2015

Early Childhood Mental Health Consultation: A Comparison of Unlicensed and Licensed Professionals

Pamela A. Morrison
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Pamela Morrison

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Peggy Gallaher, Committee Chairperson, Psychology Faculty
Dr. Anne Morris, Committee Member, Psychology Faculty
Dr. Rodney Ford, University Reviewer, Psychology Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2015

Abstract

Early Childhood Mental Health Consultation: A Comparison of Unlicensed and Licensed Professionals

by

Pamela A. Morrison

MS, Wilmington University, 2007

BS, Wilmington University, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

November 2015

Abstract

This study was conducted to comparatively examine child specific expulsion rates and parent satisfaction of children who received early childhood mental health consultation (ECMHC) services delivered in 2 states for the 2012 program year: Maryland (unlicensed) and Delaware (licensed) . This current study examined secondary data to determine whether unlicensed (Maryland) ECMHC professionals are equally or more effective than licensed (Delaware) ECMHC professionals. Of the total number of child specific consultations or cases referred for services in Maryland (unlicensed), $N = 370$, $n = 266$ children avoided expulsion and were able to remain at their childcare placements while $n = 17$ children were expulsed. Of the total number of child specific consultations or cases referred for services in Delaware (licensed), $N = 135$, $n = 119$ children were able to remain in their childcare placements while $n = 3$ children were expulsed. The results of this study revealed that there is no statistically significant difference in expulsion rates between Unlicensed (Maryland) professionals and Licensed (Delaware) professionals. Results suggest that licensure status of ECMHC professionals has no affect on expulsion rate outcomes and should receive further examination. Additionally, results could support policy changes that could lead to a national credentialing process that would address the current gap in ECMHC services due to the shortage of qualified ECMHC professionals. This study was unable to determine the outcome of parent satisfaction due to missing data. Future direction should include replication using a mixed longitudinal study.

Early Childhood Mental Health Consultation: A Comparison of Unlicensed and Licensed Professionals

by

Pamela A. Morrison

MS, Wilmington University, 2007

BS, Wilmington University, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

November 2015

Acknowledgements

I cannot thank my committee enough for their support and encouragement throughout this process: Dr. Peggy Gallaher, my chair; Dr. Anne Morris, my committee member; and Dr. Rodney Ford, my URR. I extend my sincere gratitude and appreciation for the learning opportunity afforded me by my committee.

The completion of this project could not have been accomplished without my community partners. I want to thank Maryland State Department of Education: Candy Miller, Specialist Early Learning, Division of Early Childhood Development and Delaware Department of Services for Children, Youth, and Their Families: Susan A. Cycyk, Director, Division of Behavioral Health Services.

Finally, I want to thank my mother for all of her encouragement particularly during the times when I wanted to quit and give up. She has been my source of inspiration throughout this journey.

Table of Contents

List of Tables v

Chapter 1: Introduction 1

Introduction to the Study.....1

Problem Statement 3

Purpose and Significance of the Study 4

Research Questions and Hypotheses 5

Research Design.....6

Conceptual Framework.....7

Assumptions.....8

Limitations.....9

Definition of Constructs.....9

Summary.....12

Chapter 2: Literature Review.....14

Introduction.....13

Challenging Behaviors Defined.....13

Influences on the Development of Challenging Behavior.....16

Economical.....15

Environmental.....17

Psycho-Social.....20

Consequences.....25

Implications.....25

Intervention.....27

Early Intervention.....27
Approaches to Intervention.....30
Early Childhood Mental Health Consultation.....32
Overview.....32
Background.....34
Early Childhood Mental Health Consultation as an Intervention.....35
Development of Standards.....36
Barriers.....37
Conceptual Framework.....38
Solid Program Infrastructure.....39
High Quality Services.....40
Highly Qualified Mental Health Professional.....42
Variations in States' Requirements for ECMHC Professionals.....44
Educational & Training Requirements.....44
Summary.....48
Chapter 3: Research Method.....49
Introduction.....49
Purpose of the Study.....50
Research Design.....49
Population and Sample.....52
Maryland (unlicensed) 51
Delaware (licensed) 53
Data Collection.....54
Original Data Collection Processes.....54

Secondary Data Collection Processes....56
Research Questions....56
Data Analysis....57
Threats to Validity....60
Ethical Concerns....61
Summary....62
Chapter 4: Results....63
Introduction....63
Data Collection....63
Results....64
Maryland....65
Delaware....66
Summary....69
Chapter 5: Discussion....70
Introduction....70
Interpretation of Findings....71
Expulsion Rates....71
Parent Satisfaction....72
Cost Effectiveness....72
Ethical Boundaries....74
Controlling Covariates....75
Limitations....75
Recommendations....76
Social Change....78

Summary.....79
References.....80
Appendix A.. 103
Appendix B.. 104
Appendix C.. 105
Appendix D.. 107
Appendix E.....109

List of Tables

Table 1 Professional Requirements for Six States.....46

Table 2 Summary of Professional Qualifications for Maryland and Delaware.....51

Table 3 Total Number of Expulsions & Maintained Placements for YR 2012.....64

Table 4 Early Childhood Mental Health Consultation Service Results Summary for YR 2012.. 67

Chapter 1: Introduction

Introduction to the Study

The social emotional development of young children is very important but often overlooked by early care professionals. Learning skills that support social emotional development increases children's ability to engage with others more appropriately with both adults and children (Bulotsky-Shearer, Dominquez, & Bell, 2012). It also increases their ability to identify or recognize emotions in themselves and others, and to respond in positive ways to this recognition (Thompson, 2005). Many researchers have provided information or insight into how well young children perform academically while in preschool aged programs, but little is known regarding social emotional development (Gormley, Phillips, Newmark, Welti, & Adestein, 2011).

Young children lack the skills needed to support social emotional development (Diamond & Lee, 2011). These skills include the ability to identify and manage negative emotions (Diamond & Lee, 2011). Children who lack these skills are especially challenged when it comes to adequately interacting on social levels with others. More specifically, young children who lack appropriate self-management skills have poor interactions their peers and teachers in preschool settings (Cooper, Masi, & Vick, 2009). Because of this, numerous young children around the U.S. have been expulsed from preschool programs (Gilliam & Shahar, 2006).

Expulsion is the discontinuation or permanent loss of preschool or childcare placement. The preschool expulsion rate is nearly five times higher than that of school- aged children from: kindergarten through high school (Gilliam, 2008). As a consequence of this, states across the United States are attempting to provide intervention services to reverse the current problem of expulsion using intervention strategies or services (Brennan, Bradley, Allen, & Perry, 2008).

Much effort is being made to provide intervention services to support young children with maintaining their preschool placement and reduce expulsion. However, there is presently a nationwide shortage of intervention services because of the lack of qualified service professionals who have both skill and experience needed to work with this population (Gilliam, 2005). A number of states are struggling to roll out one particular intervention for young children displaying challenging behaviors for this very reason (Allen, Brennan, Green, Hepburn, & Kaufmann, 2008). The intervention service is called early childhood mental health consultation (ECMHC).

Early childhood mental health consultation is an intervention program that indirectly supports the behavioral and mental health needs of young children. This program is designed for children that are economically disadvantaged. Early childhood mental health consultation is also a supportive approach in that it provides on- site services where young children attend preschool programming. One specific benefit with providing services onsite is that it increases the ability for the economically disadvantaged to access services (Conners-Burrow, Whiteside-Mansell, McKelvey, Virmani, & Sockwell, 2010).

In the traditional sense, intervention services are provided using a 1:1 format with an individual; however, this is not the case when implementing ECMHC services. The ECMHC program works directly with those who provide care, rather than with individual children, with a focus on teachers but also including parents (Carlson et al., 2012). Services are provided onsite weekly, giving teachers access to ECMHC professionals. According to Gilliam and Shahar (2006), teachers who had access to ECMHC services reported lower expulsion rates compared to teachers who reported of having no access to ECMHC services.

When teachers had access to ECMHC professionals, they were able to use the opportunity to have concerns addressed and were able to apply immediate corrective action yielding the best results (Perry et al., 2011). Further, teachers who had ongoing access to an ECMHC professional on site reported of enjoying their work more (Perry, Holland, Darling-Kuria, & Nadiv, 2011). This was due to increased compliance of the children who were –before receiving ECMHC services- displaying challenging behaviors (Zaghlawan & Ostrosky, 2011).

Teachers that worked directly with ECMHC professionals displayed better classroom management skills and reported of having better self confidence in addition to a heightened awareness of children's social emotional needs (Raver, Jones, Zhai, Metzger, & Solomon, 2009). While working with ECMHC professionals, teachers were able to acquire skills that improved their interactions with families and children in their care. Teachers also learned strategies for promoting appropriate social interactions between children and their peers (Perry & Linas, 2012). Notably, the rate of expulsion among young children increases when teachers lack the skills needed to support compliance and identify social-emotional needs of young children in preschool settings (Gilliam, 2008).

Problem Statement

The expulsion rate among preschoolers is a major problem. Preschoolers have the highest expulsion rate out of all categories of schooling (Gilliam, 2008). According to Stephan and Miclea (2010) expulsion rates have reached crisis levels because of preschoolers' inability to self-manage. A number of states nationwide are attempting to address the expulsion issue through ECMHC. The problem, however, lies in the overwhelming shortage of individuals who meet licensure requirements (Gilliam, 2008). This shortage is a persisting problem (Connors-

Burrow et al., 2012; Kaufman et al., 2012; Perry & Linas, 2012) that is especially prevalent in communities where access to such programs is nonexistent (Azzi-Lessing, 2010).

Reportedly, states looking to provide services have not been able to successfully acquire individuals to implement the services (Stephan & Miclea, 2010). One reason for this is the absence of a general consensus as to what skills and training an individual needs to possess in order to be classified as a qualified professional (Gilliam, 2008). The views of states currently providing services vary as it relates to skills and training of those hired to implement ECMHC services (Schultz, Richardson, Barber, & Wilcox, 2011). Some states are using unlicensed professionals while others are using licensed professionals (Duran et al., 2009).

It is not known if states who utilize unlicensed professionals are equally or more effective than states who utilize licensed professionals. This study will conduct a comparison analyses between the state of Maryland which uses unlicensed ECMHC professionals and the state of Delaware which uses licensed ECMHC professionals to provide more understanding of this gap in research literature.

Purpose and Significance of the Study

The purpose of this current study was to comparatively investigate child-specific consultation expulsion rates and parent satisfaction of ECMHC service delivery in two different states level programs. This study compared ECMHC service delivery in a state level program that uses unlicensed professionals (Maryland) and another that uses licensed professionals (Delaware) in the implementation process. Results from this study add to current ECMHC literature and provide support for policy makers regarding the development of nationwide standards of service professionals needed to address current shortages of service delivery.

Economic implications for ECMHC programs are not as emergent as the implications for there being a shortage of service professionals although funding is a big part of service implementation (Johnson, Knitzer, & Kaufmann, 2002). Although funding is linked by some of the current research, it was not the focus of this study.

Research Questions and Hypotheses

Research has shown that ECMHC services are effective in preventing expulsion of young children. Prior to this current study, it was unknown as to whether or not a difference in service outcomes based on professional licensure status existed. Specific questions that guided this study include:

RQ1: Is there a difference in child-specific consultation expulsion rates between Maryland (unlicensed) and Delaware (licensed)?

