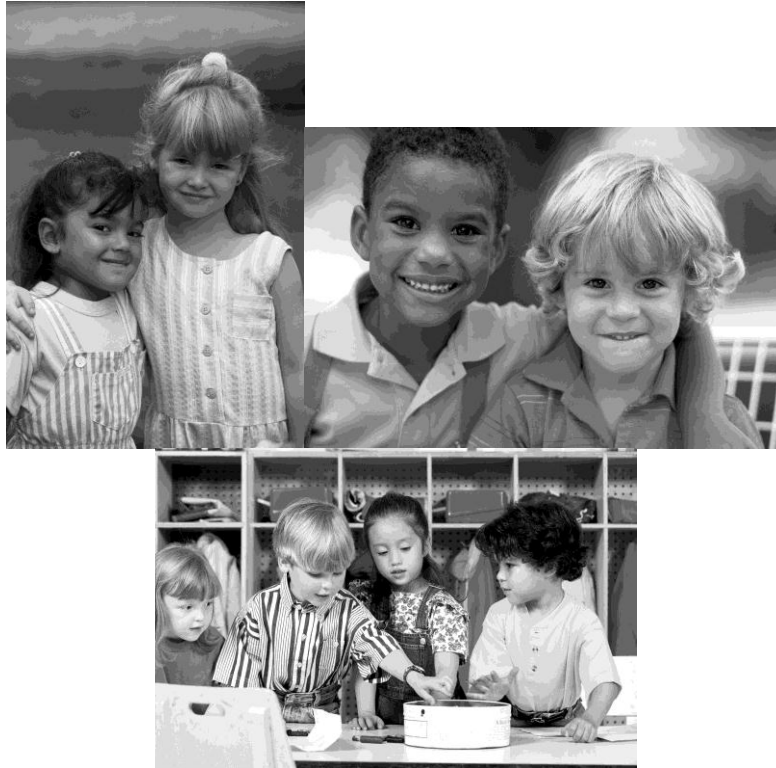


SFY 2010 EARLY CHILDHOOD MENTAL HEALTH CONSULTATION PROGRAM REPORT

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Table of Contents

- **OHIO EARLY CHILDHOOD MENTAL HEALTH CONSULTATION4**
 - **PROGRAM STRENGTHS6**
 - **CHALLENGES.....8**
 - **CULTURAL AND LINGUISTIC BARRIERS9**
 - **ECMH CONSULTATION SERVICES10**
 - **COMPREHENSIVE EVALUATION OF ECMH CONSULTATION SERVICES10**
 - **DEMOGRAPHICS10**
 - **CENTER FOCUSED OUTCOMES.....11**
 - **CHILD FOCUSED OUTCOMES12**
 - **TRAINING EVALUATIONS13**
 - **DEVEREUX EARLY CHILDHOOD ASSESSMENT (DECA)13**
 - **EVIDENCE-BASED/RESEARCH-BASED/PROMISING PRACTICES14**
 - **POSITIVE IMPACT14**
 - **BUILDING PROTECTIVE FACTORS15**
 - **PROFESSIONAL DEVELOPMENT16**
 - **RESOURCE DIRECTORY17**
- **APPENDIX A - NARRATIVEA**

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

The Early Childhood Team at Georgetown University Center for Child and Human Development (GUCCHD) is at the forefront of defining Early Childhood Mental Health Consultation (ECMHC), supporting the design and implementation of effective ECMHC programs, and promoting rigorous evaluations by states and communities. GUCCHD recently published a study regarding ECMHC:

What Works? A Study of Effective Early Childhood Mental Health Consultation Programs

Early childhood mental health consultation (ECMHC) is emerging as an effective strategy for supporting young children's social/emotional development and addressing challenging behaviors in early care and education (ECE) settings (e.g., child care centers, Early Head Start/Head Start programs, and family child care homes). Growing evidence supports its efficacy in reducing problem behaviors and the risk of preschool expulsion, as well as improving provider skills and ECE program quality (Brennan et al., 2008; Perry et al., 2009). As a result, more and more states and communities are investing in ECMHC programs, underscoring the need for accurate, data-driven information about the central features of effective consultation. To attend to this need, the Georgetown University Center for Child and Human Development (GUCCHD) embarked on this study, exploring the following key questions:

1. What are the essential components of effective mental health consultation programs?
2. What are the skills, competencies, and credentials of effective consultants?
3. What are the training, supervision and support needs of consultants?
4. What level of intervention intensity (i.e., frequency and duration) is needed to produce good outcomes?
5. Which outcomes should be targeted and how should they be measured?

