be expected to perform. The written plan should address:

- The type of data analysis to be performed;
- Who will complete the data analysis;
- How often the data would be analyzed;
- The format and process for sharing preliminary and final results; and
- Expectations for publishing the findings.

IN MARYLAND

Input from Maryland Stakeholders

Stakeholders representing areas throughout Maryland examined their existing data and concerns to develop and design their pilot programs and evaluation plan. Many turned to the Maryland State Department of Education's Work Sampling System (WSS) data for the 2004-2005 school year that provided a portfolio-based assessment of the school readiness of all kindergarten students in Maryland. Teachers are trained to conduct in-depth observations and document students' readiness across seven domains. Reports of students' readiness are aggregated by school and by county. These results are reported annually and changes are monitored actively by state and local policy-makers. Children's progress is reported at three levels: the percent of children who are fully ready, those that are approaching readiness (i.e., are exhibiting these skills and behaviors inconsistently) and those that are developing readiness. The latter group is not demonstrating the skills, abilities and behaviors that are needed to meet the expectations for kindergarten. Overall, approximately 60% of the children are fully ready (in the composite score). In the social-personal domain, four indicators of readiness involve: self-concept, self-control and interaction with others (Maryland State Department of Education, 2005). In this domain, roughly two-thirds of the children are fully ready, while 7% are developing readiness. More boys than girls fall into this latter category, as do children from higher risk populations (i.e., Head Start, Special Education, and those with Limited English Proficiency).

A recent survey of more than 1,200 child care providers across the state conducted through Healthy Child Care Maryland (Hall, 2005) found that behavior management was their number one health and safety training issue, endorsed by 780 child care providers. School readiness was ranked second (n=624) and early childhood mental health ranked fourth (n=489). When asked if they had dis-enrolled children due to behavior, roughly 25% said they had (372 of 1,296).

Taken together, these data were foundational to policy makers' decision to fund the ECMHC "pilot sites.", the Early Intervention Project (EIP) and Project Right Steps (PRS). Motivated by a desire to impact on areas of the state where the percentage of students who were not "fully ready" lagged behind the state average, a rural and an urban site were both selected. Policy makers were also concerned with ensuring that data on different models of ECMHC would be collected, and mandated an outside evaluator to work with the two pilot projects. Advocates seeking to expand funding for ECMHC were successful in passing a piece of state legislation that mandated the results of the evaluation be presented to the Executive and Legislative branches upon completion of the pilot projects.

Evaluation Design and Approach

An external, University-based evaluation consultant developed a participatory action approach to the evaluation of the both pilot sites. The consultant actively involved key stakeholders at each site in the evaluation's design and implementation. A logic model was developed with each project, specifying the target population, activities and outcomes. Core data elements and tools were selected that aligned with the logic models and allowed the findings from the pilot sites to be compared with data on outcomes. (See example logic model from Project Right Steps, pp. 23)

IN MARYLAND

Maryland's Evaluation Questions and Evaluation Measures

Shared across sites:

- Can ECMHC reduce the number of children expelled from their child care program?
- Can ECMHC reduce children's problem behaviors in child care settings?
- Can ECMHC increase children's social skills in child care settings?

Unique to each site:

- Are there changes in the classroom environment related to the provision of programmatic consultation? (EIP)
- Are changes in the children's social competence and problem behavior observed by parents too? (PRS)

Data Collection Plan

Common demographic variables were collected by both sites for each child-specific case including: age, gender, maternal education, zip code of home residence and child care provider, and primary presenting concerns. The social skills and problem behaviors for each three-through-five year old served were assessed using the *Preschool Kindergarten Behavior Scales* (PKBS; Merrell, 2002) in both sites. In addition, Project Right Steps collected similar data on infants and toddlers (one through three years old) and from the parents of all children served (ages birth through five years old) using the *Ages and Stages: Social-Emotional* (ASQ; Squires et al, 2002) questionnaires. Each site developed an instrument to assess changes in the child care environment. Case studies of children served were developed, and satisfaction data were collected from consumers.

Plan for Managing and Analyzing the Data

Working with the evaluator, each site developed a list of demographic variables to track in addition to the children's social skills and problem behaviors. These were incorporated into their intake forms and gathered for all child-specific referrals. Project staff then aggregated these data in a Microsoft Excel spread sheet. Periodically, each site would send the data to the evaluator who would analyze them using SPSS statistical software. Reports, graphs, charts and statistical data were presented to the project team for their review and discussion. This process allowed for feedback on coding mistakes, or changes that needed to be implemented in the data collection protocol. These data, once vetted by the teams, would also be shared with state-level stakeholders, such as the Maryland Early Childhood Mental Health Steering Committee. The project staff worked closely with the evaluator to develop the data incorporated into the final report to the Legislature (Perry, 2005). These data were also included in a PowerPoint presentation to be shared more broadly with statewide audiences at meetings and conferences.

Section 3: Key Questions Checklist

Programs and communities that are planning and investing in early childhood mental health consultation services must ask the right questions to inform decisions to design and implement high quality program evaluation.

What is our process for designing services and an evaluation plan for early childhood mental health consultation?

- ✓ Who are our key stakeholders (e.g. families, funders, program administrators, managers, and providers) and what are their interests?
- ✓ What evaluation strategies are important—process or outcome evaluation, or both?
- ✓ What is our theory of change, and what are our assumptions about what will lead to our desired outcomes?
- ✓ How can we use a logic model to illustrate our plan?

How will these factors influence the tools and measures that we choose?

What is included in our early childhood mental health consultation program description and have we included enough detail to inform design and implementation of the evaluation plan?

- ✓ Who is the target population for early childhood mental health consultation?
- ✓ What is our rationale for focusing on this group, and what are our expectations for outcomes?
- ✓ What services will be delivered and how will they be provided?
- ✓ Who will provide these services and in what administrative, supervisory, or relational context?

How will these factors influence the tools and measures that we choose?

What are the primary evaluation questions, measures, and strategies for collecting and managing data in our early childhood mental health consultant evaluation plan?

- ✓ Have we identified the primary evaluation questions that are important to all key stakeholders, including families?
- ✓ What tools are available to measure our desired outcomes?
- ✓ What is our data collection plan?
- ✓ How will we manage and analyze the data?

How will these factors influence the tools and measures that we choose?

Evaluation Tools: Measuring Process and Outcomes

In order to gauge the impact of ECMHC, an evaluation must be based on the selection of a set of reliable and valid measures. These evaluation tools need to accurately capture (a) essential features of the intervention itself in the form of **process measures**, and (b) key outcomes for children, families, staff, and/or the program itself through **outcome measures**.

All of the selected measures should be **reliable**, that is, they should yield consistent results without much error. The measures should also be **valid**, which means that the measurement instrument should accurately reflect what we believe it is measuring.

For example:

- If we wish to see whether ECMHC is helping to reduce staff stress, we need to select an instrument that accurately gauges the level of stress felt by individual staff members, perhaps through their self-report on an evaluation tool with a number of items. If we have selected a tool which provides a *reliable measure*, staff members should be able to rate their own stress without a lot of error, due for example to unclear questions or directions. If the evaluation tool is a *valid measure*, a staff member who truly experiences more work stress should have a higher score than one who has less work stress.

Cultural Sensitivity: Although the early childhood field has developed reliable and valid measurement tools for some outcomes, most notably changes in child behaviors, there are few measures that have established reliability and validity in other key domains. Additionally, some of the measures that have been used effectively in evaluation studies in some communities may not have cultural relevance for other communities. The Family Empowerment Scale (FES; Koren, DeChillo, & Friesen, 1992) has been successfully used with European American and African American family members. However, researchers working with a group of families living in poverty who did not speak English as a first language found it necessary to eliminate some FES items and replace them with measures of connectedness which were appropriate for that set of families (Frieberg, Homel, & Lamb, in press). Tools or instruments that are identified for the evaluation should have been tested and used with a sample that includes sufficient representatives of the evaluation participant's racial or ethnic group. If comparisons will be made across diverse cultural groups, then it will be necessary to use instruments that can measure constructs across cultures. Finally, researchers should recognize that some participants may find surveys to be intrusive.

Measuring Process

The team of administrators and service providers need to work closely with the evaluator to make sure that the set of measures chosen really addresses the ECMHC intervention as it was conceptualized. Process measures should help to capture the unique design features of the consultation model and describe how it is **being delivered**. They may also help to determine if the services are being **delivered with fidelity** to the conceptual design. One of the greatest challenges in evaluating ECMHC is that, more often than not, there is no manual to follow and consultation services are individualized to the presenting concerns of the child, family and setting. This makes assessing fidelity to the model very difficult. In addition, even in those cases where there may be a more prescribed approach, interventions may change mid-stream for a variety of reasons. Attention must be paid to whether the consultants were able to implement the intervention as it was conceptualized. Changes made to the consultation process and intervention implementation over time should be documented, and linked to the conditions that influenced implementation as well as linked to changes in outcomes.

The set of process tools selected will help describe how ECMHC is being delivered and may help to support fidelity. These process tools might include **measures** of:

- The qualifications and experience of the participating mental health consultants.
- The full array of activities that the consultants engaged in.
- The extent to which the consultant provided a set of services specified in the logic model.
- The numbers and characteristics of children and families served.
- The quality of relationships between staff and mental health consultants.
- The cost of the time and services of the mental health consultants.

Currently, there are few well-established process measurement tools. In many cases, evaluators have designed their own instruments to capture the data they needed to establish that mental health consultants were providing services funded by the grant or contract. Some evaluators have used program records to establish consultant qualifications and service costs. They also worked with administrators and staff to develop reporting forms for the consultants themselves to track their own service activities. Alkon et al. (2003) reported some sample items from a tool they developed to measure mental health consultant activities (Consultant Activity Survey) in their published report. These were completed by the child care directors and teachers and included: (1) observing children; (2) consulting with director; (3) consulting with individual teachers; (4) meeting with individual families; (5) participating in staff meetings; (6) consulting with groups or teams of staff; and (7) modeling appropriate behavior management techniques. Several evaluators have also developed measures of staff satisfaction with consultant services. Bleecker and Sherwood, 2003, used a Child Care Opinion survey with staff to measure their perception of the helpfulness of consultant services.

We have included some **sample tools** that have been developed as process measurement tools as part of this tool kit. Three tools were developed for use in a statewide evaluation in Maryland: Model Description, Qualification and Skills of Mental Health Consultant, and Satisfaction with

ECMH Consultation. The first serves as a template for collecting data from programs about the specific activities included in their model of ECMHC; the second gathers data on the qualifications and skills of the mental health consultants; and the third gathers data from staff about the usefulness, influence, and impact on practice of ECMHC. A fourth tool, adapted from the work of Beth Green and her research team (2004), presents scales that can be used in process evaluations to collect staff reports. Staff provides information on the activities of consultants and data are used to measure the mental health consultants' relationships with family members, staff and programs, and the extent to which ECMHC services are integrated into the everyday program of the early childhood setting. Copies of these four measures are included in Appendix B.

Measuring Outcomes

Of particular interest to administrators, funders, and policymakers is the answer to the question **“Did the ECMHC result in targeted outcomes?”** In order to answer this question, evaluators and program staff need to have clear, mutual understandings about the exact outcomes that are to be tracked. As explained in **Section 3**, services can be offered which are centered on children, families, staff, and/or the program itself. Evaluators have used measurement tools to establish outcomes at each of these four levels.

When making a decision about which instruments to use to determine the impact of the program, evaluators and program collaborators should consider whether or not it is reasonable to expect change in that outcome given the focus, intensity, and duration of the consultation effort.

For example:

- Several evaluations reviewed by Brennan et al (2007) measured parent stress prior to, and after a period of consultation, and did not find significant decreases. However, parents were living under very stressful conditions in low-income neighborhoods, and although they were better able to handle their children's behavior after consultation, they did not have a notable decrease in their overall level of stress, as it was measured.