RQ2: Is there a difference in parent satisfaction of children who received child-specific consultation between Maryland (unlicensed) and Delaware (licensed)?

Hypotheses

$H_1$0: There is no difference in child-specific consultation expulsion rates between Maryland (unlicensed) and Delaware (licensed).

H_1A: There is a difference in child-specific consultation expulsion rates between Maryland (unlicensed) and Delaware (licensed).

$H_2$0: There is no difference in parent satisfaction of children who received child-specific consultation between Maryland (unlicensed) and Delaware (licensed).

H_2A: There is a difference in parent satisfaction of children who received child-specific consultation between Maryland (unlicensed) and Delaware (licensed) .

Research Design

This quantitative study comparatively examined if there is a difference in child-specific consultation expulsion rates and parent satisfaction of ECMHC provided by service professionals in Maryland (unlicensed) and service professionals in Delaware (licensed) . This study used ECMHC secondary data from the 2012 program year. Data from Maryland (unlicensed) and data from Delaware (licensed) that included child-specific consultations, parent satisfaction of children who received child-specific consultation and expulsion rates was acquired.

In the total number of cases available (N = 505) it was estimated that 10% (n = 50.5) would be incomplete. Subsequently, this study used all remaining cases, n = 455 (w = 0.168, p = 0.05, power = 0.80), to detect if there are any differences in expulsion rates of child-specific consultation and parent satisfaction of children that received child-specific consultation.

The independent variable for this study is licensure status with two levels: unlicensed and licensed, and the dependent variables are child-specific consultation expulsion rates and parent satisfaction of children who received child-specific consultation. Possible confounders included SES, time spent in childcare, class size and ratios, teacher/child interaction, classroom management, and parenting style; however, there were very few differences across states.

This study used a two –tailed test. For this quantitative, nonexperimental research study, IBM SPSS Statistics (Statistical Product and Service Solutions) 22.0 was used for statistical analyses descriptive analysis, chi square test, and independent samples *t*-test. Descriptive statistics was used to summarize the following data separately for each state to provide an overall picture: (a) the number of programs serviced, (b) number of child specific cases (c) the average time to complete a case, (d) the average number of hours per case, and (e) the number of

community based referrals made. These particular variables were chosen to provide an overall picture of the work provided by ECMHC professionals. It was proposed that the chi square test would be used to test the null hypotheses presented in this study. However, to correct for the small sample size and/or small number of expected frequencies, Fisher's exact test was used. It was further proposed that the independent *t* –test would be used to analyze differences between incomplete and complete cases within each state. Incomplete cases are those cases where data are missing; however, there was not enough data available to perform this analysis. After child specific consultations are completed, parents are given satisfaction surveys for the purposes of improving services. A comparison was to be made of the proportion of parents of the children that received child-specific consultation; however, this study was unable to analyze parent satisfaction because there was not enough data available to do so. This study reported data results separately by state.

Conceptual Framework

The conceptual framework used for this study is the Duran et al. (2009) model for effective ECMHC. This model was developed from extensive research conducted on ECMHC services. According to Duran et al (2009), ECMHC program professionals typically follow the same format and structure when implementing services. This model identifies key components used by ECMHC professionals that include: a solid program infrastructure, highly qualified professionals, and high quality services (Duran et al., 2009).

A solid program infrastructure provides leadership through the kind of individual that is able to excel in management, through the creation of a positive work environment, supervisory support, and advocacy of the ECMHC program relative to sustainability (Duran et al., 2009).

The highly qualified professional is someone that has met the standards and criteria set forth by the state, reflective of experience, education, and/or licensure status, where employment takes place, and high quality services are defined as services that address the child, the preschool program and staff as well as the family in efforts of supporting and improving upon the social emotional needs of children and to reduce problematic behaviors (Duran et al., 2009; Kaufmann et al., 2012).

These factors that are linked to successful implementation are provided throughout the literature in great detail. As such, these factors are currently being replicated although the results of service delivery in every state where ECMHC services are being provided, is not known. This model will provide a framework for determining child-specific expulsion rates and parent satisfaction of ECMHC services in Maryland (unlicensed) and Delaware (licensed).

Assumptions

Secondary data were used for this study. Subsequently, the following assumptions were made regarding the data in association with this study:

1. The secondary data analyzed were relevant to this study and would address the research questions.
2. The data were collected appropriately and accurately.
3. The data collected would reflect minimal researcher bias.
4. The answers provided by responders would be answered to the best of the responders understanding.

Limitations

This study utilized secondary data sources. Relevant data were collected from the state of Maryland (unlicensed) and the state of Delaware (licensed). Although this study was carefully conducted, limitations did exist.

Using secondary data does not allow for the control over how data was collected nor the accuracy in how data was collected and coded, lost data, response bias, problems associated with a low number of responders, and whether or not any vague questions or terminologies were adequately explained by data collectors and understood by responders (Boslaugh, 2007). Also, this study was conducted using two states to represent or provide a generalization of all other states that are currently providing ECMHC services. Other potential limitations included the differences between states regarding administrative systems, support policies and procedures, access to service levels, and populations.

While the results of this study provide some insight into the current gap in research regarding qualified service professionals and effective outcomes, further research is needed involving more states in order to provide further or deeper insight.

Construct Definitions

*Action plan***:** A written document of strategies or goals used to decrease challenging behaviors and increase emotional health of young children. This document is created by the ECMHC and the teacher and/or early care provider.

Case completion rate: The length of time it takes for ECMHC services to complete or conclude. Case completion rates will be determined by the dates provided on the pre/post test measures provided.

Case consult: A case consult is defined as the opening and closing of a referral or request for ECMHC services. In other words, from the start of ECMHC services up until the end of services as agreed upon by all parties constitutes a case consult. Case consult, case consultation, and cases will be used interchangeable.

Challenging behavior: defined as violent tantrums, physical aggression towards self, others, and/or property. Challenging behaviors are measured by the frequency and duration and/or occurrence of the displayed behavior or behaviors as revealed by results of the tools and measurements (e.g., Preschool and Kindergarten Behavior Scale, Eyberg Child Behavior Inventory, Sutter-Eyberg Student Behavior Inventory-Revised, Strengths and Difficulties Questionnaire as well as by naturalistic observations).

Early childhood mental health consultation: "Early childhood mental health consultation (ECMHC) involves a professional consultant with mental health expertise working collaboratively with early care and education staff/programs and families to improve their ability to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age 6" (Cohen and Kaufmann 2005, p. 60).

Effectiveness: Expulsion avoidance, or the maintaining of childcare or preschool placement due to ECMHC service implementation. The reduction in the expulsion rate is attributed to or associated with the decrease in exhibited challenging behaviors and the increase of teacher and/or parent/caregiver skills given to manage challenging behaviors. Effectiveness is measured using pre/post assessment tools and measures designed to do so.

Equal or greater success outcomes: Having the same or less number of expulsions.

Expulsion: The permanent loss of preschool or childcare placement.

High qualified professionals: An individual that meets a set of required predetermined standards outlined by the state in which the individual is.

High quality services: Services that address the whole child and programs in efforts to reduce expulsion rate. This includes, but not limited to, child-specific consultation, program consultation, and family resource referrals when needed. Included in high quality services is the ECMHC professional's willingness to be flexible and available in meeting the immediate needs of children and programs being serviced.

Maintaining placement: Children or cases –because of ECMHC services- avoided expulsion and are able to continue to actively attend program enrolled.

Parent satisfaction: The opinions and feelings of parents or caregivers regarding the effectiveness and experiences of ECMHC services rendered. Satisfaction is measured using a survey that is provided at the end of a consultation.

Pre/post test measurements: Pre- and posttest measurements are a set of assessment tools used to assess the severity and frequency of behaviors at the commencement of ECMHC services and at the conclusion of ECMHC services when parties agree that action plan goals have been reached.

Program infrastructure: Three core components that are used during ECMHC service implementation. The three core components are: (a) strong leadership possessed by project managers and directors that allows them to be able to promote the program, establish and maintain relevant partnerships with stakeholders, create a system for acquiring data and feedback for program evaluation for improvement, and modeling a professional attitude for the ECMHC staff; (b) a clear model design that explains roles and responsibilities of all partners and

stakeholders as well as how services will be implemented and access outcomes; (c) organizational structure that promotes accountability; (d) hiring ECMHC professionals and training them in efforts of increasing their knowledge and understanding of early childhood mental health and service delivery; and (e) funding to implement and sustain programming.

Referral: The initial request made for ECMHC services when a child is on the verge of expulsion.

Social emotional development: The ability of young children to be able to self regulate or manage their own internal and external social responses appropriately as well as appropriate interpersonal interactions.

Summary

While states continue to be challenged with finding qualified individuals to provide ECMHC services, the expulsion rate grows. Results from this study add to current ECMHC literature and provide support for policy makers regarding the development of nationwide standards of service professionals needed to address current shortages of service delivery.

Chapter 1 summarized the study's background, purpose, and significance. This study comparatively examined child-specific consultation expulsion rates and parent satisfaction of ECMHC services provided by the state of Maryland, which uses unlicensed service professionals and the state of Delaware, which uses licensed service professionals. An overview of the history of origin of ECMHC service implementation, challenging behavior expressed by young children, and risk factors of challenging behaviors are presented in Chapter 2. Chapter 3 looks at the research methodology used for this study.

Chapter 2: Literature Review

Introduction

The display of challenging behaviors by young children has become a major problem. According to the U.S. Department of Education (2007) challenging behaviors displayed by young children in preschool settings has dramatically increased over recent years. This may create a negative impact because preschool settings provide a foundation for early learning. Preschool settings provide a place for young children to develop skills needed for success in later educational years. In such settings, emphasis is typically placed on creating and maintaining supportive learning environments where young children are nurtured and developed both in the areas of academics and social- emotional development (Brennan, Bradley, Allen, & Perry, 2008). However, according to Gilliam (2005), a growing percentage of young children are not experiencing early learning success due to the alarming increase in the number of expulsions that are a result of displayed challenging behaviors.

Challenging Behaviors Defined

Challenging behaviors can be defined as tantrums, physical aggression towards self or others, impulsivity, destruction of personal or others' property, failure to follow classroom rules and norms, verbal abuse towards others, and disruption. Some cases are more severe. More than a quarter of young children display symptoms relative to oppositional defiant disorder and/or conduct disorder (Webster-Stratton and Hammond, 1998; U.S. Department of Education, 2007). Children who display a single episode of aggression, tantrums, or noncompliance to instructions are not considered to have a challenging behavior. In some cases, it is the level of intensity and frequency of a behavior being displayed that determines if children are displaying a challenging

behavior. The problem lies in the behavior that interferes with children's ability to learn and their inability to establish and maintain healthy pro-social relationships (Zaghlawan & Ostrosky, 2010).

Conversely, not all children who display such challenging behaviors do so in the same manner or for the same reasons. According to Bornstein, Hahn, and Haynes (2010), young children with challenging behaviors express in two ways: externalizing and internalizing. Externalizing expressed behavior manifest as tantrums, self-harm, and aggression towards others (Bornstein, Hahn, & Haynes, 2010). Internalizing expressed behavior manifest as non compliance, anxiousness, compulsion and self-isolation (Bornstein, Hahn, & Haynes, 2010).