Central Features of Effective ECMHC Programs

The framework for effective early childhood mental health consultation that emerged from this cross-site analysis suggests that there are five factors that are important in the design of an effective ECMHC program (i.e., a program that achieves positive outcomes). First, three core program components must be in place:

- 1) solid program infrastructure (e.g., strong leadership, clear model design, strategic partnerships, evaluation, etc.);
- 2) highly-qualified mental health consultants; and
- 3) high-quality services.

These core program components are hypothesized to be strongly associated with positive outcomes of consultation, measured at multiple levels (e.g., changes in child behavior, teacher behaviors, and ECE environments). Yet, these components alone are not sufficient to produce the desired outcomes.

This study uncovered two other elements that are essential to achieving positive outcomes and, in fact, serve as **catalysts for success** (i.e., as yeast is to other ingredients in making bread).

These elements are:

- 1) the quality of the relationships between and among consultants and consultees; and

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2) the readiness of families and ECE providers/programs for ECMHC (e.g., openness to gaining new skills and knowledge, opportunities for collaboration).

Duran, F. et al. (2009). *What Works?: A Study of Effective Early Childhood Mental Health Consultation Programs*. Washington, DC: Georgetown University Center for Child and Human Development.

Full report available at <http://gucchd.georgetown.edu>

The Ohio ECMH Program will be reviewing this report to compare Ohio's current ECMH Program model and ascertain what elements may be strengthened.

OHIO ECMHC PROGRAM

ODMH is celebrating completion of the tenth year of supporting Early Childhood Mental Health (ECMH) in Ohio. Since 2000, the Ohio Department of Mental Health (ODMH) has provided cross-system leadership in the development of the ECMH Program. This program supports evidence-based programs to equip parents and caregivers of young children, age birth to six, with the skills to help their children develop into mentally healthy individuals. Parents and teachers who effectively nurture, support and connect with young children, especially those experiencing social or emotional difficulty, can ameliorate future disabling problems.

The primary goal of ECMHC is to increase knowledge, awareness, resources and skills necessary for communities to meet the behavioral health needs of young children and their families. The program's objectives are to build protective factors in young children, increase parents' skills and promote the competencies of early childhood providers, especially relating to children ages birth to six years who are at risk for abuse, neglect and poor social/emotional health. ECMHC aims to achieve healthy social and emotional development for all young children in Ohio to ensure they thrive and are ready for school.

The ECMH Program is considered to be a continuum of services and supports of which ECMH Consultation is the primary focus for Ohio. As part of a continuum of ECMH, ODMH has also provided resources and funding to support ECMH Treatment, Incredible Years Programs, and Maternal Depression screening and referral. While ODMH continues to support the use of these services and supports, ODMH no longer allocates funding specifically for these programs.

The purpose of the Early Childhood Mental Health Consultation (ECMHC) Program for SFY 2010 was to identify and address early childhood behavioral health needs in subsidized child care and Head Start settings in high risk, low-income communities. Funds appropriated for ECMHC continue to be allocated to the ADAMH/CMH Boards.

Prior to SFY 2010, funds for consultation services were allowed to be used for any early childhood setting that the providers chose to serve. The Social and Emotional Workgroup of the Early Childhood Cabinet recommended that funded consultation activities for SFY 2010 and 2011 be focused on providing consultation services in low income and high risk areas, to include only subsidized child care and Head Start settings. Children identified as being at risk of expulsion from an early care setting remained a priority. SFY 2010 funds were not permitted to

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be used to provide consultation services to other early childhood settings and providers such as Help Me Grow, public and private preschools not licensed by ODJFS, Public Children Services Agencies, and other entities. This included at least 186 settings that were reported as being served in SFY 2009. While ECMHC program allocated funds were not used to serve these settings, many providers chose to use other available funding sources to continue to provide services.

Ohio Department of Job and Family Services (ODJFS) provided a list of all licensed child care centers in Ohio. This information was used to create a list of centers that would be eligible to receive services in SFY 2010. All ODJFS licensed Head Start programs were eligible as were all ODJFS licensed child care centers serving at least 10 infants, toddlers and/or preschool children who received some government subsidy. ODMH provided a list of centers determined eligible to receive ECMHC services to each Board. It was the responsibility of the provider, with the assistance of the Board, as needed, to prioritize the centers that were offered services. Providers in each board area were provided a targeted number of centers to be served based upon the total board allocation. The minimum number of centers expected to be served was eight.

Providers reported this change allowed consultation services to be provided to many centers that were previously unaware of ECMH services. Providing center based services allows for more children and families to be served and more efficient use of funds to reach more children.

Children identified at risk of removal from a child care setting due to behavioral issues could be served regardless of whether the center where the child was located was on the eligible center list.