Another challenge in measuring outcomes can occur when the focus is on child-level outcomes and the ECMHC model is program-focused. The connection between the intervention and the outcomes may be unclear and the measures less direct; vulnerable to the potential impact of other (unmeasured) variables on the outcomes (e.g., training that child care providers made have received outside the ECMHC project). It is also important to find out whether the measures you have selected were sensitive enough to detect change in other similar settings.

For example:

- Evaluators have found that the Early Childhood Environment Scale (ECERS), an instrument to assess the quality of group programs for children of preschool through kindergarten age, 2 1/2 through 5, is often not sensitive to changes that may have resulted in the emotional climate of the classroom as a result of program-focused ECMHC (Brennan, et al. 2007).

Appendix C offers a table of outcome measures that have been used in multiple evaluations of ECMHC. The table indicates the purpose of each of the measurement tools and the target population and/or data source (e.g., caregiver, teacher, parent, trained observer). For each instrument, the tool kit provides the domains that the instrument measures and the number of items used in the measurement. Finally, the table lists the source from which each instrument can be obtained, and whether it is in the public domain for free use or is proprietary. Some of the instruments can be costly in terms of fees for use, salaries for trained observers, and evaluator time spent determining scores. Evaluation teams may also wish to consider keeping track of some easily obtained data which can be very convincing evidence, such as numbers of children expelled from the setting prior to, and after consultation. They may also wish to obtain data on the type and number of linkages that the consultant has made between the early childhood setting and community resources.

Gathering Supplementary Information

In addition to the measurements obtained using the quantitative evaluative tools discussed above which provide indicators in the form of scores or numbers, the program evaluation team may wish to consider gathering other types of data, for example qualitative evidence. Gathering qualitative data involves the collection of non-numerical information by methods that can be quite varied. By recording, transcribing, and analyzing interviews or focus groups with staff members, family members, or consultants, evaluators can obtain important qualitative information. Qualitative data often take the form of personal stories, or case studies that convey the details of an individual's experience with ECMHC. These have often been used successfully as an aid to explaining the results of quantitative process or outcome measures.

IN MARYLAND

Maryland's Evaluation Tools and Measuring Outcomes

In both of the funded pilot sites, the Preschool Kindergarten Behavior Scale (Merrell, 2002) was completed at the time of initial referral from the child care providers and then at discharge. This standardized assessment included data related to:

- Level of social skills (3 domains: Social Cooperation, Social Interaction, and Social Independence)
- Level of problem behaviors (2 domains: externalizing and internalizing)

Specifically, at the time of referral, 71 percent of the children identified in Baltimore City (Early Intervention Project; EIP) and 56 percent of the children identified on the Eastern Shore (Project Right Steps; PRS) were more than 15 points higher than their peers would be on problem behaviors overall. These children were especially high in “externalizing” or acting out behaviors: roughly two-thirds of these preschoolers scored more than 15 points higher than the norm. In Baltimore City, there were also a large percentage of children who had high levels of “internalizing” behaviors at the time of referral—which typically manifest as withdrawal, sadness or anxiety. At intake, children also had lower than expected social skills scores: a little more than half of the children identified in both sites had scores below 85, indicating significant deficits in these school readiness skills.

Outcome Evaluation Tools Included:

Child Outcomes

- *The Preschool Kindergarten Behavior Scale* (Merrell, 2002); for children 3-5 years completed by child care providers in both sites
- *Ages and Stages Questionnaires: Social Emotional* (Squires et al, 2002) for children birth through five years old (for parents; PRS only)
- *Brief Infant Toddler Social Emotional Assessment* (BITSEA; Briggs-Gowan & Carter, 2002) for children aged 12 through 36 months (completed by child care providers, PRS only)

Program and Staff Outcomes

- Locally developed program-classroom level data instrument containing six items ranked on a three-point scale based upon the frequency with which each indicator is observed by the consultant (1=Not often; 2=Sometimes; 3=Often)
- Locally developed Child Care Environments scale across the four domains measured. The 17-item scale documents elements of the daily practices, interpersonal environment, physical environment, and affective environment of the classroom, rating on a four-point scale (0=not observed; 1=rarely; 2=occasionally; 3=frequently), adapted from a self-assessment tool developed and disseminated by the Early Childhood Resource Center at Research Triangle Institute through the *Nurturing the Brain* trainings funded by the Maryland State Department of Education (1998)

This evaluation was designed to focus on changes in child-level outcomes (i.e., expulsion, social skills and problem behavior) based upon child-specific consultation, especially on the Eastern Shore. As the project evolved in Baltimore City there was a shift to a greater reliance on program-focused ECMHC; although they continued to gather data on individual children referred for child-specific consultation. Data on the impact of program-focused consultation were gathered using these “home-grown tools” and complete data on all of the programs and child care staff that participated were not always able to be collected.

Section 4: Key Questions Checklist

When selecting tools to track the process of mental health consultation and to evaluate the effectiveness of this capacity-building strategy, evaluators must consider some crucial questions. They may also wish to consult with program funders, administrators, and staff regarding the options they have for measuring process and outcomes.

Which process measures will truly capture whether or not our consultation program has been delivering the services we intended?

- ✓ Have the established process measures we are adopting been successfully used to track consultation services delivered in similar settings?
- ✓ Do we need to design and test some of our own measures, due to unique features of our program or consultant services?
- ✓ Are the tools we are considering user-friendly; that is will the staff who are providing process data be able to easily understand the measures and complete them?
- ✓ Is the package of process measures realistic in terms of staff time needed to fill them out?

Do the tools actually address the outcomes we intend to produce through the consultation process?

Which outcome measures will successfully gauge the short- and long-term consequences of the program?

- ✓ Is there evidence that the tools have been successfully used in other evaluation studies in early childhood settings?
- ✓ Have the reliability and validity of these measures been established?
- ✓ Are the measures we are considering sensitive enough to detect changes given the duration and intensity of our consultation program?
- ✓ Do we need to adopt measures that have norms for populations similar to ours, so that we can compare our outcomes to the scores of other groups?
- ✓ Are the tools culturally appropriate for the staff, children, and families in our program?
- ✓ Is the package of outcome measures realistic in terms of the staff members' and family members' time required to complete it?

Do the tools actually address the outcomes we intend to produce through the consultation process?

Using the Data: Integrating Evaluation Into Program Improvement and Communicating Outcomes

Program evaluation data can be used at multiple levels for program improvement and communicating outcomes. Depending on the design of the evaluation plan for early childhood mental health consultation, evaluation data can focus on the individual child; the family or caregivers; program staff; the early care and education classroom or program, the mental health consultant themselves; or the community, state or even national impact. Using the evaluation data effectively to inform a variety of stakeholders, including families, in meaningful ways requires forethought, planning, creativity, communication and timing. Crafting the right message, in the right format or product, for the right audience is also a key element.

Integrating Evaluation into Program Improvement

Evaluation data can be powerful as an influence on assessing progress, decision-making, resource allocation, and policy making. In their 2000 study of promising practices in the use of evaluation data at sites funded by the federal Center for Mental Health Services as part of the Comprehensive Community Mental Health Services for Children and Their Families Program, Woodbridge and Huang discovered that effective programs used publication of their service and outcome evaluation data to:

- Plan, fine-tune, and sustain services;
- Support parent involvement and decision making as well as strengthen the family voice;
- Build partnerships and give credence to interagency efforts;
- Market achievements and increase awareness of strengths and needs of the system;
- Boost morale and demonstrate progress of front-line staff and family members;
- Ensure equitability and accountability of service delivery;
- Promote strengths-based service planning and the value of services;
- Encourage the development of sophisticated integrated information systems; and
- Increase federal and state appropriations for similar programs or initiatives.

Kubisch and colleagues (1998) highlight three important components of a successful evaluation: a **political** component; a **practical** component; and a **teaching/learning** component.

- Politically, it is important that funders, stakeholders, and key players know what sort of progress their initiative is making, and whether or not it is “paying off.”
- Practically, good evaluation data are vital to feedback into the system to improve implementation.
- From a teaching/learning perspective, evaluation is vital for researchers and practitioners to discover “what works,” and for that knowledge to be available for improving services and systems for young children and their families. (Perry et al, 2007)

Whatever the context, there are basic tips for using evaluation data that must be considered early in the design of an early childhood mental consultation program.

Tips for Using Evaluation Data

- **Understand the interests of each stakeholder group:** Right from the start, engage in dialogue with stakeholder groups, including families, in order to understand their interests, identify outcome indicators of most value to them, and accountability expectations.
- **Build evaluation into the mental health consultant contracting process:** When engaging a mental health consultant, define the goals of consultation, identify a continuous feedback loop, negotiate an agreement related to evaluation expectations (individual, child, family, program), enlist the consultant’s expertise in identifying and defining outcomes, clarify a process for evaluation and assessing overall effectiveness and performance, and agree upon how the consultant will participate in contributing to and communicating results.
- **Use data regularly to inform practice and program adjustments:** Making evaluation data available at regular and timely intervals and with direct links to current practice and program goals can assist decision making, program improvement, and capacity building.
- **Make evaluation data reports concise, easy to understand, and tailored to the audience:** Use evaluation data to convey messages that can educate, enrich, and persuade stakeholders in the direction of outcomes-based decision making and service and system improvements. Be clear about what the data shows and does not show and interpret the implications clearly.
- **Combine message delivery methods for maximum impact:** A variety of venues and modes of communication can deliver the message of evaluation data. Using articles, reports, graphics, presentations, personal stories, public events, community meetings, open houses, training sessions or combinations of these strategies may be useful.

(Adapted from: Hepburn, 2004.)

Communicating Outcomes

The true test for using and communicating evaluation data comes down to one thing: **Meaningfulness**. Can the public, policy-makers, and other stakeholders, including families and providers, easily understand what the data mean and what the implications are for the child, family, staff, programs, and ultimately the community well-being? (Child Trends & SRI International, 2002; Perry et al, 2007)

Often early childhood mental health consultation programs are in the position of having to justify themselves by defining ECMHC; establishing it as a valuable service; describing the benefits to children, families, programs, and communities; and demonstrating the cost or cost savings associated with its implementation. Communicating evaluation data in meaningful ways often requires data analysis that links these features: benefits, costs or cost savings, and the unknown or inconclusive implications (Karoly et al, 1998). Gilliam (2003) provides an example of calculating cost-benefit (p.10), however when preparing to communicate outcomes to diverse audiences, a more complicated analysis may be required in order to use the data to influence decision making, policy, program planning, and community investments in early childhood mental health consultation (Karoly et al, 1998). Communicating outcomes through families who understand the evaluation process, have had personal benefits, and understand the implications of evaluation data can enhance its meaningfulness. Involving families in reporting evaluation data can also assist in outcomes dissemination and provide a strong voice to advocate for effective services and system change (Hepburn, 2004).

In general, reporting evaluation data has some key guidelines:

1. Be sure that you completely understand what the data are indicating or saying and their meaning.
2. Know ALL of your data: The good, the not so good, and the inconclusive.
3. Consider your audience, their interest, and your purpose.

Evaluation data can then be crafted into a message by blending science, marketing, communications, and graphical skills. The information can convey concrete take-away messages, comprehensible facts, and ideas for promoting early childhood mental health consultation as a valuable service to young children, families, staff, and programs (Woodbridge & Huang, 2000). The content of any evaluation report or descriptive message depends on its purpose and the audience.

Cultural Sensitivity: Researchers can gain greater trust with culturally diverse communities by providing community members with action-oriented feedback. All system stakeholders should have an opportunity to review the data to provide interpretations. The community members should be informed of not only the results, but also the potential actions and programs that could be impacted by the results. Publication in a final report or professional journal should *not* be the primary means of dissemination of culturally based research. Ideally, the results should be published in user-friendly formats accessible to all diverse populations.