While there are various types and kinds of challenging behaviors displayed by young children, the most common or regularly occurring behavior is aggression in the forms of: screaming, biting, spitting, and punching (Lyon et al., 2009). There are also self-injurious behaviors such as scratching and biting (Lyon et al., 2009). Children also exhibit behavior directed at property, which includes: throwing toys and/or furniture and stealing (Roane, Ringdahl, Vollmer, Whitmarsh, & Marcus, 2007). When these forms of behavior are exhibited, the safety of all children is a concern and children who display such behavior benefit most by seeing a mental health professional. Unfortunately, young children who display such behavior tend to be limited in their access to mental health services due to the lack of affordability and denied access to common or basic community services like childcare because of their behavior (Boslaugh, 2007).

Influences on the Development of Challenging Behavior

Reasons for challenging behavior are numerous. Many children who display challenging behavior come from poor families (Williford, et al., 2009). Lower income families have less or minimal access to the mental health services that are needed to eliminate the signs and symptoms of such behavior. Others display challenging behavior because they are exposed to negative environments. Negative peer influences are linked to challenging behavior of children as early as preschool age (Harwood, O'Brien, Carter, & Eyberg, 2008). Additionally, children display challenging behavior simply because they have poor or no social skills that are needed to build positive relationships.

There are various influential factors that are attributed to the emergence of challenging behavior in children. However, influences on the development of challenging behavior typically fall under the headings of economical, environmental, and psychosocial (Bolger et al., 1995).

Economical

Low socioeconomic status (SES). It is also not uncommon for those that come from impoverished families to display behaviors that are impulsive, oppositional and/or aggressive. Newland et al. (2013) posited that such behavior is a result of children from impoverished families attending childcare at a young age due to the families' need to work outside of the home. The U. S. Census Bureau (2009) identified that 20% of families experience economic hardships which makes it is not surprising that many children attend some variation of childcare as early as six weeks old. Accordingly, there are negative results developmentally as well that are derived from living in poverty among young children particularly in the area of behavior (Newland et al., 2013).

Children who come from impoverished families experience trouble with executive functioning (Raver et al., 2012). Children that have trouble with executive functioning are challenged with managing their own emotional regulations. Chaos and adversity experienced within children's environment places them under more stress and allows for negatively altered responses where self-managing ability is weakened (Raver et al., 2012). Further, Brown, Ackerman, and Moore (2013) identified that an important part of executive functioning is the ability to manage emotions and behavior, and the lack of a stable family lifestyle contributes to the inability of young children to effectively develop the ability to do so.

Children who are raised in poor family settings express a higher tendency for developing a number of socioemotional problems (Dornfeld & Kruttschnitt, 1992). Such problems can run from moderate to severe in nature. Additionally, Bolger et al. (1995) asserted that children from poor families tend to suffer from peer rejection, isolation, and other conflict ridden peer relationships. This stems from the inability of poor families to being able to afford pricey or more popular items such as up to date clothing, electronics, and other gadgets that children typically have within peer groups (Bolger et al., 1995). As a result, in some cases, children from poor families are constantly stigmatized by their peers and suffer constant traumatizing emotions through peer isolation (Bolger et al., 1995).

Stigmatization and isolation often leads to feelings of alienation. This results in a lack of desire to participate in any peer-group social activities (Bolger et al., 1995). A decrease in opportunities for social-oriented interactions does not support social emotional development. According to Dodge, Petit, and Bates (1994), children from poor families who suffer alienation

from mainstream peer group circles may form or develop peer relationships with those who have like behaviors. Notably, such relationships may foster increased negative behavior.

Some suggest that aggression and other challenging behavior serve as predictors of future behavior and reveal the social and emotional state of young children (Dufrene, Doggett, Henington, & Watson, 2007). Challenging behavior can be the result of social and cultural influences that are frequent and, at times, greatly intense: affecting the personal and physical safety of the individual displaying the behavior and others that the behaviors may be directed at (Dufrene et al., 2007).

Environmental

Time spent in care. Among all of the likely influential factors to be named, the environment where young children spend the most of their time can be considered more important and relative to overall learning success of young children (Brennan et al., 2008) This, of course, would include not just the home but also where children attend school. 84% of young children attend some form of non paternal care (Bradley & Lowe-Vendell, 2007). Single parent and two parent households alike utilize non-paternal child care services within the first 12 months of a child's life (Bradley et al., 2007). According to the U.S. Census Bureau (2009), more than 11 million children, birth through 5 years, spent up to 40 hours or more a week in a childcare setting.

Much concern has been given to the overuse of childcare early on in a child's life and that it may be a contributor to both internalizing and externalizing behaviors that children display in early care settings (McCartney et al., 2010). McCartney et al. (2010) identified that the longer children spend in childcare, the more likely challenging behaviors will manifest (e.g.,

noncompliance, aggression, and tantrums.). To this point, the NICHD Early Child Care Research Network (1998) posited that inappropriate social interactions with peers can be connected to the number of hours children spend in childcare settings beginning at 2 years of age. In addition, the earlier children start daycare, the more at risk they are at experiencing challenging behavior (Bradley & Vandell, 2007).

Classroom management. While the number of hours children spend in child care settings may contribute to the birth of challenging behavior, the teachers' or providers' inability to manage the classroom when behaviors occur, may be an additional contributing factor. Conversely, it is helpful for teachers to know that while children may display challenging behaviors for a myriad of reasons, it is not uncommon for children to do so particularly when verbal and social skills are lacking (Brendgen et al., 2008). For example, children who bite, hit, and kick at others typically do so because they either want or need something, and/or they simply do not have the verbal or social skills to articulate what their needs and wants are (Schultz, Richardson, Barber, & Wilcox, 2011). Teachers who only respond to the challenging behavior displayed by children may be actually conditioning children to seek attention for getting their needs by doing negative things even if it means that the consequence of such behaviors is negative (McCabe & Altamura, 2011).

While it is important for early care educators and providers to understand the why behind negative or challenging behavior, incidentally, not many are able to limit their ability to address any ongoing behavioral issues displayed in early learning settings (Lyon et al., 2009). , According to Brennan et al. (2008), this is due in part a lack of skill or training in areas associated with managing challenging behavior; thereby, expulsion is used as an only alternative

for handling children with challenging behavior. The teachers of children who lost their preschool placements due to challenging behaviors reported that implementation of a quality learning experience was a number one issue they faced (Hemmeter, Fox, Jack, & Broyles, 2007). When asked, as told by Hemmeter et al. (2007), teachers further reported that their greatest professional development need was regarding the need for more training in dealing with challenging behaviors of young children within the classroom setting. Early care educators also expressed their concern for the long term implications of young children because of their inability to effectively manage the challenging behaviors in the classroom: creating a safe environment for all children (Stoiber & Gettinger, 2011).

It is worth noting, that the environment in which children engage in the majority of time may contribute to how children engage with others or respond to internal and external stimuli in general (Lyon et al., 2009). Teachers having the ability to manage the learning environment while building positive interactions with children in their care, set the tone or climate of the learning environment, reducing the likelihood of challenging behavior occurring (Brown, Jones, LaRusso & Aber, 2010; Raver, Jones, Zhai, Metzger, & Solomon, 2009).

Classroom size and ratios. Preschool classes that have a large number of children but a small number of staff are non-conducive to learning. Class sizes that are large in number do not allow for teachers to be able to provide quality emotional and educational support particularly for children considered to be at risk (Rentzou & Sakellariou, 2011). Low staff ratios does not allow for children with challenging behavior to get the one on one time that may be needed. Class size affects peer to peer interaction, teacher to child interaction, and also hampers teachers' ability to effectively manage behavior (Sandstrom, 2012).

Over time, policy makers have worked to improve the learning environment by reducing the number of children per class (Stadelmann-Steffen, 2012). For example, in Delaware the ratios are one teacher to eight 3 year olds and one teacher to 12 four and five year olds where previously, the ratios were 1:12 and 1:15 respectively (Delacare, 2007). Benefits of having smaller class sizes include but are not limited to opportunities for small group and 1:1 time with staff, a classroom that is more manageable, and support for pro social opportunities with peers (Thorpe, Staton, Morgan, Danby, & Tayler, 2012).

Psycho-Social

Teacher/child interaction. How a child views his/her teacher and how the teacher views the child impacts the nature of the teacher/child relationship and interaction. According to Bulotsky-Shearer, Dominquez, and Bell (2012), the views each has of the other plays a key role in how well children adjust to the learning environment. It also affects early learning success of young children.

Graves and Howes (2011) posited that the views a teacher may have regarding children and their behavior is indicative of how the relationship will develop. For example, teachers who had favorable views of children in their class tended to have a close knit bond with them and, in which case, did less reporting of challenging behavior (Graves & Howes, 2011). In addition to this, students that had close and positive relationships with their teacher also got along appropriately with their peers (Bulotsky-Shearer et al., 2012). Interestingly, minority students who reported of having a close bond with their teacher were less aggressive in the classroom setting at the end of a program year than at the beginning (Peisner et al., 2003). This is important as, nationally, African American males in contrast to their non African American peers

perpetually dominate the discussion relative to emotional and behavioral categories due to unsupported teacher/child interaction (Dobbs & Arnold, 2009

Social learning. Behavior is learned. Because behavior is learned, it is not uncommon for children to learn and adapt individual behaviors from their peers. This included challenging behavior that is often displayed in the learning environment. Albert Bandura's (1971) social learning theory presupposes that learning takes place via direct observation or simply by watching others. Bandura (1971) posited that children are highly susceptible in imitating and adapting behaviors modeled before them. To this point and according to Nyber, Henricsson, and Rydell (2008), it is possible for peers to influence one another simply for the purpose of engaging in socially deviant or aggressive behavior. The impact of this, however, is more pronounced in children who are of adolescence age than with children who are preschool aged (Nyber et al., 2008). Conversely, it is possible to teach young children more appropriate ways of behaving and interacting. This can be done by using appropriate rewards and positive acknowledgment when new skills are exhibited (Deeming & Johnson, 2009). This, too, can pose a challenge. Research shows that over the course of time, challenging behavior is nothing more than a result or bi-product of an equally challenging environmental setting that providers and/or parent/caregivers continue to recreate: intentionally or unintentionally (Aunola & Nurmi, 2005).

In such environments, according to McCarthy et al (2010), challenging behavior among children can very easily become chronic in nature if not addressed or properly managed in the early stages. This type of result yields from, again, children's inability to communicate feelings and emotions. In addition, teachers and parent/caregivers must be able to recognize and be sensitive to the emotional needs of children and adapt the environment in ways that reflect the

needs of the children rather than the needs of the adults who are caring for the children (Goodman & Aber, 2010). Because behavior is learned, providing support through modeling and role play provides a way of fostering children's ability to learn and practice appropriate ways of interacting and positively expressing negative emotion (Brown et al., 2010; McGencey, 2011). Challenging behaviors are less influenced when appropriate social modeling is performed in the classroom setting.

Parenting style. The challenging behavior of children and the risk factors mentioned can be exacerbated by parental styles of discipline along with socio-demographic factors typically found within the dynamics of the family (Parens et al., 2006). According to Laible, Panfile, and Makariev (2008), the kind of relationship a mother has with a child has more of an impact on the behaviors young children display as opposed to socio-demographic factors when it comes to predicting future behaviors. Brown, Ackerman, and Moore (2013) posited that the establishment of family structure is one socio-demographic factor that parents put in place when establishing rules, routines, and expectations and where there is a lack of family structure, chaos is the result and challenging behavior a bi-product.