Program funds were to be focused on universal prevention and intervention and intended to drive classroom change. Quality of services, rather than mere quantity, is important. Written agreements between the service provider and the center receiving services were required and were to be shared with the funding Board. The use of the partnership agreements assisted in clarifying services available and developing a clear plan on the amount of time/services needed and to be provided at each site.

<http://mentalhealth.ohio.gov/assets/children-youth-families/early-childhood/ecmh-consultation-partnership-agreement.doc>

All 50 ADAMH/CMH Boards were eligible to receive funding. (Note: Muskingum Area ADAMH Board chose not to participate for SFY 2010. However, they resumed participation for SFY 2011.)

Services and activities funded included the following:

- ECMH consultation to identified centers, including mentoring, coaching, and classroom observation
- Training and educational sessions, as part of the consultation process, including problem identification, referral processes, classroom management strategies, the impact of maternal depression, substance abuse, domestic violence, and other stressors on young children's well being

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- Work with families of children who have been identified as being at-risk of removal from their early childhood setting due to behavioral issues, to enhance the families' ability to create strong, nurturing environments for and relationships with their young children in partnership with the early childhood setting

Guidelines were developed and shared with all boards and providers. Each Board and its funded providers were required to submit a signed agreement to ODMH assuring compliance with these Guidelines as well as the ECMHC Guidelines for Data Collection, including directions for submitting data and reports.

For each of the past 4 years, \$2,500,000 per year has been allocated for the ECMHC Program. For SFYs 2010 and 2011, ODJFS has dedicated \$2,150,000 per year from federal Quality Child Care funds for the ECMHC Program. For SFYs 2010 and 2011, ODMH allocated funding of \$200,000 per year, for a total ECMHC Program funding amount of \$2,350,000 per year. This is a reduction in funding of \$150,000 for each year of the biennium.

In addition to the state and federal funds allocated through ODMH, over \$2,000,000 in other funds were dedicated to support local early childhood mental health programs. These funds came from a variety of sources including:

- Local funds
 - mental health board
 - United Way
 - Family and Children First Council
 - Children's Trust Fund
 - Provider agency
 - Community foundations
 - Job and Family Services
 - Community action
 - Contracts with early care and education programs
- State funds
 - Ohio Children's Trust Fund
- Federal funds
 - Medicaid
 - grants

One program reported that several local foundations agreed to assist with paying child care staff time to attend training provided by the ECMH consultants, which helped significantly in eliminating a barrier for the staff.

All 49 participating Mental Health Boards submitted narrative reports for SFY 2010 as well as data to the ECMHC data collection system.

ECMHC Program Strengths

The themes that emerged from the statewide feedback of the program for 2010 were consistent with those in previous years.

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- Knowledge and skills of the ECMH consultants –These professionals are highly qualified with the skills, experience and training needed to excel in their field. They are seen as very dedicated to the children, families and providers that they serve. Many of these programs have employed the same dedicated ECMH professionals since the beginning of the ECMH initiative creating a great deal of stability of the staff. Families and caregivers voice the benefits of ECMH professionals and their knowledge and skills. Consequently, the directors and staff feel comfortable approaching the consultant with concerns and questions about children in their care. They are equally receptive to learning from the consultant’s observations of classroom functioning and to integrating suggestions that would improve the classroom environments, making childcare centers more conducive to promoting the social/emotional development of young children. This was by far the most common strength noted in the reports.
- Relationships – Building positive relationships with center staff and parents is viewed as a key component of an effective ECMHC program. Many of these programs have had a positive ongoing relationship with the centers they serve that has enabled them become well-established within the center program. The teachers respect and trust the ECMH consultants. ECMH consultants meet with parents of children identified with concerns to discuss issues and offer suggestions, as well as possible referrals. The ECMH consultants have built a positive reputation that carries over into the work with children and parents.
- Strength-based approaches – Recognizing positive attributes and behaviors with the strength-based philosophies and practices has a greater impact on achieving positive outcomes. ECMH Consultants are effective in presenting information in a supportive and strength-based manner. ECMH professionals serve children who would typically not utilize the mental health service delivery system allows providers and families to view mental health as a resource, eliminating barriers to service and the stigma often attached to mental health services. Centers have been motivated to improve the social and emotional development of the children in their programs.
- The use of evidence-based programs – Offering both research and evidence-based programs accounted for success. The quality of the programs is well documented. They desire to improve on existing programs and maintain up-to-date practices. Ongoing professional development opportunities provided by ODMH are seen as a significant strength to the ECMH Consultants’ work.
- Continuum of Care – Many of the ECMH consultants also provide therapeutic services within their agencies and are experienced in ECMH therapy. Understanding the continuum of services from prevention through treatment and the consultants being able to refer to their own agency for more intensive needs than consultation services offers identified children and families continuity of care and ensures that the needs of each child and family are met. This comprehensive approach facilitates access to a range of services and encourages a more complete continuum of care.
- Strong community relationships – Many ECMH consultants have long-standing positive relationships with the early childhood community and are familiar with the community culture. They are seen as key advocates and valued members of the local early childhood community, trusted members of community groups and reliable sources of information. These strong ongoing relationships have developed over time leading to collaborative community projects. Strong support from the community has enhanced the actual

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programming areas. Cross-systems collaboration has helped to maximize resources with limited funding and staff.