Using Evaluation Information for Program Development and Decision Making: Continuous Program Quality Improvement

The most frequent use for evaluation results should be program improvement and development. Evaluation data enable those who are “in the work”—agency board members, administrators, staff, providers, and family members receiving services—to have “real time” information that can impact policy and practice, which in-turn can impact outcomes. Preparing interim, and periodic reports provides ongoing opportunity for reflection, reviewing program performance, making mid-course

corrections, and hopefully, celebrating successes. Meaningful and specific messages about measurable progress and outcomes reinforce program commitment, maintain focus, sustain motivation, and encourage learning and problem solving. For families, having reports about their own child's progress as well as the ECMHC program's outcomes encourages family engagement, feedback, and a "check and balance" to data interpretation and program quality.

IN MARYLAND

Data and Decision Making in Maryland

An evaluator from Georgetown University worked with one of two pilot ECMHC projects in Maryland—Project Right Steps—from the time that they initially hired the consultants through the successful refunding of their program 3-years later. Along the way, the evaluator met regularly with the project team to: review their needs for data; help develop intake forms and a spreadsheet database to aggregate data on child/family characteristics, child behaviors at referral and discharge; periodically analyze the data for program improvement; and prepare summaries of impact data to communicate to state-level funders and policy-makers. Procedures for deciding when a child-specific referral became a "case" that would be tracked over time were developed through use of process data collected by the team; other procedures for how to ensure more post-intervention data were implemented as the ECMH consultants gained insight about the power of these data in communicating with state-level stakeholders.

Using Evaluation Information to Build the Evidence Base: Sharing Lessons Learned

Evidence-Based Practice versus Practice-Based Evidence

The early childhood and mental health communities and families are eager to learn about "what works" in supporting early childhood social, emotional development and managing challenging behaviors. There is increasing pressure on states, communities and programs to adopt so-called evidence-based interventions. The term "evidence based" refers to a specific set of criteria that an intervention has met, including evidence of effectiveness documented in a peer-reviewed journal, based upon a randomized controlled trial, and replicated by a research team that is not the developer of the intervention (Huang et al, 2003). In contrast, there are data generated by field-based practitioners about what is effective in real-world settings termed "practice-based evidence" that is considered less scientifically rigorous. Since most data on the effectiveness of early childhood mental health consultation is just beginning to emerge and the majority of the studies have not been randomized trials, much of this evidence would be classified as practice-based.

In order to build the evidence base for the effectiveness of mental health consultation, research and program evaluation need to address the following gaps in our current knowledge.

- How we define and implement early childhood mental health consultation,

- What we know about what works in early childhood mental health consultation, and
- What is practiced in the field.

Incorporating a quality evaluation plan into early childhood mental health services, including the components described in this tool kit, can move what appear to be innovative strategies and “promising practices” into practice-based evidence. In this way, early childhood mental health consultation can move “from service to science”. Incorporating program evaluation and using evaluation data can build the evidence base for early childhood mental health consultation and provide lessons learned to others in the early childhood and mental health fields.

Research Professionals as Partners

Moving from “service to science” has its challenges. At the community practice or service level, designing and implementing an early childhood mental health consultation program that includes an evaluation plan can be challenging and may require additional resources, including partnerships with universities or professional evaluators. Some feel that far too little attention has been focused on developing research designs, methods, and measures that are valued, respected, and understood by program managers or that “fit” into a community service setting so that programs are increasingly able to naturally incorporate both quantitative and qualitative evaluation strategies into their mental health consultation services and programs (National Research Council and Institute of Medicine, 1999). University faculty or professional evaluators can offer preparation and training as well as technical assistance in evaluation design guidance, recommendations for measures, and forms for data collection. Some may provide data analysis and reporting services, including assistance on interpreting data and crafting meaningful messages for dissemination to identified audiences (Hepburn, 2004). In addition, these partners often have experience and access to publication in professional or field specific journals, national newsletters, or other opportunities and can help community programs share lessons learned and make important contributions to the field and evidence base.

Using Evaluation Information for Investors: Sustaining Your Program

Reporting outcomes to funders who have already invested in an early childhood mental health consultation program may require a comprehensive report. It is likely that funders will be interested in a detailed description of the program, the evaluation design and methods, types of data analyses conducted, and discussion of conclusions and recommendations; especially those relevant to their initial interests and commitments as key stakeholders. The voice and experience of families who have benefited from ECMHC can also be an essential feature of reporting to investors who are ultimately interested in investing in outcomes for children and families. In addition to their vested interest in knowing that their money was well spent, program funders such as federal agencies, state agencies, and foundations are eager to demonstrate the effectiveness of their grant initiatives and potentially make decisions to expand or support similar programs. Funders themselves may need the evaluation and outcome data for a number of “in house” or “interagency” purposes and in a variety of formats. Some funders have their own technical supports, media departments, or publications units. Work with funders to co-create messages and media for your evaluation and outcomes that will meet both your needs.

IN MARYLAND

Data and Funding in Maryland

A state-level interagency working group was interested in promoting and expanding ECMHC services within the state. Building on preliminary positive findings from the evaluation of one project in Anne Arundel County, state policy makers seized an opportunity to fund two additional pilot sites when funding from the Child Care Development Block Grant (quality assurance set-aside) became available. The fiscal/political climate was not ripe for a statewide expansion at that time, nor was there general consensus that sufficient data on the effectiveness of this approach existed, so policy makers mandated an evaluation of the pilot sites. Concurrent with this, advocates were able to get legislation passed that required the evaluation results to be reported to the legislative and executive branches several years later. These findings (Perry, 2005), which confirmed the positive effects of mental health consultation on child and program level outcomes, contributed to the legislature's decision to appropriate \$1.87 million in new funds for ECMHC across the state.

Using Evaluation Information to Increase Public Interest and Understanding: Informing and Advocating

Program evaluation data can also be used to increase public awareness of an early childhood mental health consultation program as well as build awareness and advocate for attention to related issues such as: school readiness young children with behavioral health concerns, early childhood mental health treatment services, family support services, or policy change. These purposes and the relevant potential audiences (policy makers, community members, advocacy groups, etc.) will require a summary of both program implementation and participant outcomes. Collaborating with families in program evaluation builds trust and working relationships that can help promote strategies for informing about and advocating for ECMHC services. The message must include a clear, concise, and understandable, including a discussion of the connection between the program, practices, and outcomes for participants. It may also include potential benefits to the state or community. Depending on the audience, the message may be diverse in length and format, including easy access media such as brochures, flyers, newsletters, posters, newspaper and articles; family friendly communication strategies and use of family portraits or stories; and annual reports that have wide distribution. Build relationships and consider partnering with local media, advocacy organizations, community business groups, collaboratives, and other agencies and groups with related interests.

Conveying Your Message

Conveying your message is where research, evaluation, and social marketing converge. Social marketing is generally defined as the design and implementation of a program that introduces and promotes a social idea or cause. Social marketing brings the critical features of communication and marketing to the field of human services, using marketing techniques to promote healthy communities by encouraging people to change behavior and to make informed decisions. Rather than marketing a “product” to consumers to benefit the “seller”, marketing principles are used to

“sell” ideas, attitudes, and behaviors that benefit the consumer or communities. Social marketing includes addressing a mix of audiences, supportive partners, and policy implications (Weinreich, N., (undated); Substance Abuse and Mental Health Administration, (undated)).

A social marketing effort related to early childhood mental health consultation might include the following elements:

- Audiences of early care and education staff and administrators, families and those who influence their decision making (i.e., physicians, faith based communities, schools); early childhood mental health providers; community leaders; county or state administrators; policy makers; and funders;
- Supportive partners such as local, state-wide, or national groups; community organizations; medical organizations; school readiness efforts; and advocacy groups for children and families; and
- Policy implications related to building the capacity of the mental health services community in early childhood mental health consultation; increasing access to services; negotiating Medicaid or EPSDT coverage for services; and requiring early childhood mental health consultation in licensed early care and education settings.

Planning for social marketing and communications is a process. Preparing and conveying your message may include some of the **partners** listed below for bridging the gap between research and evaluation and those to whom you wish to convey your messages.

- Researchers and evaluators themselves
- Families
- Local program administrators
- The media
- Advocacy and professional organizations
- Foundations
- Interested policy makers
- Public champions

After you understand your data and have crafted your take-away messages, comprehensible facts, and ideas for promoting early childhood mental health consultation, select your communication strategies that will be most suited to your audience, their interest and your purpose. Consider **techniques for designing evaluation reports**, such as those listed below.

- Media
- Titles or headlines (Message, type face, font size)
- Visual aids (Graphic displays, such as graphs, charts, tables, diagrams)
- Photographs (Pictures of children, families, etc.)
- Checklists

Over time and experience, it is also important to evaluate the penetration, impact, and effectiveness of your message, by exploring a short list of **critical questions**.

- Did the intended audience receive the message?
- Is the audience interested in and affected by the message? How do we know?
- Did it achieve our purpose?
- What are the outcomes?

IN MARYLAND

Data and Advocacy in Maryland

Once the evaluator had completed the study for the Maryland legislature, the Maryland Committee for Children—an effective advocacy group for child care issues—posted the report on their website. The evaluator was invited to present the findings to a group of child care providers and this dialogue armed the child care community with a strong understanding of the data on effectiveness. They were able to use this to communicate to their local representatives and community partners.

Selections for Crafting and Conveying Your Message

Who is Your Audience?

- Legislators
- State and County policy makers
- State and County service systems
- National organizations or advocacy groups
- The fields of early childhood and mental health
- Local elected officials
- Local agencies and providers
- Agency board members
- The media
- Funders
- Community members
- Families
- Staff members
- Other _____

What is your Purpose?

- Influence policy
- Public awareness
- Advocacy
- Grant seeking or funding
- Building partnerships and collaboration
- Reporting progress
- Program improvement
- Contributing to the evidence base
- Other _____

What are your Strategies?

- Formal report
- Position paper
- Journal article
- Presentations
- Community meetings
- Training sessions
- Fact sheets
- Newspaper or newsletter
- Sound bite
- Public service announcement
- Posters
- Display
- Scripts
- “Report Card”
- Video
- Family stories
- Narratives
- Snap shot
- Folders
- Letters/mass mailing
- Electronic media: list serves, websites, newsletters
- Word of mouth
- Other _____

Other Considerations

- Cultural diversity
- Linguistic diversity
- Current trends and associated language
- Organizational structure
- Political climate
- Political climate
- Graphics
- Resources
- Distribution
- Other _____

IN MARYLAND

Using the Data in Maryland

In the Maryland pilot projects, the combined, overall findings were very positive and meaningful to the initial stakeholder evaluation questions.

- Nearly 90% of children at risk for expulsion were maintained in their child care placement; in each site, only 2 children were expelled.
- Strong gains were seen in children’s social skills: roughly 75% of all children served in both sites had improved social skills.
- Reductions were seen in the highest rates of problem behaviors: across the two sites, the majority of children presented with extreme levels of behavior problems. At discharge the majority of these children had behavior in the normal range.
- Changes in teachers’ behaviors and improvements in the classroom environment were seen in child care programs that received consultation services.

Communicating Outcomes

Families and Individual Care Decision Making

Through the process of the ECMH consultant working with the child, family and child care provider; some parents discovered that their child might benefit from a different placement. Most of the parents who chose to move their children to a different child care program were motivated by the desire to find a child care environment that would be responsive to the needs of their child (e.g., smaller classes or a more structured program). As a result of the consultation process, these families were able to make these changes in placements in a proactive not a reactive manner, which reduced stress for the parents and the child.