A study was conducted on family adversity and children's ability, or inability to manage their behavior (Brown et al., 2013). 120 preschool attendees from impoverished families took part in the study. Within the study, three variables tested, and family chaos was one of them. The results yielded that family structure, or the lack there of, contributed to children's inability to develop skills necessary for controlling impulses and managing behavior (Brown et al., 2013).

While some research supports the importance of having family structure in order to minimize challenging behavior, notably, other research shows that there is some argument as to

whether or not children who display aggression, noncompliance, and impulsivity are doing so simply because of harsh, coercive, and/or inconsistent parenting (McGilloway et al., 2012; Shaw & Bell, 1993). Parenting styles of discipline that are harsh, coercive, and/or inconsistent can be associated with overall poor child behavior outcomes and can have a lasting or lifelong impact (Parens et al., 2006; McGilloway et al., 2012).

Negative styles of parental discipline can serve as a means for predicting future clinical status of children at the school age level especially given the notion that conduct related issues are more prominent in older children (Aunola & Nurmi, 2005). In Aunola and Nurmi's study, the parenting styles of parents, mothers and fathers, of 196 preschool children and tracked the participants over a three year period (2005). Each year, both parents completed surveys describing their style of parenting, and the outcomes of the study yielded that parents who provided limits and showed affection, being sensitive to the needs of their children saw decreases in challenging behavior; whereas, those who attempted to control their children by withdrawing affection and using guilt saw an increase in challenging behavior (Aunola & Nurmi, 2005). However, according to Shaw and Bell (1993), in order for this to be conclusive, more would have to be known as to when or whether or not negative styles of discipline were employed from the onset of a child's life or if such practices started later in the life of a young child.

Overall, parents who receive training or attend workshops that function to improve parenting skill and increase understanding of challenging behavior yield good results in reducing challenging behavior (McGilloway et al., 2012); Parens et al., 2006; Webster-Stratton, Reid, & Beauchaine, 2011).

Consequences

It should be noted that there are some far reaching consequences associated with challenging behavior among children. In understanding these consequences, it is imperative to recognize that young children also struggle developmentally and academically as well when skills needed to appropriately interact are missing (Hemmeter et al., 2007). One such consequence to this is that young children are unprepared for kindergarten (Bornstein, Hahn, & Hayes, 2010; Mashburn & Pianta, 2006). Children who enter kindergarten unprepared social-emotionally have poor relationships with peers and their teachers (Campbell, 2011). This is due in part to their inability to problem solve and express feelings and emotions during times of conflict.

Another consequence is that stressful learning and working environments exist because teachers and programs are not equipped to handle the overwhelming number of children who display challenging behavior (Bulotsky-Shearer, Dominiquez, & Bell, 2012; Hemmeter et al., 2007). Teachers often complained of their limited or lack of educational training when it related to dealing with young children with challenging behavior (Gilliam, 2008; Grining et al., 2010). In addition to this, early care program administrators reported of the lack of resources available to them for dealing with children with challenging behavior (Hemmeter et al., 2007; Kaufmann et al, 2012). The consequences described serve as predictors of long term implications of children who experience expulsion at the preschool age level.

Implications

The implications of expulsion of young children are great. When children do not have early exposure to the skills needed to manage negative behavior and emotions, they are in direct

position of not only being expulsed from preschool but also are at risk of academic failure, poor relationships, truancy, drug and alcohol abuse, and violence against others later in life (Gilliam, 2008; McGilloway et al., 2012). Children who lack skills needed to appropriately communicate their inner feelings manifest aggressive and disruptive ways of dealing with conflict (Fabes, Gaertner, & Popp, 2006; McCabe & Altamura, 2011). These behaviors only intensify without early support.

Children who do not get early support are at risk of displaying more serious behavior at greater frequency. Behavior that intensifies in its display eventually lead to more mental health disorders (Williford & Shelton, 2008). Without early intervention, oppositional and defiant behaviors are likely to increase (Campbell, 2011). As children age, such behaviors are less resistant to treatment (Campbell, 2011). However, with early intervention treatment, services expectantly have a far greater successful and lasting effect in reducing the behaviors (Waliski & Carlson, 2008).

The early support provided by ECMHC programs resulted in a decrease in challenging behavior of young children (Low & Shepard, 2010). Further, ECMHC services helped to reduce or eliminate the rate of expulsion in one state where prior to services the rate of expulsion was 27 children per 1000 (Gilliam, 2005; Perry & Linas, 2012). Without intervention services, young children will continue to experience expulsion at alarming rates; thereby, jeopardizing future learning success and development.

Intervention

Early Intervention

Providing early intervention services for young children is not necessarily a new concept. Such services provided to and for young children predates 1960 (Crane & Barg, 2003). Initially, early intervention programs were designed to support academic development and school readiness of children who were considered to be at-risk or disadvantaged (Perry, Holland, Darling-Kieria, & Nadiv, 2011). According to Griffin (2009), children considered to be at risk are likely to be subject to academic failure without the support of intervention services. However, what was discovered early on is that while some children experienced some overall growth academically, the growth is not sustaining (Hayes, Giallo, & Richardson, 2010). Despite this, important information did generate from this discovery.

Research has grown to show that intervention services support growth and lasting effects on young children's social behavior. Where intervention was utilized, the number of social conflicts was dramatically reduced from the time an issue was first noted to the time the intervention service was concluded (Green, Malsch, Kothari, Busse, and Brennan, 2012).

Identifying and implementing services early is believed to be the best approach as behaviors of young children are not as deeply rooted and young children are learning (from a developmental viewpoint) self regulation (Lakes et al., 2011). Morrison and Bratton (2010) posited that early intervention services also help to reduce early onset behaviors that are usually due to the financial and societal status of families. Many intervention services include the family when working with young children. Services that encompass the educating of parents facilitate helpful ways of identifying and reducing early symptoms (Goodman & Abner, 2010).

An advantage services and programs offer is that they are free or of low cost to families through federal programs like Head Start or through child care subsidies offered to families that qualify (Lakes et al., 2011). For example, families that are of a low SES and in need of financial assistance in order to pay for childcare services are able to do so because of programs like Head Start, which provides free funding for qualified families, and Purchase of Care. Purchase of Care is a child care subsidy provided via federal and state resources that allows for financial support for children childcare age whose families meet income guidelines and are in need of help paying for childcare while parents or caregivers work or attend some type of job training. Such programs use federal poverty guidelines to determine family eligibility in order for children to be able to participate in either program (U.S. Department of Health & Human Services, 2013). Children that attend Head Start programs or receive Purchase of Care are able to do so because their families meet the required income eligibility set forth at the federal level: below 200% (Child Subsidy Program, nd).

Over the course of time, there have been a number of intervention programs that have attempted to support the social-emotional development of young children. Early intervention programs, such as Head Start, have been instrumental in identifying children who are at risk both socially and emotionally (Morrison & Bratton, 2010). Head Starts' ability to do this is due in part to the federal standards and requirements put in place to screen all children in the program within the first month and a half of the programs' start (Morrison & Bratton, 2010). As an intervention and prevention program, Head Start came into existence in 1965. It started out as a six to eight week program, and was an attempt to prepare impoverished children for kindergarten during the summer months as it was determined that such a program could help improve the IQ

of children who were from poor families (Welshman, 2010). As more insight about children's overall development began to surface, it was determined that young children not only lacked the academic fortitude to be successful but also the social and emotional development as well (Welshman, 2010). Therefore, the Head Start program developed into a five day a week program to help young children be more prepared for school: with emphasis on social- emotional and cognitive development (Welshman, 2010).

Head Start is one of the oldest programs designed to address the educational and behavioral needs of impoverished young children; however, the effects long term continue to be a debated issue, specifically relative to social emotional development outcomes (Morrison & Bratton, 2010). Past research has indicated that the benefits of participants gain from attending Head Start outweighs the cost associated with implementing the program (Ludwig & Phillips, 2008). However, the outcomes of any previous studies, particularly longitudinal ones, do not allow for the ability to make inferences of service impact on current or most recent participants. Because Head Start programming is ever evolving and taking on new ways of implementing its services to meet the needs of its population, ongoing research is needed (Gormely et al. (2011).

There is a reported unprecedented gap in research relative to effectiveness of intervention programs on social emotional development of preschool aged children (Gormely et al., 2011). This may be due in part to a lack of strategic ways or processes designed to deliver mental health intervention services (Green et al., 2012). Such strategies include ways that place priority on the mental health needs of children and ways for ensuring that service delivery supports staff as well (Green et al., 2012).

Other intervention programs, namely, Incredible Years, also attempts to support children who experience behavioral challenges in preschool settings. Incredible Years was originated by Professor Dr. Carolyn Webster-Stratton, also the Director of a renowned Parenting Clinic in Washington State, who has more than 30 years of experience with programs designed to enhance socio-emotional development of young children and their effectiveness (Webster-Stratton, Gaspar, & Seabra-Santos, 2012). Incredible Years is a training series for parents and teaching staff which provides ways for them to strategize and work together to reduce challenging behaviors of young children (Jones, Daley, Hutchings, Bywater, & Eames, 2007). Research has revealed that the skills of the parents show improvement from the training provided from the Incredible Years program; likewise, skills of teachers to better manage behaviors are also improved (Jones et al., 2007). Although the Incredible Years has gotten good reviews for being efficacious and for having more moderate long term results, Its primary focus is on children with attention deficit hyperactivity disorder (ADHD) and/or oppositional disorder (OD) (Olchowski, Foster, & Webster-Stratton, 2007) which was the reason for the program's development initially (Webster-Stratton, Reid, & Beauchaine, 2011).

Approaches to intervention

Not all programs have the same approach. For example, the Head Start program uses a three-tiered approach to helping children: child-centered, community partnerships and cultural relevance and competence (Ohio Department of Education, 2012). Child centered programs typically support the whole child. In such cases, Pianta, Howes, and Burchinal (2005) posited that such progress produces outcomes that are more favorable when programming emphasis is placed on children and when quality community partnerships are established. An example of

quality partnerships include collaborations between programs that provide intervention services and professionals that support programs such as, medical doctors, dentists and mental health consultants at zero costs (Wat & Gayl, 2009). Additionally, programs that give consideration to cultural relevance and competence allows for children to experience learning opportunities within the framework of individual children's ability to comprehend (Ohio Department of Education, 2012).

There are some programs that use empirically based approaches such as social learning theory. Social learning theory is based on the notion that learning occurs merely by the observation of another who has the same or like attributes of the observer (Deeming & Johnson, 2009). According to Campbell (2011), teachers and early educators have a vital part to play when it comes to ensuring young children develop appropriate social interactions as they utilize modeling and scaffolding strategies. Providing opportunities to learn social skills as well as opportunities to role play skills learned greatly supports children's ability to have acceptable peer interactions and to better self manage (Stanton-Chapman, Kaiser, Vijay, & Chapman, 2008).

While research shows that children benefit more when behavior intervention services are implemented during preschool aged years, there still remains a bigger push for more effective services. According to Conners-Burrow, Whiteside-Mansell, McKelvey, Virmani, & Sockwell, (2012), for more than a decade there has been little change in providing services that are more effective in efforts to meeting the social-emotional needs of young children. This is due, in part, to the fragmentation of service structure and implementation; in other words, children could benefit more from an effective practice based service that not only reduces challenging behaviors that lead to expulsion, but that also incorporates service components that address the whole child

(e.g., family, daycare, etc.) as a whole. Some feel that the answer to this problem has been discovered.