- Flexibility – Flexibility to adapt to the meet the specific needs of providers, families and children is seen as a key strength to the program. The ECMH professionals are available for evening meetings and trainings. They provide consultation services in the centers and are also able to visit families in their homes.

Challenges

The identified challenges and barriers also shared many of the same themes and were consistent with reports from previous years.

- Funding – The most often mentioned barrier of ECMH programs providing services was reduced funding. This has lead to a decrease in the number of full-time staff available to provide consultation services. In turn, this leads to a reduction in the amount of time available for services to be provided in centers, especially when serving a multi-county area. This also equated to a reduction in the number of overall ECMH staff.
- Capacity - Providers were asked to address any issues of capacity versus need for ECMH Consultation services in their area. The change in focus of the ECMH Consultation Program appeared to have impacted some programs in this area. Only 3 of the board areas reported that they had a waiting list for ECMH consultation services as opposed to 12 in SFY 2009. Instead of being put on a waiting list, non-targeted early childhood programs are either not served or other sources of funding are secured. In total, reports indicated that 56 early childhood settings requested consultation services that were unable to be provided. Over half (33) of these were from one provider. The majority of the centers were requesting services for a specific child and not center based services. Most of the centers requesting services on the list also did not provide care for children with subsidies. There were 60 requests for child specific issues which were not able to be provided, 91% of which were for children not in center based care. Some programs cited the change in focus as a barrier to the services they provide; to whom and in what settings.
- Understanding of roles and responsibilities - There were some providers that were unwilling to allow sufficient time to develop and implement an action plan before asking a child to leave a program. There were also unrealistic expectations for a “quick fix” by the ECMH consultant of a child’s behavior (as opposed to working together to find a solution). Some teachers showed a lack of interest and did not cooperate and follow through with recommendations developed as part of action plans. The providers were required for the first time to enter in to a “Partnership Agreement” with each of the centers that were being served. The agreements spelled out the expectations and responsibilities for each partner in an attempt to bridge any gaps. This did present a challenge for some “chain” centers the party responsible for signing the agreements. There were also issues with some Head Start centers who wanted to continue to have a separate contract with a private mental health provider for observations but then another for referrals to ECMH services. Having providers from different agencies has caused a fragmentation of services for some centers and children. Building trust and relationships with centers that had never been served before also presented some challenges.
- Center stability - Another barrier was the extent of early childhood staff turnover in the settings that receive consultation services. It is difficult to implement strategies in the classroom and maintain continuity for the children when there is ongoing turnover of

ODMH ECMH CONSULTATION SFY 2010 REPORT

teachers. Caregiver turnover requires continuous training to assure that new staff are empowered as soon as possible to maintain and improve environments for children. This also creates a challenge for evaluation of a program and outcomes for a child when different teachers are looking at a child through different lenses at different times. Several centers had significant budget issues and some closed during the year further disrupting children and families. The lack of funds for resources impacts the quality of care centers are able to provide for children with challenges and needs.

- Parent engagement and reluctance to follow through with referrals presented challenges for achieving positive impact for some programs. Some parents have trouble acknowledging their child's issues. Transportation issues were also a factor. Issues of poverty, high-unemployment and parents own behavioral health issues have also impacted services to children and families. In-home visits with the families helped to alleviate some of the problem as well as being flexible with time and location of services.
- Training - Additional challenges cited by the providers included the conflict many early childhood programs experienced with scheduling specialized training that they wanted and needed to serve the children with behavioral issues with the mandated pre-requisite training requirements of Step Up To Quality (SUTQ) that do not include social/emotional issues. Many ECMH consultants have become approved trainers for SUTQ to provide approved training on improving the social and emotional environment as requested.

Collaboration with other providers has been essential to meeting families' needs. Service coordination/case management linked families to services and supports, including "natural" supports. Inter-systems planning, education, and advocacy provided additional means for addressing these challenges.

Cultural and Linguistic Barriers

For SFY 2010, providers were asked for the first time to describe any cultural and linguistic barriers that were encountered and how these were addressed. The majority did not cite any specific barriers for their programs.