Staff and Programs for Program Development and Improvement

The positive staff- and program-level findings from both sites suggested that one way changes in child-level outcomes might be happening was through changes in teachers’ behaviors and modifications made to the child care environment. These new behaviors and changes to the routine and physical environment occurred in response to suggestions made by the ECMH consultant, after observing the way the classroom was operating. Changes in teachers’ behaviors have a cascading effect, improving the quality of the child care program overall, and yielding positive results for children who were not specifically referred for intervention. But specific tools to measure these “downstream” effects were not in place in the Maryland evaluation.

Building the Evidence Base

In Maryland, policy-makers built upon the initial promising findings from an evaluation of and ECMH consultation project in Anne Arundel county (Perry, et al. in press); they ensured that similar evaluation data would be collected on their “pilot” projects as they expanded funding for two new parts of the state (Perry, 2005). The evaluation results of these three Maryland projects, together with findings from similar projects nationally, suggest that this strategy should remain part of a comprehensive approach to school readiness (Brennan et al, 2005). While there are limitations to the current findings, the data strongly suggest that children gained important social skills, manifest reductions in problem behavior and are maintained in their current child care programs at encouraging rates.

IN MARYLAND

Public Interest, Policy Making, and Funding in Maryland

The evaluation data were used to make the following **recommendations** to state and local planners through the broad dissemination of the report to the Legislature.

- Continue to fund the existing pilot sites and expand access to early childhood mental health consultation efforts statewide.
- Require consultation projects to collect process and outcome data; this will allow policy makers to monitor the extent to which sites are implementing high quality programs and whether they are effective.
- Provide funding for an ongoing evaluation of statewide expansions so that stakeholders have access to data on program effectiveness and outcomes.
- Identify additional sources of state agency flexible funding and expand partnerships with existing efforts to leverage additional funding and support for building capacity to provide a range of early childhood mental health services.
- Continue to expand high-quality training for child care providers in young children’s social emotional development. Include evidence-based strategies for promoting healthy social-emotional development as well as preventing mental health problems and provide support to implement these approaches.
- Expand services to families at-risk for poor outcomes due to domestic violence, substance abuse, and/or maternal depression. Of particular concern are those children who are exposed to these risks and also live in poverty. Young children’s mental health is intimately tied to the well-being of their caregivers and services must be responsive to the needs of the whole family.
- Continue the development of local systems of care for young children and their families concurrent with state-level policy and infrastructure development. Partnerships between local and state-level stakeholders should include a substantive role for families in designing these systems and defining their outcomes.

Policy makers used these data to inform the development of a statewide initiative that resulted in \$1.87 million in new funding to expand ECMHC to 13 ECMHC projects. Based upon the successful model of the pilot sites, policy-makers included a comprehensive evaluation design for the newly funded sites to ensure data will continue to inform the development of this effort. Maryland is one of the leaders in this country in making a long-term commitment to building a system of services and supports for young children and their families. Access to high-quality mental health consultation has become an important component of the state’s comprehensive school-readiness strategy that will allow more children to arrive with the social emotional competence needed to be successful in kindergarten.

Section 5: Key Questions Checklist

Programs and communities that are planning and investing in early childhood mental health consultation services must ask the right questions to inform decisions about how to use and communicate evaluation and outcome data.

What is our plan for using evaluation information for program development, decision making, and quality improvement?

- ✓ What information is most meaningful to our stakeholders, staff, providers, and family members?
- ✓ Which data from our evaluation shows successes and challenges in implementing consultation services?
- ✓ What opportunities exist for review and discussion to improve service delivery, including with families?

What outcome data are most relevant and how can we present it in the most meaningful way to our intended audience?

What is our plan for using evaluation information to build the evidence base?

- ✓ Who are our community partners, such as Universities, funders, etc. that can help to identify the opportunities for publication that will reach our preferred audience?
- ✓ Which data from our evaluation show valuable outcomes to share and inform practice, policy, or further research?
- ✓ How would we assess and describe our level of scientific rigor?
- ✓ How can we gear our effort toward those publications likely to publish our work, including publications that are family focused?

What outcome data are most relevant and how can we present it in the most meaningful way to our intended audience?

What is our plan to use evaluation information to support new fund-raising efforts?

- ✓ Have we identified the primary mission of any funding sources we want to approach?
- ✓ Have we selected the data from our evaluation that show that we are addressing this mission and doing so successfully?
- ✓ How can we use these data and gear our presentation to the funding source's interests and purpose?

What outcome data are most relevant and how can we present it in the most meaningful way to our intended audience?

What is our plan to use evaluation information to inform and advocate related to early childhood mental health consultation?

- ✓ What are the current trends or current concerns that are most meaningful to our program, population, or community?
- ✓ Which data from our evaluation show that we are addressing this issue and doing so successfully?
- ✓ How can we use these data and gear our presentation to those who may have a similar or related interest and influence in areas that influence funding, research, services, and policy?

What outcome data are most relevant and how can we present it in the most meaningful way to our intended audience?

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Glossary

Activities—The processes, tools, events, technology, and actions that are an intentional part of the program implementation (W.K. Kellogg Foundation, 2004).

Assessment—The process of gathering an array of information about a child’s strengths and needs from caregivers, across environments, and using various methods of observation for the purpose of making evaluative or diagnostic decisions. (Kaufmann & Hepburn, 2007).

Capacity building—To improve or increase the ability of early childhood programs to address the social and emotional needs of young children (Cohen & Kaufmann, 2005).

Child/family centered consultation—Early childhood mental health consultation services that address the factors that contribute to a child’s strengths and challenges in the early childhood setting (Cohen & Kaufmann, 2005).

Collaborative relationship—A productive working relationship between a mental health consultant and an early childhood professional which allows them work together to solve problems (Cohen & Kaufmann, 2005).

Confidentiality—Assurance that a person’s identity will not be revealed before, during, or after data collection (Sieber, 1998).

Consultative stance—Consultant “way of being”; ten identified elements: mutuality of endeavor, avoiding the position of expert, wondering instead of knowing, understanding another’s subjective experience, considering all levels of influence, hearing and representing all voices, the centrality of relationships, parallel process as an organizing principle, patience, and holding hope (Johnston & Brinamen, 2006).

Control group—A group of participants who do not receive the intervention, so that their responses can be compared with the intervention group to determine if a change in the intervention group occurred.

Cost benefit study—Evaluates a program’s operating costs in relation to the benefits of the program to determine the cost of the outcomes (Gilliam & Leiter, 2003).

Cultural competence—A set of behaviors, attitudes, and policies within a system, agency or “among professionals that allows them to work in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989).

Direct service intervention—Therapeutic services delivered to a child, family, or staff member in accordance with clinical or professional practice standards.

Early childhood mental health consultation—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, primarily child care center staff or parents with other areas of expertise or knowledge of the child.

Evidence based practice—A body of scientific knowledge about service practices or the impact of clinical treatments of services on the mental health problems of children and adolescents (Hoagwood, Burns, Kiser, Ringelsen, & Schoenwald, 2001).

Focus groups—A research technique that collects information through a group discussion on a topic that is determined by the researcher (Morgan, 1996).

Impact study—A rigorous evaluation study that utilizes a control group to compare outcomes with an intervention group to determine if participation in the intervention was responsible for the observed outcomes (Gilliam & Leiter, 2003).

Informed consent—A process through which a person agrees to participate in a research project based full knowledge of the conditions of the project (Sieber, 1998).

Intervening variables—The identified cause of the problem that is to be addressed by a program or intervention (Chen, 2005).

Intervention group—The group that receives the intervention.

Interview—A data collection technique in which participants are asked a series of open ended questions to gain information about a topic.

Logic model—A systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan, and the changes or results you hope to achieve (W. K. Kellogg Foundation, 2004).

Long term outcome—The specific changes in program participants' behavior, knowledge, skills, status and level of functioning that are achievable within a 4 to 6 year timeframe (W. K. Kellogg Foundation, 2004).

Manualized intervention—An intervention that is implemented according to a specific set of procedures, so that program evaluation can determine the degree to which the intervention impacted the desired outcomes.

Outcomes—The specific changes in program participants’ behavior, knowledge, skills, status and level of functioning. Short-term outcomes should be attainable within 1 to 3 years, while longer-term outcomes should be achievable within a 4 to 6 year timeframe (W. K. Kellogg Foundation, 2004).

Outcome evaluation—Assesses a program’s success in meeting its goals (Chen, 2005).

Outputs—The direct products of program activities and may include types, levels and targets of services to be delivered by the program (W. K. Kellogg Foundation, 2004).

Process Evaluation—Assessment of how the program is implemented (Chen, 2005).

Program consultation—Early childhood mental health consultation that focuses on improving the quality of the early childhood program or agency and assists the program to address challenges that impact more than one child, family, or staff member (Cohen & Kaufmann, 2005).

Promising practices—Interventions that are believed to be effective, but have not been established as an evidence-based practice through randomized control trials.

Resources—The human, financial, organizational, and community resources a program has available to direct toward doing the work. Sometimes this component is referred to as Inputs (W. K. Kellogg Foundation, 2004).

Screening—A brief procedure, often completed universally and at regular intervals using a standardized tool, to identify children who may need further assessment or evaluation for developmental or other concerns, such as social emotional development. (Kaufmann & Hepburn, 2007).

Short term outcome—The specific changes in program participants’ behavior, knowledge, skills, status and level of functioning that are achievable within a 1 to 3 year timeframe (W. K. Kellogg Foundation, 2004).

Social marketing—The use of marketing techniques to promote healthy communities by encouraging people to change behavior and to make informed decisions.

Stakeholder—Those who have an interest in the evaluation.

Survey—A set of questions designed to determine the attitudes, beliefs, and behavior of a population of people.

Theory of Change—What stakeholders believe will lead to the desired outcomes. The theory of change is based on available knowledge and previous research with an evidence base that guides the selection of intervention strategies.

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Logic Model

A Generic Logic Model Illustrating Key Considerations

The logic model presented in this appendix describes the possible resources, activities, theories of change, and outcomes for mental health consultation focused on four levels of intervention: Child, Family, Staff, and Program.