Behavioral and conduct problems are currently being considered among health policy makers and psychologists/psychiatrists as a mental health problem. Aggressive or challenging behavior among children are being rightly considered or treated as a mental health problem or disorder as a result of its abnormal orientation and its negative impact on both the individual and on the society as well (Morrison & Bratton, 2010). With this view, there have been a number of paradigms and measures developed for the purpose of managing and curbing the onset of this social menace (Morrison & Bratton, 2010).

Early Childhood Mental Health Consultation

Overview

A number of states have implemented a statewide intervention service to target the behavioral issues of young children ages two through five (Lyon et al., 2009). State-wide programming allows for a particular set of standards to be used when implementing services including qualification standards for those supporting services implementation (Duran et al., 2009). The state-wide intervention that states are using is called early childhood mental health consultation (ECMHC). According to Cohen and Kaufmann (2005), ECMHC can be defined as the following:

> "Early childhood mental health consultation (ECMHC) involves a professional consultant with mental health expertise working collaboratively with early care and education staff/programs and families to improve their ability to prevent, identify, treat and reduce the impact of mental health problems

among children from birth to age 6".

A major challenge to providing ECMHC services is the lack of adequate and ongoing funding. States previously and currently are tasked with finding creative ways of putting together funds from resource streams in order to start and sustain services (Wishmann, Kates, & Kaufmann, 2001; Gilliam, 2008; Perry & Linas, 2012). Conversely, some states utilize Medicaid to pay for services while others pull from State block grants and/or federal block grants from sources like that of the Substance Abuse and Mental Health Services Administration (SAMHSA) (Johnson, Knitzer, & Kaufmann, 2002). During times of advocacy, some administrators and agency directors advocate for funding by appealing to federal and state legislature as well as top policy makers (Wishmann, Kates, & Kaufmann, 2001). Notably, federal funding is one of the biggest sources of funding for implementation of ECMHC services (Johnson, Knitzer, & Kaufmann, 2002). Consequently, ECMHC intervention services are free to participants due to the funding that States receive from federal and/or state block grants, private funders and/or state Medicaid sources (Wishmann, Kates, & Kaufmann, 2001).

Although not an evidenced based program, it is important to briefly mention that the ECMHC model is a data driven, practiced based program or model designed to support young children considered to be at risk for significant mental health problems (Perry, 2011). This, notably, is due to funding being acquired from governmental sources at the state and federal level. According to Wishmann, Kates, & Kaufmann (2001), funders and grantors who provide funds for services require programs that receive funds to report annually to ensure accountability and to track overall outcomes (Johnson, Knitzer, & Kaufmann, 2002).

The ECMHC model was developed to provide help for children considered to be at risk and in need of the necessary support or intervention to avoid any future or long term mental health problems (Low & Shepard, 2010). As a result of increased concerns for the social-emotional development of young children, ECMHC was designed to alleviate or minimize challenging behaviors exhibited by young children in preschool-aged settings. Importantly, while it is not yet an official evidenced- based model, the success outcomes, revealed through research, imply that it is both reliable and valid in reducing expulsion (Williford & Shelton, 2008).

Avoiding expulsion, improving the teacher/child and child/peer interactions, decreasing negative or problematic classroom behavior and helping young children be better prepared for school are key elements of success outcomes (Duran et al., 2009). Success outcomes are fostered when more appropriate skills are learned to replace those that are causing challenges in early care settings (Duran et al., 2009). Notably, more appropriate replacement skills include self management skills, coping skills and social/peer interaction skills.

Background

Mental health consultation has been employed since the early 1960's. According to Green, Everhart, Gordon, and Gottman (2006), Gerald Caplan, known for his work in psychiatry, supported and encouraged mental health professionals to get to know and understand their clients better through consultation practices that fostered enhanced communication between client and psychologist (Green et al., 2006). Later, it was Greenspan and some of his colleagues who expressed that consultation could positively impact the mental health needs of young children (Green et al., 2006).

Since consultation was first mentioned or introduced, it has become a wide spread approach towards addressing the emotional and challenging behaviors of young children (Green et al., 2006). Additionally, ECMHC works towards achieving positive results and outcomes via the use of an indirect approach to enhance the socio-emotional development and well being of young children (Cohen & Kaufmann, 2005). Conversely, the mental health consultation concept birthed in the 1960's has evolved over time. The ECMHC model was created and developed out of this concept.

Early childhood mental health consultation as an intervention

Early Childhood Mental Health Consultation (ECMHC) fosters social emotional development in that it arguably enables young children the ability to better positively manage challenging behaviors in ways that leads to preschool placement sustainability, better relationships and interactions, and school readiness (Perry, Trivedi, & Duran, 2009). ECMHC also works to build the teaching skills of the caregiver in efforts of supporting the social emotional needs of young children, thereby avoiding expulsion (Mackrain, 2011). Notably, ECMHC is provided within early care settings and is uniquely distinguished or different from other early intervention services for young children in that it focuses on the whole child (Perry, 2011). Overall, ECMHC focuses on problem solving and capacity building involving children aged three to five, their families, early care professionals and early care programs (Allen, Brennan, Green, Hepburn, & Kaufmann, 2008). Although this intervention places emphasis on the reduction of challenging behavioral health issues associated with young children, it is not manualized or curriculum based; rather, it is an eclectic hands-on approach that is rooted in mental health (Cohen & Kaufmann, 2005).

When it comes to ECMHC, capacity building is an important piece to service implementation with collaboration among key stakeholders at the core of ECMHC service delivery (Perry et al., 2009). It is important to note, however, that ECMHC services provides indirect consultation and is not a direct or one on one treatment therapy (Allen et al., 2008). Indirect services consist of observations both of young children and classroom learning environments, while direct contact services consists of intake interviews with early care staff, and supportive action plan meetings that focus on ways in which early care providers, families and ECMHC professionals agree to work collaboratively on changing challenging behaviors (Perry, 2011).

Development of standards

Development of standards and guidelines is necessary for operating or implementing ECMHC services in a way that yields good outcomes, fidelity, and program success. In 2000, the state of Maryland, one of the many states currently implementing ECMHC services, led the nation in the development of standards and guidelines under which ECMHC professionals would use to guide service implementation (Perry, Trivedi, & Duran, 2009).

These standards and guidelines have great importance as other states reflect the need for such standards necessary for effectively operating but lack the financial means in which to conduct the research that is needed to develop program standards (Mackrain et al., 2011). These standards and guidelines were birth upon the three- year completion of a pilot project conducted in Maryland from 2002-2005 (Perry, Trivedi, & Duran, 2009). In addition to standards and guidelines, a conceptual framework along with terms and operational definitions were also developed as a result of the outcomes of the three year pilot project.

Barriers

There are at least three main or relevant barriers to ECMHC service implementation: parent and program compliance, stigma, and program sustainability (Duran et al., 2009). According to Duran et al. (2009), ECMHC services thrive when parents and program staff fully comply with the strategies provided by the ECMHC professional as it relates to the reduction of challenging behavior. Being in compliance reflects the willingness to learn new skills needed to participate fully in collaborations as well as the flexibility needed for implementation of the new skills learned on an ongoing basis (Duran et al, 2009).

Stigma is not a new concept as it relates to mental health. Individuals with mental health issues are more likely to experience discrimination, rejection, or be labeled as being crazy (Ward & Heidrich, 2009). For these reasons, individuals having mental health challenges avoid seeking professional help (Ward & Heidrich, 2009). Seeking out mental health treatment for young children supports the likelihood that they will not develop long term issues over the lifespan (Harwood, O'Brien, Carter, & Eyberg, 2008). Conversely, mothers of young children in particular avoid such a service out of fear that their child would be treated adversely by peers, community and family members and school personnel (Harwood et al., 2008).

Program sustainability is an important component to any program. States that have ECMHC services rely heavily on funding sources-state and federal- in order to be able to implement services to young children (Duran et al., 2009). Accordingly, much work is given to educating and lobbying the public and state and federal legislature to acquire and maintain program funding (Perry, Trivedi, & Duran, 2009). While some states rely heavily on grants derived from state and/or federal funding sources, other states are more creative in soliciting

funding by using the private insurance of referred children, and/or Medicaid, to pay for ECMHC services (Duran et al., 2009). In general, without adequate funding, states are, or would be, unable to enact and carry out effective servicing. Compliance, stigma and funding concerns regarding mental health can be reduced as barriers through rapport building, psycho-educational training, and the production of outcomes that reflect the need for funding necessary to continue services (Duran et al., 2009).

Conceptual Framework

At the core of effective ECMHC services are a set of important components. According to Duran et al. (2009), efficient services are borne from results acquired from the implementation of services that encompass the following elements. First, a robust program infrastructure: (a) strong leadership possessed by project managers and directors that allows them to be able to promote the program, establish and maintain relevant partnerships with stakeholders, create a system for acquiring data and feedback for program evaluation for improvement, and modeling a professional attitude for the ECMHC staff; (b) a clear model design that explains roles and responsibilities of all partners and stakeholders as well as how services will be implemented and access outcomes; (c) organizational structure that promotes accountability; and (d) hiring ECMHC professionals and training them in efforts of increasing their knowledge and understanding of early childhood mental health and service delivery; (e) funding to implement and sustain programming.

Duran et al. also suggest highly trained and qualified mental health professionals, which is defined as someone having met the requirements set and outlined by the standards for performing ECMHC services set in the state in which the professional is employed. Finally, high

quality service which is defined as services that address the whole child and programs in efforts to reduce expulsion rates and includes, but not limited to, child-specific consultation, program consultation, and family resource referrals when needed. Included in high quality services is the ECMHC professional's willingness to be flexible and available in meeting the immediate needs of children and programs being serviced. It can be noted that despite having the aforementioned incorporated into program services, an effective program is not successful without positive relationships and vital stakeholders expressing a readiness and willingness to implement ECMHC services (Duran et al., 2009).

Accordingly, the core components used independently of each other may produce minimal results, but together they produce a strong unified force that has the capacity to yield strong positive results on many levels; namely, a decrease in negative behavior, teachers that reportedly experience reduction in stress associated with the job, thereby creating more job satisfaction and an overall more positive learning environment for young children (Duran et al., 2009).

Solid program infrastructure

Strong leadership within the ECHMC program is essential. Individuals providing leadership are tasked with both hiring and training ECMHC professionals, providing support and clinical supervision, and being an advocate for the sustainability of the program (Cohen & Kaufmann, 2005). This, of course, requires that leadership connect with the appropriate sources for abstracting funds to ensure the longevity of the program. Leadership is a model for others and evaluates the program regularly to ensure efficacy among staff (Hepburn et al., 2007). Leadership is expected to be able to handle multiple tasks and think as well as act in an

organized and systematic fashion that strengthens the mission and vision of the program (Hepburn et al., 2007).

A solid program must employ a design model that is clear, concise and easy to implement. Such a model, allows for roles and responsibilities of key stakeholders to be clearly defined and outlined (Duran et al., 2009). Ensuring that roles and responsibilities are employed can be done through ongoing or regular communication and feedback between all parties. In addition to this, a clear organizational structure is also needful. While most consulting professionals are contractors, having accountability to a central management entity or leader supports in ensuring service fidelity (Duran et al, 2009). When consulting professionals followed the same program model, accuracy in data gathering could be more consistent thereby determining more concise and reliable outcomes (Green et al, 2006).