The most often cited issue was an increasing Hispanic population and the mostly language barriers that were created. Programs addressed issues by having bilingual staff, providing interpreters and translators either through engaging university staff and students or agency staff, using materials that were bilingual or in Spanish, engaging other Spanish speaking parents to come into the classrooms and providing specific training to staff on the Hispanic culture specific to the community.

Other barriers included:

- staff of a different culture than the local community. This was cited as an issue in Appalachian communities.
- staff expectations differ from the family culture

Addressing other cultural barriers was addressed in several ways

- all staff trained annually in cultural awareness, diversity and sensitivity
- building relationships with community cultural centers
- hiring a cultural and linguistic coordinator

ODMH ECMH CONSULTATION SFY 2010 REPORT

Mental Health Consultation Services

- Total of **652** child care and Head Start centers received consultation services
 - 417 child care
 - 235 Head Start
- Total of **1582** classrooms received consultation services
- Total of **3348** early childhood providers received consultation services
- Total of **2463** families received consultation services
- Total of **24,281** children in group settings received consultation services
- Total of **2302** individual children received consultation services

In SFY 2009, services were provided to 301 child care centers and 167 Head Start centers. The change in focus provided a significant increase to the numbers of children being served in group settings, an **increase of 9085 children**. There were 950 less children receiving individual consultation services. Reports indicated that this could be attributed to the increase in center based services which lessened the need for the child specific services that had previously been requested.

There were **155** Early Childhood Mental Health Specialists reported to be providing consultation services as part of this program during the fiscal year. This included 37 full-time and 118 part-time positions. This is a decrease of 12 total consultants from SFY 2009. A reduction in the number of consultants was predicted due to the decrease in funding. The number of full-time positions decreased 34%. This was attributed to the reduction in funding and the need for ECMH consultants to also provide other therapeutic services to achieve full-time status.

Comprehensive Evaluation of ECMHC

Beginning January 1, 2008, all data reporting was to be submitted in accordance with the Guidelines for the ECMH Consultation Comprehensive Evaluation drafted as part of the Logic Model development process completed in December 2007. Development of a web-based data collection system was developed and implemented in SFY 2009.

Participants in the Early Childhood Mental Health Consultation Program were required to collect data for center focused outcomes, center focused satisfaction, child focused outcomes, child focused satisfaction, and training evaluation. The following represent data collected for the SFY 2010.

Demographics:

- The racial makeup of the classrooms included 65.6% white, 23.8% Black or African American, 4.4% multiple racial heritage, and others accounting for less than 1% each. Race was not available for 5.0% of the respondents. 5.1% of the total clients served were Hispanic or Latino. The gender represented in the classrooms was 49.8% female and 50.3% male.
- *This represents a decrease of 14.3% white and an increase of 10.7% Black or African American from SFY 2009. There was also a 1% increase for Hispanic or Latino.*
- The racial makeup of individual children served included 65.3% white, 22.3% Black or African American, 5.0% multiple racial heritages, 6.9% race not available, and others accounting for less than 1% each. The gender of children served was 62.3% male and 37.7% female. 89.6% of the children were not Hispanic or Latino, 10.4% were Hispanic or Latino.

ODMH ECMH CONSULTATION SFY 2010 REPORT

- *This represents a decrease of 14% white and an increase of 7.9% Black or African American from SFY 2009. There was also a 6.8% increase for Hispanic or Latino.*

Center Focused Outcomes

BCHFS received center focused outcomes data from **53** different sites representing **1,582** classrooms. The **1,582** classrooms had a total of **3,348** teachers (an average of **2.12** teachers per classroom) and **24,281** students (average of **15.3** students per classroom). **83** students were removed from the classrooms (<1%).

As part of the continuous improvement process, for the first time in SFY 2010, dosage information (frequency and duration of visits) was collected. **1,236** of the 1582 classrooms reporting data included dosage information. Consultants reported a total of **16,258** visits to classrooms with a total duration of visits equal to **1,290,146** minutes. The average number of classroom visits was **13** and the average duration of time per classroom was **1,044** minutes. Overall, the average length of each visit was **79** minutes.

The program types that were represented in the 1582 classrooms include:

<i>Type of Program</i>	
Childcare Center	48.90%
Head Start	47.5%
Other	3.6%

993 children were referred and 2010 children were assessed for brief consultation services. Results were discussed and recommendations were offered to 854 teachers. There are some programs that offer very brief services to child care centers and are typically offer some form of assessment score review and a few classroom interventions which may be helpful to the teachers. This is different from a more complex consultation model which includes a detailed classroom assessment and action plan.

753 classrooms responded yes to having a written Intervention / Action Plan. Of those responding yes, 32.7% had fully implemented the plan, 23.0% were at least 90%, 17.1% were at least 80%, and 11.4% were at least 70% implemented. 15.8% had implemented less than 70%.