<p>Context of early childhood mental health consultation: Staff report that an increased number of children in early care & education settings experience social and emotional challenges that put them at risk for expulsion from programs. Staff, children, and families need support to address these challenges.</p>			
Resources	Activities	Theory of Change	Outcomes
<ul style="list-style-type: none"> • Funding: To hire, train, support, and supervise qualified mental health consultants; to provide childcare, transportation, and food for parent trainings • Support from local schools (special education services), school districts, mental health programs, and family support programs • Community Partnerships: With early childhood programs who are willing and eager to work with mental health consultants, and with higher education system that educates professionals in early childhood mental health 	<ul style="list-style-type: none"> • Conduct individual child observations and classroom observations • Conduct child mental health screenings • Develop individualized child plans • Design and implement program practices responsive to the identified needs of an individual child • Participate in staff meetings about individual children • Provide individual child case management/case consultation • Refer children for community mental health services • Provide one on one, individual child support • Provide direct therapeutic services or therapeutic play groups 	<p>CHILD LEVEL</p> <ul style="list-style-type: none"> • Children with emotional and behavioral challenges are identified before those behaviors negatively impact their early childhood care & education placement. • 1:1 support allows children with challenging behaviors to practice prosocial skills. • Individual plans assist staff with providing individual services that directly target specific internalizing and externalizing behaviors. • Children referred by a mental health professional to community mental health services are more likely to receive services. 	<p>Short Term</p> <ul style="list-style-type: none"> • Decrease in frequency of problem behaviors (externalizing & internalizing) • Decrease in intensity of problem behaviors • Improved socialization skills • Improved peer relations • Improved communication skills • Improved emotional competence • Improved adaptive skills • Increased social interaction • Increased referrals to early intervention services <p>Long Term</p> <ul style="list-style-type: none"> • Increase access to and availability of community resources for children with challenging behaviors

<p>Context of early childhood mental health consultation: Staff report that an increased number of children in early care & education settings experience social and emotional challenges that put them at risk for expulsion from programs. Staff, children, and families need support to address these challenges.</p>			
Resources	Activities	Theory of Change	Outcomes
<ul style="list-style-type: none"> • Funding: To hire, train, support, and supervise qualified mental health consultants; to provide childcare, transportation, and food for parent trainings • Support from local schools (special education services), school districts, mental health programs, and family support programs • Community Partnerships: With early childhood programs who are willing and eager to work with mental health consultants, and with higher education system that educates professionals in early childhood mental health 	<ul style="list-style-type: none"> • Provide parent training on early childhood mental health topics: behavior management techniques; identifying & accessing mental health resources; promoting positive behaviors & transforming negative behaviors • Refer parents for community mental health services • Conduct home visits • Facilitate communication between staff and families • Provide crisis intervention services for families • Conduct family support groups • Advocate for parents • Support parents in helping child 	<p>FAMILY LEVEL</p> <ul style="list-style-type: none"> • Families who feel supported are more likely to share and communicate with staff. • Parent knowledge of ECMH best practices helps them to address child behaviors more positively. • Parents with knowledge of mental health services are more likely to access those services. 	<p>Short Term</p> <ul style="list-style-type: none"> • Improved communication between parents & staff about children's strengths and needs • Improved parent ability to cope with problem behaviors • Improved parent & child interactions <p>Long Term</p> <ul style="list-style-type: none"> • Decrease in parenting stress

<p>Context of early childhood mental health consultation: Staff report that an increased number of children in early care & education settings experience social and emotional challenges that put them at risk for expulsion from programs. Staff, children, and families need support to address these challenges.</p>			
Resources	Activities	Theory of Change STAFF LEVEL	Outcomes
<ul style="list-style-type: none"> • Funding: To hire, train, support, and supervise qualified mental health consultants; to provide childcare, transportation, and food for parent trainings • Support from local schools (special education services), school districts, mental health programs, and family support programs • Community Partnerships: With early childhood programs who are willing and eager to work with mental health consultants, and with higher education system that educates professionals in early childhood mental health 	<ul style="list-style-type: none"> • Evaluate how well the center or learning environment supports the social & emotional development of children • Model classroom management strategies • Provide staff training on early childhood mental health topics: behavior management techniques; identifying & accessing mental health resources; promoting positive behaviors & transforming negative behaviors; cultural competence • Provide crisis intervention services for staff regarding child behavior • Support staff working with children with challenging behaviors and their families • Support staff capacity building • Participate in staff meetings • Provide staff support groups 	<ul style="list-style-type: none"> • Teachers who are knowledgeable of classroom management strategies feel competent and able to address problem behaviors. • When staff understand why children experience challenging behaviors, then they are more sensitive, less harsh, and they have more positive interactions with children. • When staff understand children's behaviors, they are less blaming of parents and they feel more competent to communicate with them. 	<p>Short Term</p> <ul style="list-style-type: none"> • Increased staff self-efficacy • Increased teacher competency • Increased recognition of meaning of child behavior • Increased teacher sensitivity • Decreased teacher harshness, detachment, permissiveness • Improved staff interactions with children • Improved quality of teacher/parent relationships • Improved management of disruptive behavior • Promoted more parent involvement • Increased teacher confidence • Improved communication between parents & staff about children's strengths and needs <p>Long Term</p> <ul style="list-style-type: none"> • High job satisfaction • Decreased staff stress • Reduced staff burn-out

<p>Context of early childhood mental health consultation: Staff report that an increased number of children in early care & education settings experience social and emotional challenges that put them at risk for expulsion from programs. Staff, children, and families need support to address these challenges.</p>			
Resources	Activities	Theory of Change PROGRAM LEVEL	Outcomes
<ul style="list-style-type: none"> • Funding: To hire, train, support, and supervise qualified mental health consultants; to provide childcare, transportation, and food for parent trainings • Support from local schools (special education services), school districts, mental health programs, and family support programs • Community Partnerships: With early childhood programs who are willing and eager to work with mental health consultants, and with higher education system that educates professionals in early childhood mental health 	<ul style="list-style-type: none"> • Provide mental health perspective in program planning & improvement • Identify and address program needs related to mental health policies and procedures • Assist program with setting goals for implementing mental health practices • Support early childhood programs to integrate mental health best practices into their program activities • Promote team building & program-wide staff wellness • Consult with the director 	<ul style="list-style-type: none"> • When staff feel that they are part of a team, they work together, communicate, and problem solve more effectively. • When staff are knowledgeable of program mental health policies, they are more likely to utilize strategies that promote positive social and emotional development. • Staff with knowledge of mental health best practices utilize classroom strategies that decrease challenging behaviors, decrease child expulsion, and increase attendance. 	<p>Short Term</p> <ul style="list-style-type: none"> • Increased center communication • Increased staff teamwork • Increase in positive classroom environment <p>Long Term</p> <ul style="list-style-type: none"> • Decrease staff turnover • Improved center quality • Decreased child suspension & expulsion • Increase in program wide attendance rates

Instruments—Sample Process Measures

Tools Designed for Describing and Evaluating Dimensions of Early Childhood Mental Health Consultation Model Design, Implementation, and Fidelity

The instruments presented in this appendix include four sample measures:

- Model Description
- Qualifications and Skills of Mental Health Consultant
- Satisfaction with ECMH Consultation
- Early Childhood Mental Health Consultation Staff/Provider Survey

These samples represent instruments designed by the authors for research and evaluation studies of early childhood mental health consultation programs. They are designed to capture the unique features of the ECMHC model and describe how the ECMHC services are being delivered. They may also help to support fidelity to the ECMHC services model.

Tool Kit readers may use these instruments with permission by meeting the requirement that proper credit be given using the citation indicated with each sample measure.

Model Description

This questionnaire is designed to capture the unique features of the mental health consultation model you have developed. Please answer each question as fully as possible.

General Information

1. Name of grantee for the program: _____

Number of mental health consultants available: _____ (full-time equivalents)

Program Profile:

2. Please indicate whether or not the mental health consultant provides the following activities.

<input type="checkbox"/>	a) Observes all children in a child care program
<input type="checkbox"/>	b) Observes children selected by the caregivers because of concerns
<input type="checkbox"/>	c) Observes overall quality indicators (e.g., room arrangement, transitions, classrooms schedules, rules, etc.)
	d) Discusses observations with: Check all that apply: <input type="checkbox"/> Caregivers <input type="checkbox"/> Administrators <input type="checkbox"/> Families
<input type="checkbox"/>	e) Conducts social and emotional screenings for individual children
	f) Develops an intervention plan: Check all that apply. <input type="checkbox"/> Alone <input type="checkbox"/> With caregivers <input type="checkbox"/> With administrators <input type="checkbox"/> With families
<input type="checkbox"/>	g) Develops a written intervention plan
<input type="checkbox"/>	h) Conducts home visits
<input type="checkbox"/>	i) Models interventions for the caregiver
<input type="checkbox"/>	j) Models interventions for the family
<input type="checkbox"/>	k) Evaluates and modifies intervention strategies implemented by care givers
<input type="checkbox"/>	l) Evaluates and modifies intervention strategies implemented by families
<input type="checkbox"/>	m) Uses an evidence-based practice(s) with children If YES, please specify _____
<input type="checkbox"/>	n) Conducts parent groups
<input type="checkbox"/>	o) Provides training to families
<input type="checkbox"/>	p) Conducts play therapy
<input type="checkbox"/>	q) Meets regularly with caregivers to reflect on their practices

<input type="checkbox"/>	r) Helps staff understand cultural differences and preferences
<input type="checkbox"/>	s) Provides training to staff? If YES, how frequently? _____
<input type="checkbox"/>	t) Provides brief counseling to staff
<input type="checkbox"/>	u) Works with staff to develop a crisis-response plan
<input type="checkbox"/>	v) Refers to community resources
<input type="checkbox"/>	w) Works as part of a resource team (with early intervention, physical or occupational therapists, etc.)
<input type="checkbox"/>	x) Attends child care staff meetings
<input type="checkbox"/>	y) Other _____
<input type="checkbox"/>	z) Other _____

3. Please define your geographic target area (counties, zip codes, etc):

4. What ages are the children served? *Check all that apply.*

- < 1 year old
- 1-3 years old
- 4-6 years old
- > 6 years old
- Other ages, please specify _____

5. What ages are the children referred? *Check all that apply.*

- < 1 year old
- 1-3 years old
- 4-6 years old
- > 6 years old
- Other ages, please specify _____

6. Do you consult to family childcare?

- YES NO

7. Does your consultant(s) meet individually with families?

- YES NO

8. Does your consultant receive clinical supervision from someone with mental health expertise?
 YES NO

8a. If YES, from whom? _____

9. Is your mental health consultation model: *You may check both.*

Child-focused

OR

Program-focused

10. On average, how long do consultants work with a particular child?

< 3 months

3 - 6 months

6 - 12 months

> 1 year

11. On average, how long do consultants work with a particular child care program?

< 3 months

3 - 6 months

6 - 12 months

> 1 year

12. On average, how many hours of on-site consultation are provided to an individual child?

< 5 hours

5 - 10 hours

10 - 15 hours

15 - 20 hours

> 20 hours

Other, please specify _____

13. On average, how many hours of on-site consultation are provided to a child care provider/program?

< 5 hours

5 - 10 hours

10 - 15 hours

15 - 20 hours

> 20 hours

Other, please specify _____

14. How do mental health consultants establish their relationships with individual child care providers and families?

15. How do mental health consultants communicate their roles and expectations to the child care providers and families?

16. On average, how much time does a consultant spend meeting with **program administrators** per **month**?

- < 5 hours
- 5 - 10 hours
- 10 - 15 hours
- 15 - 20 hours
- > 20 hours
- Other, please specify _____

17. On average, how frequently does a consultant meet with an individual **family** in a **month**?

- < 5 hours
- 5 - 10 hours
- 10 - 15 hours
- 15 - 20 hours
- > 20 hours
- Other, please specify _____

Required Citation:

Hepburn, K. S., Kaufmann, R. K., Perry, D. F., Allen, M. D., Brennan, E. M., & Green, B. L. (2007). *Early childhood mental health consultation: An evaluation tool kit*. Washington, DC: Georgetown University, Technical Assistance Center for Children’s Mental Health; Johns Hopkins University, Women’s and Children’s Health Policy Center; and Portland State University, Research and Training Center on Family Support and Children’s Mental Health.

Qualifications and Skills of Mental Health Consultant

Please answer each question fully by checking the relevant answer or filling in the blank space.

Education and Experience

1. What degree(s) do you have? *Check all that apply.*

- AA MSW Other _____
 BA or BS LCSW
 MA or MS PhD or equivalent

2. Are you licensed mental health provider?

- YES NO

3. Are you a certified or licensed early childhood educator?

- YES NO

4. Do you have training in early childhood development?

- YES NO

5. Do you have a degree in mental health?

- YES NO

5a. If YES, please specify: *Check all that apply.*

- Social work
 Psychology
 Counseling
 Psychiatric nursing
 Marriage and family therapy
 Other, specify: _____

6. Do you have training in early childhood or infant mental health?

- YES NO

7. Are you a behavior specialist?

- YES NO

8. Are you a special education teacher?

- YES NO

9. How many years experience do you have in mental health consulting?

- < 1 year
- 1-3 years
- 4-6 years
- 7-9 years,
- Over 10 years

10. How many years of experience do you have in delivering mental health services to young children?

- < 1 year
- 1-3 years
- 4-6 years
- 7-9 years,
- Over 10 years

11. How many years experience do you have as an early childhood educator?

- < 1 year
- 1-3 years
- 4-6 years
- 7-9 years,
- Over 10 years

12. If your experience is not addressed above, briefly list relevant experience.

13. What is your philosophy, orientation, or framework for providing mental health services?

Knowledge and Skills

Please indicate the whether or not you have knowledge or skills in the following areas:

Check all that apply.