A program that has infrastructure that is solid also has a marketing strategy that brings awareness to ECMHC services within the community (Low & Shepard, 2010). This effort can be achieved through relationship building or partnerships that are established and maintained with community stakeholders, by attending community meetings, contacting early care providers and families of young children to promote services, and through participation at vending events in local communities (Duran et al, 2007). Further, brochures explaining services can also be used.

High quality services

Service delivery begins with knowing which kinds of services will be utilized based on individual and/or program needs assessment acquired at or during intake meeting with administrative director of program or teacher. There is an array of services that effective

ECMHC programs utilize, but the main service types employed are child-specific consultation and programmatic consultation (Duran et al., 2009).

Child-specific consultation focuses on individual children and facilitates a child-specific action plan that details the strategies and techniques to be used by the teacher/provider of a referred child (Allen et al., 2008; Carlson, 2012). Additionally, strategies written within the action plan provides the teacher/provider with new skills and ways for managing behavior of all children (Low & Shepard, 2010). Child-specific consultation is typically employed when an early care provider or staff administrator, through observation, has determined that a child is not only having behavioral challenges, but the kind of behavioral challenges that is resulting in a negative impact on both the child and the class, or learning environment, as a whole (Kaufmann, Perry, Hepburn, & Duran, 2012). Such behavior includes uncontrollable tantrums and aggression towards self and/or others (Lyon et al., 2009; Perry & Linas, 2012).

In addition to this, some children express symptoms that resemble anxiety or depression related to stressors experienced within the family structure that also leads to the display of challenging behaviors, and in such cases, child-specific consultation is ensued (Campbell, 2011).

A second type of ECMHC service is called programmatic consultation. According to Mackrain et al, (2011), programmatic consultation is initiated in efforts of providing technical assistance and supportive services. This service type leads to improved quality early care programming and improved skill level of providers and/or teaching staff in a way that supports the overall morale of the early care staff, as well as the social emotional needs of young children being serviced within early care settings (Mackrain et al., 2011).

Programmatic consultation encompasses training for early care providers, teaching staff, and administration on topics that help promote their understanding of the behavior of young children (e.g., classroom management, stress management, strategic ignoring, etc.) and effective ways for implementing new strategies and best practices for supporting social emotional development (Mackrain, 2011). Use of programmatic consultation can also be instrumental in reducing teacher stress and increasing staff retention (Campbell, 2011). In addition to this, programmatic consultation fosters the early care providers' ability to effectively build working relationships with the families that are serviced (Brennan et al., 2008).

In general, both consultation types tend to overlap when used in that as strategies implemented on a program wide level impact individual children in positive ways that may be displaying challenging behaviors but who have not yet been individually referred for ECMHC services (Mackrain et al., 2011). Determining the service type and ECMHC activities can be determined upon initial meeting with site facility director (see Table 7 for consultation checklist).

High quality service also includes directing and referring families to community resources when ECMHC services are not enough (Duran et al, 2007). Since ECMHC is an in direct service, referrals are made to a community based mental health provider in cases where children may need to be evaluated for symptoms that are beyond atypical (Perry, 2011).

Highly qualified mental health professional

Highly qualified ECMHC professionals are an important part of the consultation process. According to Duran et al (2009), the level of quality that each professional brings to the work determines the success of the programs being serviced. Like most professions, ECMHC professionals are required to meet certain prerequisites before being able to provide ECMHC

services to early care facilities. There are specific skills, characteristics, and education they are required to have. They must have skills necessary for: building good foundational relationships, communicating effectively to families and providers, working in multiple and diverse group environments, and influencing and encouraging families and providers to implement new techniques (Perry, 2006). ECMHC professionals must also have the following: 1) a solid working knowledge and understanding of challenging behaviors of young children birth through five as well as ways of dealing with the challenging behaviors exhibited; 2) latest up to date best practices for implementing mental health strategies with young children; 3) the culture in which they work with and how to be culturally competent in services approach; 4) relevant resources within the community; and 5) service systems relative to young children, families and early care providers (Perry & Kaufmann, 2009).

In addition to this, high quality ECMHC professionals are responsible for conducting assessments of children through observations and information gathered from providers and families (Mackrain, 2011). They are also responsible for providing action plans that reflect strategies and techniques to support the reduction of challenging behaviors of young children (Brennan et al., 2008). ECMHC professionals support the skill development of families and early care providers through training and coaching opportunities (Duran et al., 2009).

While having the skills that are needed to appropriately carrying out services, ECMHC professionals have certain character traits that are necessary for engaging key stakeholders (Perry & Kaufmann, 2009). Such characteristics include: respect for those being serviced, confidence to carry out services, non judgmental attitude, great introspection, easily entreated by others, strong ethical practices, active listening, full of compassion, able to work well with others to

solve problems, open for changes, and patience with those involved (Perry & Kaufmann, 2009). Even though States require that all ECMHC professionals meet the same requirements in the areas of skills and attributes, regardless of which state services are being employed, States differ in what is required in other areas; namely, licensure status and educational requirements.

Variations in States' Requirements for ECMHC Professionals

Educational & training requirements

There are 35 states that currently have an ECMHC program being implemented in some form or another, and out of those 35 states, 21 have programming being carried out throughout the entire state yet without any set or state-wide standards (Perry et al., 2009). Interestingly, there are only nine states that have state-wide required standards for those hired as ECMHC professionals (Perry et al., 2009).

When it comes to the educational and training requirements of ECMHC professionals, states that are implementing ECMHC services have their own unique description for what is considered highly qualified. For example, out of the 9 states that are implementing state wide ECMHC services, less than half require ECMHC professionals to have a four year degree in a human services branch of education: psychology, social work, counseling, special education (Brennan et al., 2008). Importantly, this is the standard throughout the entire state for ECMHC professionals where state-wide implementation is occurring. Other options do exist for those who do not meet these requirements upon being hired.

In cases where a degree obtained by ECMHC professionals is not within any human services branch of education, individuals are given the opportunity to match these requirements from accumulated credits or professional development training in a human services subject area

(Perry et al., 2009). Although individuals that possess certain skills, attributes or characteristics along with a Bachelor's degree in a human services field are considered highly qualified to carry out ECMHC services in some states, these requirements are not enough in other states.

States that are currently implementing state-wide ECMHC services determine individuals with a master's degree in a human services field to be highly qualified. According to Duran et al. (2009), not only are some states mandating that individuals have Master's degrees in a human services branch of education, but they must also have both experience and a working knowledge in young children's mental health as well as have licensure in a mental health discipline.

Table 1.

Professional Requirements for Six States

State	Programs	Educational Expectations	Professional Expectations
Michigan	Child Care Expulsion Prevention	Master's degree	• Licensure needed • Level II Endorsement—From State's Mental Health Association
Connecticut	Early Childhood Consultation Partnership	Master's degree -A working knowledge & experience in both early care & development & working with families	• Licensure not needed
San Francisco, CA	Early Intervention Program/Instituto Familiar de la Raza	Master's degree -Bilingual -Experience in the field	• Licensure needed
Baltimore City, MD	Early Intervention Project	Bachelor's degree in a human services field or special ed with a minor in early childhood -Experience	•Licensure not needed
Boulder, CO	Kid Connects	Master's degree -Knowledge & experience both in ECE & as a clinician	•Licensure needed
Central Massachusetts	Together for Kids	Master's degree -Experience	• License eligible at the time of hire

Note. Adapted from "What Works? A Study of Effective Early Childhood Mental Health Consultation Programs, by F. Duran, K. Hepburn, M. Irvine, R. Kaufmann, B. Anthony, N.

Horen, & D. Perry, 2009, Washington, DC: Georgetown University Center for Child and Human Development.

There is very limited evidence from available research literature to support ECMHC as being an evidenced based intervention service although research has revealed that results are positive when services are provided (Kaufmann et al., 2012). According to Brennan et al. (2008), ECMHC services are effective in decreasing expulsion when an ECMHC professional was paired with a provider in the child care setting. Reportedly, where preschool programs had access to an ECMHC professional over a significant amount of time, behaviors of young children dramatically improved towards more positive and socially normal behavior as did the job satisfaction of care givers and parents (Brennan et al., 2008).

Early care facilities that did not have exposure to the work of ECMHC professionals for services had greater numbers of expulsions compared to those who did (Gilliam, 2007). Skills and strategies that ECMHC professionals equip those that had access to them helps to reduce stress levels, and as a result, staff retention was increased, and improvements in the quality of the relationship with children displaying challenging behaviors was evident ((Perry et al., 2009). Research indicated that providers felt more empowered to manage their classrooms and children behaviors after having worked with ECMHC professionals (Kaufmann et al., 2012). Further, research conducted to examine the effectiveness of ECMHC services showed a notable decrease in expulsion rates of young children. This was in addition to improved provider self confidence, reduced staff turnover rates and improved relationships between child and provider because of ECMHC services (Brennan et al., 2008; Gilliam, 2005; Kaufmann et al., 2012). None however examined or revealed effectiveness of services for States that use non licensed professionals and States that use licensed professionals.

According to Cohen and Kaufmann (2000), there's been ongoing debate as to whether or not ECMHC services should be employed only by licensed professionals due to both their education and clinical training in mental health. However, Brennan et al. (2008) argued that there is no reason that anyone with a working knowledge and experience in early child mental health could not be equally effective in service delivery and simply because someone has a license in mental health does not make that person necessarily effective if they have no experience working with young children. It should be noted that the perspective of Brennan et al. (2008) lacks research support from other studies and thus has limited support. Additionally, there is no current research to prove if the use of an unlicensed professional is cheaper or has cost savings for parents.

Summary

This chapter reviewed literature that was relevant to challenging behaviors of young children and ECMHC services as an early intervention. The reviewed literature was selected from PsychInfo, PsychArticles, Academic Search Premier, EbscoHost, and Google Scholar databases. The following terms were used: challenging behavior, mental health, consultation, intervention, child care, preschool, and social skills. Studies chosen were from peer reviewed journals and articles and public domain web based cites.

This literature review provided a number of things of interest. First, it provided an explanation for what challenging behaviors among preschool children are and the short term and long term effects of behaviors described. Second, it provided insight into possible risk factors of challenging behaviors and why intervention services are both needful and beneficial. Last, it

provided insight regarding current intervention strategy, ECMHC program, and the qualifications of service providers.

The purpose of this study is to comparatively investigate child-specific consultation expulsion rates and parent satisfaction of ECMHC services delivery by two states: one that uses unlicensed professionals (Maryland) and one that uses licensed professionals (Delaware) in the implementation process.

While ECMHC is not yet an evidenced based treatment model, as a practice based model, previous research yielded results detailing the overall success outcomes of ECMHC services in that services are both appropriate and successful in reducing the expulsion rates among young children in preschool settings (Brennan et al., 2008). Unlike previous research, this study will be uniquely different in that no study prior has compared outcomes across states that have different requirements for service professionals responsible for ECMHC service delivery.

In chapter 3, the methodology to be used to complete this study will be described. The study's design and procedures for data collection will be included in that section.

Chapter 3: Research Method

Introduction

The methods used to conduct this study are described in this chapter. This chapter also includes the purpose of the study, study design, research questions, data collection and analysis processes, ethical considerations, and summary.