The Reflective Checklist for the Environment is a checklist that can be used to assess the classroom environment. It is one of five checklists that are part of the Devereux Early Childhood Assessment (DECA) Program. Information about the program may be found at: http://www.devereux.org/site/PageServer?pagename=deci_about

1206 classrooms provided initial scores and 912 classrooms provided closing scores for the Reflective Checklist for the Environment. 865 classrooms provided both initial and closing responses.

The 865 classrooms that provided both initial and closing responses were used to compare the number of “yes” responses from the initial assessment to the last/closing assessment for each of the 18 questions that make up the checklist. Eighteen of the 18 questions had an increase in “yes” responses from the initial assessment to the last assessment. Question number 4 (*Create a*

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simple system to limit the number of children who can use an area at one time) had the highest change in the number of “yes” responses from initial to last/closing with 64.6% of initial responses indicating “yes” and 81.0% of closing responses indicating “yes”.

Center Focused Satisfaction

BCHFS received a total of **824** center focused satisfaction surveys from **47** sites. The types of consultation included **183** case consultations, child specific; **421** case consultations, group focus; **45** administrative consultations, program focus; and **175** administrative consultations, staff focus. The satisfaction survey was based on a 5 point scale with a range from 1 representing *strongly disagree* to 5 representing *strongly agree*. The responses to the satisfaction survey indicate an **overall satisfaction rate of 95.0%**. The satisfaction rate is based on the number of responses that specify agree or strongly agree.

Child Focused Outcomes

BCHFS received child focused consultation outcomes data from **46** different sites representing **2302** children. The referral sources include:

Referral Source	Percentage
Child Welfare	1.00 %
Child Care Center	36.45 %
Early Childhood Education Center	2.78 %
Early Head Start	0.48 %
ECMH Consultant	0.17 %
ELI	0.70 %
Family Child Care	0.09 %
Head Start	45.83 %
Help Me Grow	0.78 %
Other	0.83 %
Parent	3.95 %
Pediatrician	0.04 %
Physician	0.04 %
Preschool Special Education	1.22 %
Private Preschool	3.48 %
UNKNOWN	2.17 %

1186 of the 2302 child specific consultations reporting data included dosage information. Consultants reported a total of **8,781** visits with a total duration of visits equal to **483,804** minutes. The average number of child focused visits was **7** and the average duration of time per child was **408** minutes. Overall, the average length of each visit was **55** minutes.

815 responses indicated an Intervention / Action Plan was written during SFY2010. Of the 815 responses indicating a plan was written in SFY2010, 20.0% had fully implemented the plan, 17.8% were at least 90%, 21.6% were at least 80%, and 26.5% were at least 70% implemented. 14.1% had implemented less than 70%. 483 cases did not open following referral

ODMH ECMH CONSULTATION SFY 2010 REPORT

There were 1,758 clients that reported enrollment in an early childhood setting at closure. **87.1% were maintained in the Center at closure or were enrolled in kindergarten**, 6.4% were transferred during services, 5.1% were removed – not participating in childcare, and **1.5% were expelled due to behavior**.

Child Focused Satisfaction

The satisfaction survey was based on a 5 point scale with a range from 1 representing *strongly disagree* to 5 representing *strongly agree*. The responses to the satisfaction survey indicate an **overall satisfaction rate of 96.7%**. The satisfaction rate is based on the number of responses that specify agree or strongly agree.

Training Evaluations

BCHFS received training evaluation data from **35** sites. The sites provided data for **2645** completed evaluations. The trainees were designated into categories that include 2008 (75.9%) Early Childhood Provider/Staff, 368 (13.0%) Other Professionals, and 269 (10.2%) Parent/Foster Parent.

The training topics that the evaluations were based on include:

Topic Areas Included	Total Number of Sessions	Total Number of Participants
Behavioral Management	68	675
Child Growth and Development	23	344
Child Observation & Assessment	2	21
Family and Community Relations	7	48
Health, Safety, and Nutrition	3	60
Learning Environment and Experiences	12	133
Other	11	57
Professional Development	18	479
Social/Emotional Processes	44	828

The respondents completing the survey indicated an overall satisfaction rate of 98.2% for the instructor and 94.5% for the learning objectives. The respondents reported an understanding of the topic prior to training as 66.9% and an understanding of the topic after training as 97.2%.