<input type="checkbox"/>	1. Knowledge of typical early childhood development
<input type="checkbox"/>	2. Knowledge of atypical development in children birth through five
<input type="checkbox"/>	3. Knowledge of social and emotional development in children birth through five
<input type="checkbox"/>	4. Knowledge of psychopathology in children birth through five
<input type="checkbox"/>	5. Knowledge of family systems
<input type="checkbox"/>	6. Knowledge of early intervention systems (Part C and pre-school special education)
<input type="checkbox"/>	7. Ability to integrate mental health activities into group care
<input type="checkbox"/>	8. Experience in consulting with caregivers
<input type="checkbox"/>	9. Experience in consulting with families
<input type="checkbox"/>	10. Good communication skills
<input type="checkbox"/>	11. Understanding of diverse cultures
<input type="checkbox"/>	12. Skill in developing individualized intervention plans
<input type="checkbox"/>	13. Experience in evaluating intervention effectiveness
<input type="checkbox"/>	14. Experience observing children in classroom settings
<input type="checkbox"/>	15. Experience in administering and scoring screening/assessment instruments
<input type="checkbox"/>	16. Experience working with children with challenging behavior
<input type="checkbox"/>	17. Knowledge of adult learning principles
<input type="checkbox"/>	18. Knowledge of community resources
<input type="checkbox"/>	19. Ability to facilitate team meetings
<input type="checkbox"/>	20. Experience working with child care program administrators
<input type="checkbox"/>	21. Knowledge of diverse mental health treatment approaches
<input type="checkbox"/>	22. Knowledge of the adult mental health/substance abuse system
<input type="checkbox"/>	23. Experience in working with children in foster care
<input type="checkbox"/>	24. Ability to manage the behavior of children in groups
<input type="checkbox"/>	25. Ability to collaborate with teachers and childcare providers
<input type="checkbox"/>	26. Experience providing training to adults
<input type="checkbox"/>	27. Experience in providing clinical supervision
<input type="checkbox"/>	28. Experience in providing direct therapy to children under 6
<input type="checkbox"/>	29. Specialized expertise such as separation and loss, maternal depression, adolescent mothers, abuse and neglect, failure-to-thrive, trauma, sexual abuse, etc.
<input type="checkbox"/>	30. Mental health prevention and promotion, and a “wellness approach” including integration of social-emotional development supports into early care and education (including curriculum)
<input type="checkbox"/>	31. Crisis intervention skills
<input type="checkbox"/>	32. Resource referral and case management skills to facilitate systems and services access
<input type="checkbox"/>	33. Openness to learning from children, staff, and families
<input type="checkbox"/>	34. Language skills to match the community diversity

Required Citation:

Hepburn, K. S., Kaufmann, R. K., Perry, D. F., Allen, M. D., Brennan, E. M., & Green, B. L. (2007). *Early childhood mental health consultation: An evaluation tool kit*. Washington, DC: Georgetown University, Technical Assistance Center for Children’s Mental Health; Johns Hopkins University, Women’s and Children’s Health Policy Center; and Portland State University, Research and Training Center on Family Support and Children’s Mental Health.

Satisfaction with ECMH Consultation

Overall level of satisfaction with consultation services

1. In your meetings with the consultant, to what degree has the consultant helped you accomplish your goals for consultation?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

2. How would you rate your relationship with the consultant?

Very poor	Poor	Positive	Very positive
1	2	3	4

Please answer the following questions only if the consultant was involved in discussion about a particular child.

3. Did the consultation increase your understanding of the child's experience and feelings?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

4. Do you feel better able to handle this child's behavior?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

5. Did consultation help you maintain this child in your program?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

6. Did the consultation help you in your relationship with this child's family?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

7. What benefits have you experienced from direct consultation? Check all that apply.

- Helped me understand child's history and its effect on current behavior
- Helped me understand this child's family situation
- Helped by relieving some of the pressure on me to respond to the family's needs
- Helped by finding services that the child and family needed

8. To what degree are you able to take what you learned from the consultant and apply it to other children?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

Please answer the following questions if the consultant was involved with you in thinking about your program.

9. Did the consultant offer useful ideas about children’s development and behavior?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

10. Has consultation influenced your thinking about program planning for children?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

11. Did the consultant help you think about the ways that staff relationships influence your program and the children?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

As someone who has used Early Childhood Mental Health Services:

12. Do you think that consultation such as you’ve received is useful to providers like yourself?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

13. Would you recommend Early Childhood Mental Health Services to others who needed help with similar concerns?

YES NO

13a. If NO, why?

14. Had you received consultation services before you used the services of the Early Childhood Mental health Services consultants?

YES NO

14a. If YES, to what degree did the consultation services help you?

Not at all	Somewhat	Moderately	Substantially
1	2	3	4

Required Citation:

Hepburn, K. S., Kaufmann, R. K., Perry, D. F., Allen, M. D., Brennan, E. M., & Green, B. L. (2007). *Early childhood mental health consultation: An evaluation tool kit*. Washington, DC: Georgetown University, Technical Assistance Center for Children’s Mental Health; Johns Hopkins University, Women’s and Children’s Health Policy Center; and Portland State University, Research and Training Center on Family Support and Children’s Mental Health.

Early Childhood Mental Health Consultation Staff/Provider Survey*

INSTRUCTIONS: The following questions ask about the work that you are doing with an early childhood mental health consultant (MHC). The first set of questions asks about how often the MHC engages in a variety of activities. The next set of questions ask about how the MHC goes about his/her work, how s/he interacts with the program, families, and with program staff. The final set of questions asks about how effective the mental health consultation services are. **If you work with more than one consultant, please think about their overall characteristics and how the consultants, on average, work with you and your program.**

Instructions: Please indicate the frequency with which your mental health consultant(s) engaged in each of the following activities during the past year . If you work with more than one MHC, think about what they do overall, in general.		Rarely or Never	1–2 Times	Every other Month	Monthly	Weekly or More
1.	The MHC(s) conducted group (classroom) screenings and observation.	1	2	3	4	5
2.	The MHC(s) conducted individual screenings of children.	1	2	3	4	5
3.	The MHC(s) conducted more in-depth assessments of children after they have been screened.	1	2	3	4	5
4.	The MHC(s) developed service plans for children with special needs (e.g., IEPs).	1	2	3	4	5
5.	The MHC(s) made referrals for children or families to community services.	1	2	3	4	5
6.	The MHC(s) attended management team meetings.	1	2	3	4	5
7.	The MHC(s) met with staff teams to discuss specific children or families.	1	2	3	4	5
8.	The MHC(s) provided direct therapeutic/counseling service to families and children.	1	2	3	4	5
9.	The MHC(s) provided formal training to teachers.	1	2	3	4	5
10.	The MHC(s) talked and met with parents.	1	2	3	4	5
11.	The MHC(s) provided support to staff for their own well-being.	1	2	3	4	5
12.	The MHC provided informal training and assistance to teachers or other staff	1	2	3	4	5
13.	The MHC(s) met with staff teams to talk about general classroom or other issues	1	2	3	4	5

Instructions: Please answer these questions by circling 1 if you <i>strongly agree</i> with the statement, 2 if you <i>somewhat agree</i> with the statement, 3 if you <i>somewhat disagree</i> with the statement, and 4 if you <i>strongly disagree</i> with the statement. If you work with more than one MHC, think about what they do, overall, in general. Answer these questions to the best of your knowledge.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
14.	I have a good relationship with the MHC(s).	1	2	3	4
15.	The MHC(s) works as a partner with me to meet children’s MH needs.	1	2	3	4
16.	The MHC(s) seems like another member of the staff, not like an outsider.	1	2	3	4

Appendix B: Instruments—Sample Process Measures

17.	The MHC(s) has good relationships with parents.	1	2	3	4
18.	The MHC(s) works closely with parents to define services to meet children's needs.	1	2	3	4
19.	I regularly go to the MHC(s) when I need help with particular children or families.	1	2	3	4
20.	The MHC(s) is able to work effectively with non-English speaking families.	1	2	3	4
21.	The MHC(s) respects staff's knowledge and perspectives on children's issues.	1	2	3	4
22.	The MHC(s) is "part of the team" trying to help families.	1	2	3	4
23.	Parents trust the MHC(s).	1	2	3	4
24.	The MHC(s) is available when I need him/her.	1	2	3	4
25.	When talking with families about their children, the MHC (s) demonstrates an awareness of each family's unique cultural characteristics and preferences.	1	2	3	4

Instructions: Please answer these questions by circling 1 if you <i>strongly agree</i> with the statement, 2 if you <i>somewhat agree</i> with the statement, 3 if you <i>somewhat disagree</i> with the statement, and 4 if you <i>strongly disagree</i> with the statement.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
26.	Our program's mental health consultation services have improved the quality of our classroom environments.	1	2	3	4
27.	Our mental health consultation services help children with challenging behaviors.	1	2	3	4
28.	Our mental health consultation services help families know how to cope with children's challenging behaviors.	1	2	3	4
29.	Our mental health consultation services help staff to feel less stress.	1	2	3	4
30.	Our mental health consultation services and approach are in need of improvement.	1	2	3	4

31. What does your mental health consultant do that is most helpful for children and families?

32. What suggestions do you have to improve the quality of mental health consultation that your program currently receives?

Required Citation:

Adapted from the *Mental Health Services Survey*, Green, B. L., Everhart, M., Gordon, L., & Garcia-Gettman, M. (2006). Characteristics of effective mental health consultation in early childhood settings: Multi-level analysis of a national ey. *Topics in Early Childhood Special Education* (26:3), 142-152.

*Used with permission.

Instruments—Outcome Measures

Tools Previously Used for Evaluating Dimensions of Early Childhood Mental Health Consultation Outcomes

The instruments presented in this table include three sets of measures: (a) child outcomes, (b) family outcomes, and (c) staff and program outcomes. The selected measures have been used by multiple researchers or evaluators in studies of early childhood mental health consultation programs. The table provides information on the source of the measures, their purpose and target populations, who completes the instruments, the domains they measure, how each can be obtained, and whether the instruments can be used free of charge or purchased.