Purpose of the Study

The purpose of this study was to comparatively investigate child-specific consultation expulsion rates and parent satisfaction of children who received child-specific consultation of ECMHC service delivery by two states: one that uses unlicensed professionals (Maryland) and one that uses licensed professionals (Delaware) in the implementation process. In testing the hypotheses this study attempted to determine if unlicensed professionals are equally or more effective than licensed professionals. This study also purposed to add to the growing ECMHC literature that will provide support for policy makers regarding the development of nationwide standards of service professionals that is needed to address current shortages of service delivery.

Economic implications for ECMHC programs are second to the implications for there being a shortage of service professionals even though funding is an important part of service implementation (Johnson, Knitzer, & Kaufmann, 2002). Although funding is linked by some research, it was not the focus of this study.

Research Design

This study used secondary data from the 2012 program year to comparatively examine if there is a difference in child-specific consultation expulsion rates and parent satisfaction of ECMHC provided by service professionals in Maryland (unlicensed) and service professionals in

Delaware (licensed). This quantitative, non experimental research study addressed the null hypotheses presented in this study: (1) there is no difference in child-specific consultation expulsion rates between Maryland (unlicensed) and Delaware (licensed) and (2) there is no difference in parent satisfaction of children who received child-specific consultation between Maryland (unlicensed) and Delaware (licensed).

The independent variable for the study is licensure status with two levels: unlicensed and licensed. The dependent variables are child-specific consultation expulsion rates and parent satisfaction of children who received child-specific consultation. Early childhood mental health consultation Professional qualifications are summarized in Table 2.

Table 2 *Summary of Professional Qualifications for Maryland and Delaware*

Program	Education/Experience	Professional Requirements	Professional Development
Maryland	Bachelor's Degree with experience in ECE. Licensed Supervision.	Not Required	Required
Delaware	Master's Degree with experience in ECE and early childhood mental health.	Required	Required

Expulsion

Expulsion is the permanent loss of a child's preschool or childcare placement. ECMHC services are instituted when a teacher or provider has determined that a child's behavior warrants expulsion (Gilliam & Shahar, 2006). In an attempt to avoid such action, a partnership begins between the teacher or provider and the ECMHC program professional (Green et al., 2006). If expulsion of a child referred for child-specific services is avoided due to the consultation, the outcome is considered successful (Hepburn et al., 2007).

Parent satisfaction

For the purpose of this study, parent satisfaction is defined as the opinions and feelings of a parent regarding the effectiveness and experiences of ECMHC services received after the completion of child-specific consultation. At the end of a child-specific consultation, the parent/caregiver is provided with a satisfaction survey. The ECMHC professional provides a satisfaction survey for the purposes of service evaluation and improvements. The questions provided are relative to the parents' experiences with the ECMHC professional throughout the consultation period. Also, questions ascertain parents' perception of service impact on their child's behavior.

Prior to data collection, permission to use data was granted by Maryland (unlicensed) (Appendix A) and Delaware (licensed) (Appendix B). Upon proposal approval and IRB approval, data regarding unlicensed professionals were collected from the Maryland State Department of Education (Appendix C), and data regarding licensed professionals were collected from the Department of Services for Children, Youth, and Their Families in Delaware. (Appendix D).

Population and Sample

All data from the 2012 program year from the states of Maryland (unlicensed) and Delaware (licensed) will be examined.

Maryland (unlicensed)

In 2002, ECMHC programming in Maryland began as a pilot program (Perry, Trivedi, & Duran, 2009). The pilot program was funded for 3 years. There were two regional sites, or counties, selected for funding which was used to determine ECMHC impact on the behavior of

children in preschool settings (Perry, 2005). Funding was provided through the Maryland State Department of Education (Mackrain et al., 2011; Perry, 2005).

The results of the three-year project showed that ECMHC services produced fewer expulsions (Perry et al., 2009). Because of this, the state expanded its programming capabilities adding 10 additional regional jurisdictional sites or counties: 12 sites that would enable service implementation throughout the entire state (Mackrain et al., 2011).

During the initial implementation stages, services offered included child-specific consultation and classroom wide consultation (Perry & Linas, 2012). Child-specific consultation deals with resolving the behavioral issues of a single identified child whereas classroom wide consultation deals with resolving the behavioral issues of multiple children within the early learning setting (Perry et al., 2008).

In addition to child-specific and classroom wide services, consultation was performed in the home for those families that received combined services of child-specific and family specific consultation (Perry, 2011). Conversely, consultation provided within the home accommodated families who lacked transportation or resources to access services normally provided within the early care environment (Perry, 2005). For this study, child-specific consultation will be analyzed.

Delaware (licensed)

Delaware's ECMHC program was created in 2009. The program was birthed out of the need for services as Delaware ranked 4th in the United States in expulsion of children preschool age (Gilliam, 2005). The Division of Prevention and Behavioral Health Services, Children's Department oversees and implements this program using contracted licensed ECMHC

professionals who provide services throughout the entire state (healthy childcare, n.d.). Program funding is made possible through federal and state resources.

Funding sources for the program include the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Health and Human Services (HHS), and the Division of Prevention and Behavioral Health Services (DPBHS), state of Delaware (ECMHC, n.d.). Funding received helps to create and implement services throughout the entire state in efforts to support the behavioral health care needs of young children and their families (Resource Details, 2011). Accordingly, services are offered at no cost to participants.

Data Collection

Original data collection processes

States that provide ECMHC services vary on their overall methodology when implementing services in efforts to avoid the expulsion of young children (Kaufmann et al., 2012). Although service implementation may vary in the general sense in some states, both Maryland and Delaware share in the use of similar processes for service implementation, and there are no differences in how data is collected. For example, common processes include the following:

1. A referral for service is received to the ECMHC professional from a early care facility or provider for a child that is in jeopardy of being expulsed from the early care environment due to the display of challenging behavior;
2. once a referral is received, an appointment is made by the ECMHC professional to visit with the referring early care facility or provider to discuss the ECMHC

processes, roles, expectations, and to have all relevant agreement forms signed to conduct services;

3. intake information on a referred child is gathered through an interview process with the primary teacher or provider;
4. intake information is gathered through an interview with the referred child's parent or caregiver;
5. appropriate assessment tools or measurements are provided to both teacher/provider and parent/caregiver for completion for the purposes of gauging the frequency and level of intensity of the behavior as well as to assess the overall needs of the family and collected upon completion;
6. an initial observation is scheduled and conducted by the ECMHC professional on the referred child referred within the learning environment;
7. the ECMHC professional creates an action plan and arranges strategy meeting with teacher/provider and parent/caregiver following the initial observation;
8. as the teacher or provider implements the strategies from the action plan, the ECMHC professional provides ongoing consultation via coaching, training, modeling, and whatever additional support necessary to assist teachers and the parent/caregiver;
9. services conclude when all parties have agreed that behavioral goals have been met using the strategies provided;
10. teacher and parents are provided with post assessment measurements used for assessing the reduction of challenging behaviors; and

11. upon consultation completion, parents also receive satisfaction surveys which are used to measure satisfaction of services and to assess areas of ECMHC that need improvement (Mackrain, 2011).

Secondary data collection processes

This study was conducted using ECMHC secondary data from the 2012 program years. This study acquired data from the state of Maryland (unlicensed) and from the state of Delaware (licensed) detailing the following ECMHC characteristics: service type child-specific consultation, parent satisfaction of children who received child-specific consultation, and the number of expulsions. Additionally, other information acquired included the number of programs serviced, the average time to complete a consult, the average number of hours per case, and the number of community based referrals. Permission to use each state's data was granted. Letters of Agreement for data usage were provided by both Maryland (Appendix A) and Delaware (Appendix B).

Upon proposal approval from the dissertation committee, an IRB application was submitted to Walden University's IRB for research approval as required. Upon IRB approval, formal letters requesting data were sent to Maryland (Appendix C) and Delaware (Appendix D). From the time letters requesting data were sent and the receipt of all data was six months.

Research Questions

Preschool programming is designed to ensure that young children are prepared for future academic success (Mashburn & Pianta, 2006). Within the preschool setting, young children are exposed to sharing, social learning, and cause and effect learning (Deeming & Johnson, 2009). When young children are unable to manage their emotions during peer exchanges or interactions,

challenging behavior is the result (Gilliam, 2008). Young children who do not develop social skills emotionally or learn skills needed to self manage typically end up expulsed from their preschool setting (Gilliam, 2005).

Early childhood mental health consultation services are designed to promote social emotional development in ways that reduce challenging behavior enabling young children to avoid expulsion (Low & Shepard, 2010).

While ECMHC services are designed to promote social-emotional development, ultimately, the ECMHC program can only exist where there is funding, and funding exists where there are good outcomes resulting from the data collected (Johnson, Knitzer, & Kaufmann, 2002). With this being the case, funding used to maintain programs rely heavily on not just children being able to avoid expulsion but also on the satisfaction of parents of children who receive the service (Johnson, Knitzer, & Kaufamann, 2002). Outcomes that reflect successful service implementation allows for funding to be provided so that services can continue.

Specific questions addressed in this study included:

RQ1: Is there a difference in child-specific consultation expulsion rates between Maryland (unlicensed) and Delaware (licensed)?

RQ2: Is there a difference in parent satisfaction of children who received child-specific consultation between Maryland (unlicensed) and Delaware (licensed)?

Data Analysis

For this study, IBM SPSS Statistics (Statistical Product and Service Solutions) 22.0 was be used to conduct all analyses (IBM Corp, 2013). This study's analyses included descriptive statistics, chi square test, and independent samples *t* –test. Secondary data from the 2012

program year was used. This study also used a two – tailed test. The independent variable for this study is licensure status with two levels: unlicensed and licensed. There are also two dependent variables: child-specific consultation expulsion rates and parent satisfaction of children who received child-specific consultation. Possible confounders of this study included SES, time spent in childcare, class size and ratios, teacher/child interaction, classroom management practices, and parenting style. However, very little differences were discovered across states based on a few reasons.

Firstly, very little differences across states exist regarding SES because ECMHC is provided to children preschool age attending Head Start or public childcare facilities. This is noteworthy because such facilities contract with federal and state agencies to receive a reduced payment amount in order for qualifying families to be able to receive affordable childcare services via childcare subsidies. Subsidies provided to qualifying families helps with the costs associated with childcare. Children receiving free or subsidized childcare are able to do so because their families meet the required income eligibility set forth at the federal level: below 200% (Child Subsidy Program, nd).

Secondly, time spent in childcare, class size, and teacher/child ratio were controlled because all licensed child care programs implement services as mandated by state requirements or standards (e.g., Maryland teacher/child ratio is 1:10, and Delaware's teacher/child ratio is 1:12). Both Maryland and Delaware have child care licensing agencies that monitor programs to ensure that required ratios are followed as well as ensure that children receiving child care subsidies do not exceed their allotted times. These allotted times are pre-determined based on need and are contracted between the parent and the state agencies in which they reside.

Lastly, little differences exist in classroom management practices and parenting style because ECMHC professionals provide teachers with technical assistance for managing classroom behavior and skills for improving the teacher/child relationship (Perry et al., 2008; Perry et al., 2011). ECMHC professionals also provide the parents of referred children training to support parent understanding of identified challenging behavior and techniques for improving parenting skills (Mackrain, 2011).