Devereux Early Childhood Assessment Program (DECA)

Devereux Early Childhood Assessments (DECA) are required to be administered to measure individual outcomes for each child receiving child-specific consultation services. Many programs also use the DECA in the classrooms. To facilitate the collection of statewide data, Devereux and Kaplan have worked with Ohio in tailoring the data collected through the e-DECA system to assist in creating reports that will inform both local communities as well as statewide. With this, we have the capability of having data on every participating program using the DECA to get a statewide picture of the protective factors and behavioral concerns of thousands of young children in Ohio. As part of this program, ODMH paid for an administrative license for each mental health board and a certain number of child administrations based upon the number of

ODMH ECMH CONSULTATION SFY 2010 REPORT

DECA administrations reported by the providers for SFY 2010. ODMH will not be able to purchase e-DECA licenses and administrations for SFY 2011. Programs may choose to continue to use the system, which is now updated, and may use their ECMH allocation to purchase a license and administrations.

During the 2009/2010 school year 28,143 administrations were recorded in e-DECA.

Evidence-based/Research-based/Promising Practices

In addition to the ECMH Consultation Model, the ECMH consultants continue to report the Incredible Years Program and the DECA Program as the most used programs for consultation services. Other programs mentioned several times were Conscious Discipline, Second Step, Facing the Challenge and Teaching Tools for Young Children with Challenging Behaviors (TTYC) from CSEFEL. Providers also reported using techniques from several different programs in the consultation services including: The Developmental, Individual differences, Relationship-based (DIR) Model; Therapeutic Interagency Preschool Program (TIP); PATHS Preschool curriculum (Promoting Alternative Thinking Strategies); Triple P; 1-2-3 Magic; Positive Behavior Supports (PBS) model; Promoting First Relationships; and co-location of ECMH providers in pediatric offices.

Positive Impact of the Early Childhood Mental Health Consultation Program

The Early Childhood Mental Health Consultation Program positively impacted children and their families by building protective factors and increasing competencies and skills of parents and providers. This was illustrated in the increase in overall protective factors, decrease in behavioral concerns and positive evaluations of services from providers and parents. Through the consultation model, ECMH specialists provide general classroom observation which affords the opportunity to provide the teachers/staff with needed information regarding social and emotional development of young children as well as commenting on specific children. Services to young children were made available where in the past they had not. Adults with information about support systems and resources for assistance may also be more likely to reach out for help when they become stressed by the challenges of raising a young child.

Teachers are more engaged and more readily come forward to ask for assistance. They continue to gain a broader understanding of the importance of social and emotional health and the role it plays in school readiness as an equal to the cognitive indicators. They are given skills that are transferable to use with older children and families. This increases the likelihood that children will be exposed to positive parenting and child care practices. Through classroom consultation, universal prevention is targeted and early intervention is available, which is a key component to the prevention of future serious mental health concerns.

One of the most positive impacts is the fact that approximately 87% of the children who were at risk of removal were maintained in the setting as a result of consultation services. The maintaining of children in the child care setting of their parent's choice clearly benefits not only the child, in terms of stability, but also the family and center, as they are able to maintain work schedules and avoid turn over.

Consultation Examples

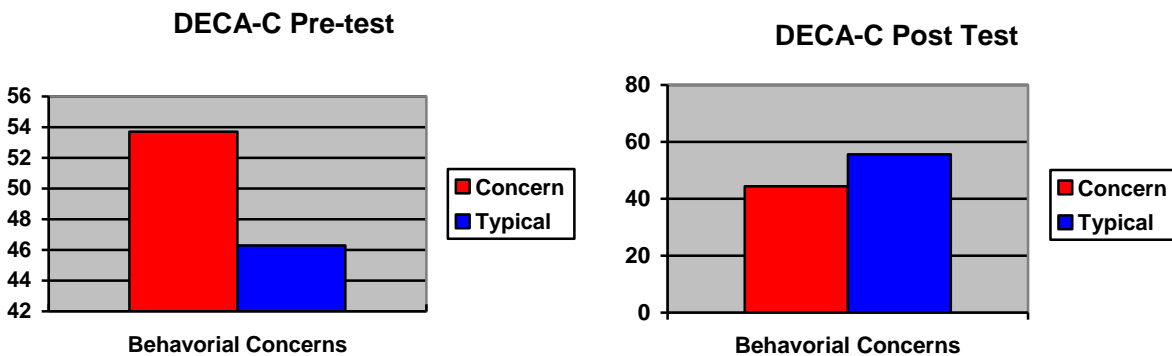
Respondents were asked to provide examples of consultation services and to include issues that were addressed, proposed solutions, and the effectiveness of these solutions in the narrative section of the final report. These descriptions provided insight into the process of mental health consultation as well as the diversity and complexity of the issues addressed through consultation services. In addition, the descriptions underscored the importance and value of the collaboration that occurred among professionals, parents, and agencies in generating solutions to problems and achieving positive outcomes for young children, families and/or child-serving staff. These descriptions serve as important illustrations of the highly complex and challenging nature of early childhood mental health consultation. This year, the most often cited issue was bullying, with aggression and sexually acting out also often cited. One consistent message from the reports was that improvements in the behavior of children were seen most often when the teachers and the parents were both involved and consistent.