Child Outcomes						
Acronym & Name of Tool	Author & Date	Purpose	Target Population/ Data Source	Domains/Number of Items	Access to Instrument: Public Domain or Proprietary	
ASQ Ages and Stages Questionnaire: Social Emotional	Squires, Bricker, & Twombly (2002).	Screening and Assessing ECMH	Birth – 5 8 forms for different ages/Parents and early childhood staff	Self regulation Compliance Communication Adaptive functioning Autonomy Affect Interaction with People (From 19-33 items)	Proprietary Available from Brookes Publishing Company, PO Box 10624, Baltimore, MD, 1-800-638-3775 or online at: www.brookespublishing.com	
BASC-2 Behavior Assessment System for Children	Reynolds & Kamphaus (2002).	Assessing ECMH	Ages 2–6.5, 6–11, 12–18, Normed for both English and Spanish-speaking children/Parent, caregiver; teacher other informed observer	Hyperactivity Aggression Anxiety Depression Somatization Atypicality Withdrawal Attention problems Adaptability Social Skills (Total of 100-139 items)	Proprietary See website for information and description www.pearsonassessments.com	
BITSEA Brief Infant Toddler Social Emotional Assessment	Briggs-Gowan, Carter, & Jones (2004).	Assessing ECMH	Infants & toddlers (age 1–3 years)/ Parent or caregiver	Problem Score Competence Score (42 items)	Public Domain Free but need to request permission of author. Available from the author by e-mail (TSEA@yale.edu) or telephone (203-764-9093)	
CBCL/1 1/2 – 5/LDS Child Behavior Checklist/1 1/2 – 5 with Language Development Survey	Achenbach & Rescorla (2000).	Assessing ECMH and Language Development	Children 1 1/2–5, available in Spanish language/Parent	Internalizing problems Externalizing problems Total problems (99 items) Language Development	Proprietary www.aseba.org	

Child Outcomes						
Acronym & Name of Tool	Author & Date	Purpose	Target Population/ Data Source	Domains/Number of Items	Access to Instrument: Public Domain or Proprietary	
C-TRF Child Behavior Checklist/1 1/2 – 5/Caregiver-Teacher Report Form	Achenbach & Rescorla (2000).	Assessing ECMH	Children 1 1/2 – 5/Caregiver or teacher	Internalizing problems Externalizing problems Total problems (99 items)	Proprietary www.aseba.org	
DECA / DECA-C Devereux Early Childhood Assessment DECA-C	LeBuffe & Naglieri (1999).	Assessing Child MH Clinical	2–5 year olds/ Caregiver	Initiative Self Control Attachment (37 items) Adds items, total 62	Proprietary www.devereux.org Order from: Kaplan (search keyword: DECA) Phone: 800-334-2014 Fax: 800-452-7526 e-mail: Info@Kaplanco.com	
PKBS Preschool and Kindergarten Behavior Scales	Merrell (2002).	Assessing ECMH	Children 3–5/ Parent or other informed adult	Social Skills — 3 subscales (34 items) Problem Behaviors — Internalizing and Externalizing (42 items)	Proprietary To order: www.proedinc.com PRO-ED 8700 Shoal Creek Boulevard Austin, Texas 78757-6869 Tel: (800) 897-3202 Fax: (800) 451-8542	
SSRS Social Skills Rating Scales	Gresham & Elliott (1990).	Assessing ECMH	Pre-K – age 18/ Parent, teacher and self reports for older children	Social Skills and Problem Behaviors subscales (55 items)	Proprietary www.pearsonassessments.com	

Child Outcomes						
Acronym & Name of Tool	Author & Date	Purpose	Target Population/ Data Source	Domains/Number of Items	Access to Instrument: Public Domain or Proprietary	
VINELAND-II Vineland Adaptive Behavior Scales 2nd Edition	Sparrow, Balla, & Cicchetti (1985).	Assessing social and personal skills	Birth – adulthood/ Parent/Caregiver or teacher	Communication Daily Living Skills Socialization Motor Skills Maladaptive Behavior (Total for classroom: 244 items).	Proprietary www.pearsonassessments.com	
VINELAND SEEC Vineland Social-Emotional Early Childhood Scales	Sparrow, Balla, & Cicchetti (1998).	Assessing social-emotional skills in EC	Birth – 6/Parent interviews	Interpersonal Relationships Play & Leisure Coping Skills (15-25 minutes)	Proprietary (Test Users should have a PhD) www.pearsonassessments.com American Guidance Service (AGS), Inc. 4201 Woodland Road Circle Pines, MN 55014-1796, USA Phone: 1-800-328-2560 Product #3601 (Manual); #3602 (Record Form and Profile Booklet)	
Family Outcomes and Context						
CES-D (also called CESD-R) Center for Epidemiologic Studies of Depression Scale	Radloff (1977).	Depression screening tool	Parents/caregivers	Depression (20 items)	Public Domain Available as a free Windows application download at www.chcr.brown.edu/pcoc/cesdscale.pdf	
FES Family Empowerment Scale	Koren, DeChillo, & Friesen (1992).	Parent self report of empowerment	Parents of children with MH challenges	Family Service System Community/Political (34 items)	Public Domain Available from the Research and Training Center on Family Support and Children's Mental Health. Contact staff at rtcpubs@pdx.edu or 503-725-4175 for an official permission letter.	

Family Outcomes and Context

Acronym & Name of Tool	Author & Date	Purpose	Target Population/ Data Source	Domains/Number of Items	Access to Instrument: Public Domain or Proprietary
FSS Family Support Scale	Dunst, Trivette, & Deal (1994).	Parent self report of social support	Parents of children with disabilities	Sources, helpfulness of support (18 items)	Public Domain Available in Dunst, Jenkins, & Trivette. (1994). <i>Journal of Individual, Family, and Community Wellness</i> , 1(4), 45-52. May be reproduced.
FSSS Family Satisfaction with Services Scale	Field, Posch, & Mackrain (2003).	Parent self report on MH services	Parents of young children receiving ECMHC services	Satisfaction with Mental Health Services	Public Domain Email first author from Wayne State University, Detroit, MI: Sharon Field, sharon.field@wayne.edu
HSQ Home Screening Questionnaire	Frankenburg & Coons (1986).	Parent self report of home environment	Parents of young children 0–6	Parenting practices, characteristics of home environment (50 items, 2 versions [0–3, 3–6])	Proprietary www.denverfii.com
NSCS Nurturing Skills Competency Scale	Bavolek (2007).	Assesses knowledge and utilization of Nurturing Parenting practices and changes in family life Used in pre-test and post-test assessment	Nurturing Parenting Program participants (Formerly Parents As Teachers Program)	Knowledge of Nurturing Parenting- knowledge of practices and strategies Utilization of Nurturing Parenting—use of skills and strategies from program's lessons (40 items)	Proprietary Family Development Resources www.nurturingparenting.com
Parental Attitudes Toward Childrearing Scale	Touliatos, Perlmutter, & Straus (1990).	Self report parents' attitudes and beliefs	Parents	Parent attitudes toward childrearing (51 items)	Public Domain Published in v. 3 of "Handbook of Family Measurement Techniques" go to www.sagepub.com (Sage Publications) and search by book title.

Family Outcomes and Context						
Acronym & Name of Tool	Author & Date	Purpose	Target Population/ Data Source	Domains/Number of Items	Access to Instrument: Public Domain or Proprietary	
PS Parenting Scale	Arnold, O'Leary, Wolff, & Acker (1993).	Self report scale on parenting discipline practices	Parents	Laxness Over-reactivity Verbosity (30 items)	Public Domain Scale can be obtained by sending the author a self-addressed stamped envelope to: Susan G. O'Leary at Department of Psychology, SUNY at Stony Brook, Stony Brook, NY 11794-2500. She may also be contacted at: susan.oleary@stonybrook.edu	
PSI-SF Parenting Stress Index	Abidin (1995).	Parent self-report of parenting stress	Parents of children from 3 months to 10 years old	Parental Distress Difficult Child Characteristics Dysfunctional Parent-Child Interaction (36 items)	Proprietary www3.parinc.com	
Staff and Program Outcomes						
CC Case-Centered Consultation	Johns & Rassen, 2003	Caregiver interaction scale Used in San Francisco evaluation	Child care provider rated by an outside observer	Quality of interactions (19 items) Caregiver-parent relationship (3 items)	Public Domain Scale itself can be found in an online PDF from Jewish Family and Children's Services at http://www.jfcs.org/Services/Children,_Youth,_and_Families/Parents_Place_Early_Childhood_Mental_Health_Consultation/ChildCareCenterConsultationinAction.pdf	
CCQC Child Care Quality Checklist	Johns & Rassen, 2003	Child Care Quality Used in San Francisco evaluation	Child care programs rated by an outside observer	Physical Space Materials & equipment Children (affect & interaction) Caregivers (affect & interaction) Group size & adult/child ratios (30 items)	Public Domain Checklist itself can be found in an online PDF from Jewish Family and Children's Services at http://www.jfcs.org/Services/Children,_Youth,_and_Families/Parents_Place_Early_Childhood_Mental_Health_Consultation/ChildCareCenterConsultationinAction.pdf	

Staff and Program Outcomes

Acronym & Name of Tool	Author & Date	Purpose	Target Population/ Data Source	Domains/Number of Items	Access to Instrument: Public Domain or Proprietary
CIS Arnett Global Rating Scale of Caregiver Behavior	Arnett (1999).	Caregiver interaction scale	Child care provider rated by an outside observer	Positive Interaction Punitiveness Detachment Permissiveness (30 items)	Private but Available Order free of charge from www.fpg.unc.edu/~smartstart/tools.cfm Smart Start Evaluation Team Frank Porter Graham Child Development Institute 105 Smith Level Rd. UNC-CH CB# 8180 Chapel Hill, NC 27599-8180 Phone: 919.966.4295 Fax: 919.966.7532 Email: smartstart@unc.edu
ECERS-R Early Childhood Environment Rating Scale, Revised Edition	Harms, Clifford, & Cryer (2002).	Child Care quality	Child care programs rated by a trained outside observer	Space and Furnishings Personal Care Routines Language-Reasoning Activities Interactions Program Structure Parents and Staff (43 items)	Proprietary ECERS-R and other versions can be ordered through Teacher's College Press. http://www.tpress.com scoring sheets may be reproduced from the original in the scale. ECERS, ITERS, FDCRS, versions available for different care environments
TOS-R Teacher Opinion Survey	Geller & Lynch (1999).	Self-reported attitudes and beliefs	Child care providers and/or preschool teachers	Skills at managing difficult behavior Sense of hopefulness about role as teacher (12 items)	Proprietary Email or contact first author: Susan Geller Wingspan, LLC 4196-A Innslake Dr. Glen Allen, Virginia 23060 (804) 967-9002 telephone (804) 967-9003 fax contact@wingspanworks.com
WES Work Environment Scale	Moos (1994).	Ratings of quality of the work environment	Center-based child care providers	Morale, equity in salaries/promotions, responsiveness (20 items)	Proprietary www.cpp.com

Measurement Tools Reference List

- Abidin, R. R. (1995). *Parenting Stress Index*. (3rd ed.). Odessa, FL: Psychological Assessment Resources, Inc.
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Resources

Books and Print

Mental Health Consultation in Child Care: Transforming Relationships Among Directors, Staff, and Families

(2006) JOHNSTON, K. & BRINAMEN, C.

This book addresses the impact of the caregiver-child relationship on the mental health of young children. The authors review current theory and offer practical suggestions for improving relationships between program directors, staff, parents, children, and mental-health consultants to help identify and remove obstacles to quality care. The text describes principles and practices related to mental health consultation and clearly illustrates the consultative stance. It also offers real-life examples of effective programmatic functioning, the importance of the working relationships between adults involved in the young child's daily care, and direct child interventions. Mental health professionals at all levels, early childhood educators and trainers, and policy makers will find this book useful guide to making positive changes in the childcare environment.

ZERO TO THREE PRESS, 2000 M St. NW, Suite 200, Washington DC 20036-3307. 202-638-1144 or at www.zerotothree.org Price: \$39.95

Mental Health Consultation in Early Childhood

(2000) DONAHUE, P., FALK, B., & PROVET, A.G.

This book provides a framework for enhancing the quality of early childhood programs by using mental health consultation to help center-based program staff and families. It describes how to use clinical mental health perspectives and skills in the service of promoting health emotional development in all young children, including those who are exhibiting emotional or behavioral difficulties. It describes the consultation process, highlights the importance of mutually respectful relationships and collaboration between the consultant, administrators, and teachers. The text focuses on the collaborative process and center-based interventions with young children and families. The book is targeted to practitioners, and is useful to those trying to conceptualize and/or implement early childhood mental health consultation.

Paul H. Brooks Publishing. Available via www.amazon.com

Social & Emotional Health in Early Childhood: Building Bridges Between Services & Systems

(2007) PERRY, D., KAUFMANN, R., AND KNITZER, J. (EDS.)