See Appendix A for narrative

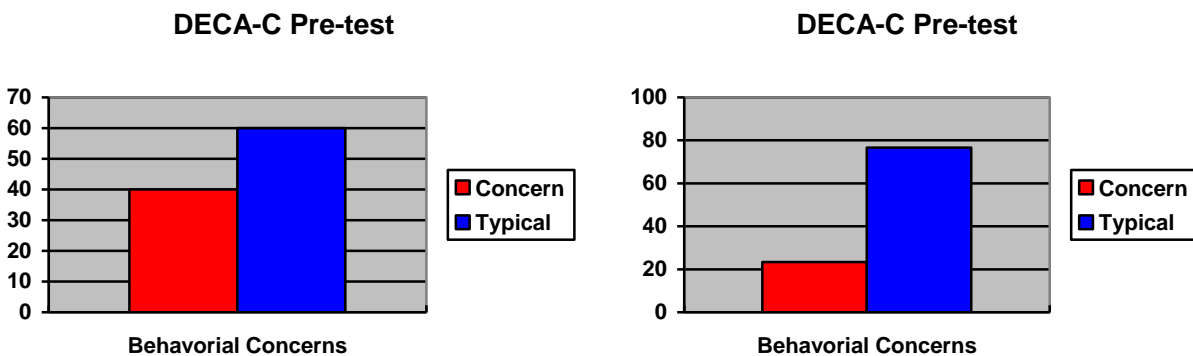
Building Protective Factors

The overall impact of ECMH Specialists on the goal of building protective factors and increasing competencies and skills of parents and providers was significant. There was an increase in protective factors and decrease in behavioral concerns between pre and post testing as shown in the following charts.

TEACHERS



PARENTS



ODMH ECMH CONSULTATION SFY 2010 REPORT

For the **DECA-C**, teachers scored 53.7% of the children scored in the concern range on the pre test and 44.4% scored in the concern range on the post test. Parents scored 40% of the children in the concern range on the pre test and 23.3% scored in the concern range on the post test.

Other ECMH activities provided that were funded through sources other than the ECMH Consultation allocation included:

- ECMH Consultation to non-targeted child care centers, Early Head Start and Help Me Grow programs
- Incredible Years programs
- Maternal Depression screening and referral services
- Parent-Child Interactive Therapy (PCIT)
- Theraplay/ Play Therapy
- Trauma-Focused Cognitive Behavioral Therapy
- Family Therapy
- Therapeutic Interagency Preschool
- Home-based intervention services
- Monthly collaborative teacher support meetings
- Triple P groups
- Additional training open to all early childhood providers

Professional Development

During SFY 2010, ODMH was able to provide many trainings that had been requested as part of the SFY 2009 reports. A total of 29 training opportunities were provided to 687 participants. Requests for specific training and technical assistance for ECMH were also included in the SFY 2010 reports. Plans have already been made or are being developed to provide training on many of these subjects.

As part of the September Regional meetings, participants were asked to rate the Top 10 trainings for ECMH Consultants that would be helpful to them in providing services to early childhood providers. A group of early childhood professionals that included ECMH consultants as well as representatives from OCCRRA and regional child care resource and referral agencies was brought together to review the surveys and develop a master training of trainers curriculum. This training began to be provided to ECMH consultants in June 2010 with more to be available in SFY 2011.

This initiative is being integrated into the Ohio Professional Development Network Registry. All ECMH consultants are required to register with the OPDN to become an approved trainer.

Five Regional Early Childhood Mental Health (ECMH) Consultants meetings were held in September with 121 attendees. The agenda included:

- Budget
- Program Updates (IY, Treatment, Maternal Depression & e-DECA)
- Update on child care center level requirements
- Data update
- Top 10 trainings for ECMH Consultants

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- Your topics..... What do you want to discuss? (Updates about your program, Challenges & What's coming up in your county)
- Networking/ Round Table (self-guided small group discussions)

Resource Directory

The resource directory that lists all of the participating ECMHC providers has been updated and shared with other agencies as appropriate and is also available on the ODMH website at:

<http://mentalhealth.ohio.gov/assets/children-youth-families/early-childhood/sfy2011-early-childhood-mh-provider-list.pdf>

Forms and additional information may be found on the ODMH website at:

<http://mentalhealth.ohio.gov/what-we-do/provide/children-youth-and-families/early-childhood/index.shtml>