This book provides a guide to systems development focused on how to improve young children's outcomes by building sturdy bridges between mental health and medical, educational, and social services. It combines the research and guidance of experts in early childhood and mental health and describes strategies for promoting early social and emotional health and development, infusing mental health services and supports, including early childhood mental health consultation, into a variety of early childhood settings and how to evaluate the effectiveness of early childhood mental health services and supports. With this comprehensive, research-based book, practitioners and policy makers will learn how to make mental health services and supports an integral part of every early childhood setting—and ensure better social-emotional and academic outcomes for all young children.

Paul H. Brookes Publishing Co., PO Box 10624, Baltimore, MD 21285-0624, or at www.brookespublishing.com. \$39.95

Theory-Based Participatory Evaluation: A Powerful Tool for Evaluating Family Support Programs

(1998, FEB./MAR.) GREEN, B. & MCALLISTER, C.

Within the full issue, *Opening the Black Box: What Makes Early Child and Family Development Programs Work?*, this article examines both theory-based and participatory evaluation and how the two methods can support program friendly evaluation design and implementation. In particular it describes the application to family support programs and the benefits and challenges and is useful to program planners, administrators, evaluators, researchers, and families.

In Bulletin of ZERO TO THREE: National Center for Infants and Toddlers, 18(4). ZERO TO THREE, P.O. Box 960, Herndon, VA, 1-800-899-4301, 703-661-1577 (fax), or at www.zerotothree.org. (\$10.00 for full issue).

On-Line Resources

Crafting Logic Models for Systems of Care: Ideas Into Action

(2003) HERNANDEZ, M. & HODGES, S.

This web-based monograph, designed for communities engaged in developing systems of care, provides a straightforward method that system stakeholders can use to turn their ideas into tangible action-oriented strategies for achieving their goals for system development.

Full text available at the Louis de la Parte Florida Mental Health Institute website at <http://cfs/fmhi.usf.edu/cfsnews/2003news/ideasintoaction.html>

University of South Florida, Department of Child and Family Studies, Louis de la Parte Florida Institute for Mental Health, Tampa, FL.

Evaluating Early Childhood Programs: Improving Quality and Informing Policy

(2003) GILLIAM, W. S., & LEITER, V.

The authors provide a description of program evaluation as it operates in early childhood settings. Particularly helpful is the discussion of cost-benefit analysis that can be done when programs need to justify their operating costs, and an extended, realistic discussion of getting programs started within an evaluation framework. A glossary of terms and a basic evaluation checklist are provided.

In Bulletin of ZERO TO THREE: National Center for Infants and Toddlers, 23(6). ZERO TO THREE. Available online through the Zero to Three Website at: <http://www.zerotothree.org/site/DocServer/vol23-6a.pdf?docID=2470>

Families as Evaluators: Annotated Bibliography of Resources in Print

(2003) JIVANJEE, P., SCHUTTE, K., AND ROBINSON, A.

This web-based resource is an annotated bibliography listing articles related to family participation in research and evaluation and general references about community/consumer participation in research and evaluation.

Full text available through the RTC Publications page, www.rtc.pdx.edu/pgPublications.php or at www.rtc.pdx.edu/PDF/pbFamEvalAnnotBib.pdf

Portland State University, Research and Training Center on Family Support and Children's Mental Health, Portland, OR.

Participatory Action Research as a Model for Conducting Family Research

(1998) TURNBULL, A.P., FRIESEN, B.J., & RAMIREZ, C.

This article discusses the advantages and challenges inherent in the PAR process and the collaboration between researchers and family members, the people who are expected to benefit from a particular service or research effort. This text is useful to administrators, researchers, and family members.

Full text available at www.beachcenter.org/research/FullArticles/PDF/PAR1PARModel.pdf

Journal of the Association for Persons with Severe Handicaps, 23(3), pp. 178-188

Participatory Action Research Involving Families from Underserved Communities and Researchers: Respecting Cultural and Linguistic Diversity

(1998) MARKEY, U., SANTELLI, B., & TURNBULL, A.P.

This overview of participatory action research (PAR) examines this research and the point of view of traditionally underserved communities as well as researchers. This text is useful to families, evaluators, and researchers planning to engage in a partnership process.

Full text available at www.beachcenter.org/research/FullArticles/PDF/PAR3PARInvolvingFamilies.pdf

In Ford, B.A. (Ed.), Compendium: Writings on effective practice for culturally and linguistically diverse exceptional learners, Reston, VA: Council for Exceptional Children

Promotion of Mental Health and Prevention of Mental and Behavioral Disorders 2005 Series Volume 1: Early Childhood Mental Health Consultation

(2005) COHEN, E. & KAUFMANN, R.

This monograph, developed by Georgetown University Child Development Center (GUCDC), through funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), provides seminal thinking on promoting healthy development among the youngest members of our society in early childhood settings by means of mental health consultation. The text addresses the questions: 1) What is mental health consultation?, 2) What must someone in the early childhood field know to hire and work effectively with a mental health consultant?, and 3) Which early childhood programs that receive mental health consultation can serve as successful models in practical settings? It discusses essential features of early childhood mental health consulting and challenges and strategies in the consulting process. Early childhood program administrators, directors, supervisors, and staff; mental health services administrators and providers; and families of young children will find this document useful in defining and implementing early childhood mental health consultation. A companion document, A Training Guide for the Early Childhood Community, is also available.

Available at www.samhsa.gov by title or by the link <http://www.mentalhealth.samhsa.gov/medial/ken/pdf/SVP05-0151/SVP05-0151.pdf>

For free copies of this document, call SAMHSA'S National Mental Health Information Center at 1-800-789-2647.

Promotion of Mental Health and Prevention of Mental and Behavioral Disorders 2005 Series Volume 2: A Training Guide for the Early Childhood Services Community

(2005) HEPBURN, K. & KAUFMANN, R.

This training guide, inspired by and based on the monograph, *Early Childhood Mental Health Consultation*, is a companion training text that offers a learning process for defining, designing, and implementing mental health consultation in early childhood settings; a way to broaden the discussion on mental health consultation across service systems; and strategies for integrating mental health consultation into early childhood services and systems of care. The guide includes trainer's text and materials for one full day's training (four modules) of progressive learning and planning for early childhood mental health consultation. The training is designed for use by training and technical assistance staff with audiences that include early childhood program administrators, directors, supervisors, and staff; mental health services administrators and providers; and families of young children.

Available at www.samhsa.gov by title or by the link <http://www.mentalhealth.samhsa.gov/publications/allpubs/svp05-0151B>.

For free copies of this document, call SAMHSA'S National Mental Health Information Center at 1-800-789-2647

Social Marketing and Health Communications

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, CENTER FOR SUBSTANCE ABUSE PREVENTION

This on-line resource provides an introduction to social marketing and how it works. It also provides eight guidelines and detailed descriptions of the process for social marketing development.

Available at <http://preventiontraining.samhsa.gov/THEORY/communications.html>

Social Marketing Skills Training

CENTER FOR SUBSTANCE ABUSE (CSAP) AND CENTRAL CENTER FOR THE APPLICATION OF PREVENTION TECHNOLOGIES

This on-line, self-paced training offers the opportunity to understand, learn, and actually practice social marketing skills and concepts. Training content includes definition of social marketing, research basis for consumer and audience analysis, designing messages and strategies, comprehensive approach, and assessment and evaluation of effort.

Available at http://www.ccapt.org/sm_skills.html

Using Evaluation Data to Manage, Improve, Market, and Sustain Children's Services, Systems of Care Promising Practices In Children's Mental Health 2000 Series, Volume II

(2000) WOODBRIDGE, M. AND HUANG, L.

This text is one of a collection of monographs of the Promising Practices Initiative of the Comprehensive Community Mental Health Services for Children and Their Families Program. The monograph describes promising practices in the use of evaluation data at sites funded by the federal Center for Mental Health Services with the intent of sharing ideas and experiences from these sites about using local data in ways that can impact the delivery, management, and sustainability of community-based services for children and families. The text is useful to administrators, providers, evaluators, and families involved in designing evaluation services and data management systems and strategies.

Full text available at <http://cecp.air.org/promisingpractices/2000monographs/vol2.pdf> or order information at www.air.org/cecp

National TA Partnership, Washington, DC.

Web-based Resource List for Evaluators and Family Evaluators

(2003) SCHUTTE, K., JIVANJEE, P, AND ROBINSON, A.

This resource list offers useful information and Internet links about evaluation. The list is divided into several categories and includes websites offering glossaries, guides to conducting evaluations, instrument and measurements, and issues related specifically to children and families and participatory evaluation.

This resource list can be accessed on the RTC Publications page, www.rtc.pdx.edu/pgPublications.php or at www.rtc.pdx.edu/PDF/pbP8webresources.pdf

Portland State University, Research and Training Center on Family Support and Children's Mental Health, Portland, OR.

W.K. Kellogg Foundation Logic Model Development Guide

(2004) W.K. KELLOGG FOUNDATION

This web-based guide builds on the experience of the Kellogg Foundation's pioneering work in the application of logic modeling in their initiatives and social improvement programs. As a companion piece to the Evaluation Handbook, the text, illustrations, and checklists focus on the development and use of the program logic model. It provides an orientation to the underlying principles and language of the program logic model so that it is most useful in program planning, implementation, and evaluation.

Full text available at http://www.wkkf.org/DesktopModules/WKF00_DmaSupport/ViewDoc.aspx?fld=PDFFile&CID=281&ListID=28&ItemID=2813669&LanguageID=0

W.K. Kellogg Foundation, Battle Creek, MI

Websites

Federation of Families for Children's Mental Health

www.ffcmh.org

The Federation is a nationwide advocacy organization for families and youth with mental health needs. With state and local chapters, the Federation provides opportunities for families around the country to link with each other, increase their knowledge about the political processes, and build their effectiveness at the local state, and national policy levels. Of particular note is their training initiative focused on family involvement in evaluation titled The World of Evaluation. This three-part training curriculum for family members provides the information, skills, tools, and strategies necessary to use research and evaluation information to advocate for individuals and for system change.

Georgetown University

National Technical Assistance Center for Children's Mental Health

http://gucchd.georgetown.edu/programs/ta_center

The National TA Center for Children's Mental Health is dedicated to helping states, tribes, territories, and communities discover, apply, and sustain innovative and collaborative solutions that improve the social, emotional, and behavioral well being of children and families. The National TA Center offers a variety training and technical assistance opportunities for states, tribes, territories, and communities to assist in transforming service delivery systems for children with mental health needs and their families. The TA Center provides specific support and resources to communities interested in early childhood mental health, mental health consultation and evaluation.

Johns Hopkins University

Women's and Children's Health Policy Center

<http://www.jhsph.edu/wchpc/>

The Women's and Children's Health Policy Center (WCHPC) was established to address current policy issues related to evolving health systems reforms impacting on the health of women, children, and adolescents. The Center's mission is to draw upon the science base of the university setting to inform policies, programs, and the practice of maternal and child health nationally. A significant emphasis is given to conducting and translating research for application in the field. The WCHPC provides timely information useful to public and private sector Maternal and Child Health (MCH) professionals, and to elected officials and other policymakers. Specific activities undertaken in support of state and local public health programs involve methods and tools development, program evaluation, and providing continuing education and expert consultation.

Portland State University

The Research and Training Center on Family Support and Children's Mental Health

www.rtc.pdx.edu

The Center is dedicated to promoting effective community-based, culturally competent, family-centered services for families and their children who are, or may be affected by mental, emotional or behavioral disorders. This goal is accomplished through collaborative research partnerships with family members, service providers, policy makers, and other concerned persons. Materials available through the RTC on Family Support and Children's Mental Health include reports on the effectiveness of mental health consultation, a web-based resource list for evaluators and family evaluators, and training resources regarding mental health consultation for child care administrators.