This study used all available data to detect if there are real differences in expulsion rates of child-specific consultation and parent satisfaction of children receiving child-specific consultation. This study predicted that of all available cases (N = 505), 10% (n = 50.5) would be incomplete making the sample size n = 455 (w = 0.168, p = 0.05, power = 0.80). The sample size and power calculations were determined using GPower3 software (Faul, Erdfelder, Buchner, Albert-Georg, 2009).

Descriptive statistics were used to summarize the following data: (1) the number of programs serviced, (2) number of child specific cases (3) the average time to complete a case, (4) the average number of hours per case, and (5) the number of community based referrals made. This study reported this information separately by state. These particular variables were chosen to provide an overall picture of the work provided by ECMHC professionals.

Chi square test was used to test the null hypotheses presented in this study: (1) there is no difference in child-specific consultation expulsion rates between Maryland (unlicensed) and Delaware (licensed), and (2) there is no difference in parent satisfaction of children who received child-specific consultation between Maryland (unlicensed) and Delaware (licensed).

Additionally, the results of chi square test were used to determine if the licensure status of a state is associated with child-specific consultation expulsion rate outcomes.

Child-specific consultation expulsion rates for each state were calculated and compared by investigating the number of expulsions divided by the total number of child-specific consultations. Rates were then multiplied by 100 to determine expulsion rates per every 100 children referred for services.

It was proposed that the differences between incomplete and complete cases within each state would be analyzed using independent samples *t* -test. It was determined that the variables that would be used for analyzing case differences within Maryland (unlicensed) would include: setting type, risk factors (e.g., incarcerated parent, homeless, foster care), and jurisdiction where services were provided. The variables that would be used for analyzing case differences within Delaware (licensed) would include: setting type, participating adult (e.g., biological parent, family member, foster parent), and jurisdiction where services were provided. However, there was not enough data to perform the analyses.

After child specific consultations are completed, parents are given satisfaction surveys for the purposes of improving services. A comparison was to be made of the proportion of parents of the children that received child-specific consultation; however, this study was unable to analyze parent satisfaction because there was not enough data available to do so.

Threats to Validity

This study used secondary data. Notably, threats to validity were present. Conversely, use of secondary data provides an array of information, yet information provided from secondary data is not perfect. The potential for confounding is did exist. When using secondary data, there

is potential for cofounders to go unmeasured allowing some covariates to not be controlled for (Cox et al., 2009). Identifying potential bias and doing what is necessary to reduce bias when performing a study is important as the outcomes of the study hangs on whether or not the results have been properly or improperly analyzed (Gambino, 2011).

This study's aim was to reduce bias and error; however, there is always the likelihood of there being the presence of unmeasured covariates which could lead to confounding outcomes if undetected or when left out of relevant analyses (Fewell, Smith, & Sterne, 2007). While there were potential problems, this study's design addressed these problems as the more important variables were controlled based on the fact that those receiving child-specific consultation had to meet established program prerequisites in order to receive services.

Ethical Concerns

This study was conducted using ECMHC secondary data from the 2012 program year. Data sources were the states of Maryland (unlicensed) and Delaware (licensed). This study acquired datasets that contain ECMHC characteristics: service type child-specific consultation, parent satisfaction of children who received child-specific consultation, and the number of expulsions. Since secondary data was used, there was no contact with participants from which data was originally collected.

Upon proposal approval by a dissertation committee, an IRB application was submitted to Walden University's IRB for research approval of this study as required. Upon approval, the Maryland State Department of Education and Delaware's Department of Services for Youth, Children and Their Families were contacted and provide IRB approval notice and information.

Data were provided in an electronic, de-identifiable format and was securely stored on a password-protected computer. Upon completion of this study, data files were permanently deleted from the stored source.

Summary

The design and methods used to carry out this study are provided in this chapter. The study employed a quantitative, non-experimental design. This study also used secondary data. This study examined child-specific consultation expulsion rates and parent satisfaction of ECMHC services between two states. This study assumed that the results would be relative to the ECMHC professionals in states currently delivering services.

The results from this study contribute to ongoing research of ECMHC. This study also provides relevant information that can be used to develop a nationwide consensus of educational and professional requirements for ECMHC service professionals that can address current shortage issues. Current policy allows for each state to determine independently what credentials a service professional is required to have (Duran et al, 2009). Because of this study's results, present policy is subject to review.

Results of this study are recorded in Chapter 4. Chapter 5 provides a summary of this study's results or findings and conclusions, provide discussion, and recommendations for future studies.

Chapter 4: Results

Introduction

The purpose of this study was to comparatively investigate child-specific consultation expulsion rates and parent satisfaction of children who received child-specific consultation of ECMHC service delivery by two states: one that uses unlicensed professionals (Maryland) and one that uses licensed professionals (Delaware) in the implementation process. This quantitative, non-experimental study used secondary data to complete this study. There were two specific research questions that guided this study: (1) RQ1: Is there a difference in child-specific consultation expulsion rates between Maryland (unlicensed) and Delaware (licensed); and (2) RQ2: Is there a difference in parent satisfaction of children who received child-specific consultation between Maryland (unlicensed) and Delaware (licensed)? The results of this study yielded that there is no statistically significant difference in child-specific expulsion rates between unlicensed (Maryland) and licensed (Delaware) ECMHC professionals. Evidence suggests that unlicensed programs (Maryland) are just as effective as licensed programs (Delaware). The difference in parent satisfaction of children who received child-specific consultation was undetermined due to missing data.

The chapter is a summary of the results and findings of this study using the aforementioned analyses.

Data Collection

Early childhood mental health consultation secondary data was used to complete the study analyses. Approval to perform this study and to collect data from data sources: Maryland (unlicensed) and Delaware (licensed), was granted by Walden University's IRB (Appendix E).

Upon IRB approval, letters requesting data to complete this study were sent to the state of Maryland's representative (Appendix C) and to the state of Delaware's representative (Appendix D). The data collection process took 6 months to receive. The data collected processes presented in chapter 3 were followed as presented.

Results

This study comparatively examined ECMHC outcome effectiveness in states: Maryland (unlicensed) and Delaware (licensed) for the 2012 year program year. Child-specific consultation expulsion rates and parent satisfaction were analyzed. The results for child-specific consultation expulsion rates show that there is no statistically significant difference between unlicensed (Maryland) and licensed (Delaware) ECMHC service professionals; therefore, the null hypothesis cannot be rejected. Further, results of this study show that an average of four out of every 100 child -specific consultation cases result in expulsion. Table 3 summarizes the number of child-specific consultation rates and the number of placements that were maintained for both states as well as the number of cases that were not completed or maintained. Parent satisfaction of ECMHC services delivered by both states was undetermined due to missing data.

Table 3

Total Number of Expulsions and Maintained Placements for Year 2012

State	Number of Expulsions	Maintained Placement	Left Programs for Other Reasons	Remaining Cases Open	Total
Maryland (unlicensed)	17	268	74	11	370
Delaware (licensed)	3	119	13	0	135
Total	20	387	87	11	505

Note: "Other reasons" refer to reasons ECMHC services ended before completion of services that include child/family moved, parent chose to move child to a different/more appropriate setting, services no longer applicable, and teacher non-compliance. Also, *n* = 11 cases were still open at the end of the 2012 program year in Maryland (unlicensed).

Descriptive statistics was used to summarize the following data: (1) the number of programs serviced, (2) number of child specific cases (3) the average time to complete a case, (4) the average number of hours per case, and (5) the number of community based referrals made. These services are summarized in Table 4.

Maryland

The number of childcare centers/facilities that received child-specific consultations in Maryland (unlicensed) was 361. There were 11 various programs that received this service. The frequency for which services were provided to each center/facility was between three and 116. The number of child-specific referrals or requests for consultation services was *n* = 370. Of the total number of child-specific consultation cases started, *n* = 268 children were able to maintain the placements; thereby avoiding expulsion. Table 3 summarizes the expulsion rates and the number of placements maintained in Maryland (unlicensed). It is worth noting that the average time to complete a consultation from start to finish was five months; however, the average number of hours per consultation was undetermined. The number of community based referrals made was *n* = 197. The number of referred cases needing additional support services ranged between *n* = 1 and *n* = 75. There were a number of cases that were referred for direct clinical services within their local communities (*n* = 75). The majority of cases, however, it was determined that *n* = 94 cases did not display a need for additional supportive services.

Delaware

In Delaware, the number of childcare centers/facilities serviced was 40. The frequency for which services were provided to each center/facility as between *n* = 1 and *n* = 16. The number of child-specific referrals or requests f or consultation services was *n* = 135. Of the total number of child-specific consultation cases started, *n* = 119 children were able to maintain the placements; thereby avoiding expulsion. Table 3 summarizes the expulsion rates and the number of placements maintained in Delaware (licensed). The average time to complete a child specific consultation (in months) was 3.76. The average number of consultation hours per case was 11.16. The number of community based referrals made was *n* = 66. The number of referred cases needing additional support services ranged between *n* = 1 and *n* = 49. The majority of cases were referred for Parent Child Interaction Therapy (PCIT) (*n* = 49). PCIT is a form of intervention or behavioral therapy that helps to reduce emotional disturbances and increase compliance among children between the ages of two and seven (Eyberg, Boggs, & Algina, 1995). Additionally, 4% were referred for either speech, occupational or physical therapies while only 3% of all cases were referred for general outpatient therapy during which time, children were able to receive services at the site of the childcare placements. Conversely, children that received an outside or community based referral were able to receive the services at their childcare placements.

Table 4 summarizes these ECMHC service characteristics for both states.

Table 4

Early Childhood Mental Health Consultation Service Results Summary for Year 2012

Service Components	Maryland (u)	Delaware (l)
Total number of centers serviced	361	121
Total number of child-specific consultations	370	135
Average number of hours per consult	n/a	11.16
Average time to complete a consultation in months	5	3.46
Total number of community based referrals	197	66

$p > 0.05$

Expulsion rates

It was proposed that chi square test would be used to test the first null hypotheses presented in this study: (1) there is no difference in child-specific consultation expulsion rates between Maryland (unlicensed) and Delaware (licensed); and (2) there is a difference in child-specific consultation expulsion rates between Maryland (unlicensed) and Delaware (licensed). In addition to this, it was proposed that chi square test would be used to determine if the licensure status of a state is associated with child-specific consultation expulsion rate outcomes; however, Fisher's exact test was employed instead of the chi square test. According to Creswell (2009), the Fisher's exact test can be used to correct for small sample and/or number of expected frequencies by providing the exact *p* –value when all assumptions are met.

The results from this study show that there were higher child-specific consultation expulsion rates among unlicensed (Maryland) professionals (n = 17; 6%) than child-specific consultation expulsion rates among licensed (Delaware) professionals (n = 3; 3%). While this is true, the results using the Fisher's exact test show that there is no statistically significant difference, p = 0.1714. Therefore, the null hypothesis cannot be rejected and it can be concluded that there is no statistically significant difference in child-specific consultation expulsion rates between unlicensed (Maryland) and licensed (Delaware).

To determine the average number of child-specific consultation expulsion rates for each state, rates were calculated and compared by investigating the number of expulsions divided by the total number of child-specific consultations. Rates were then multiplied by 100 to determine expulsion rates per every 100 children referred for services. Within the state of Maryland (unlicensed), five out of every 100 children referred for child specific consultation services were expulsed. Within the state of Delaware (licensed), two out of every 100 children referred for child specific consultation services were expulsed.

Parent satisfaction

It was proposed that the chi square test would be used to test the second null hypothesis for this study: (1) there is no difference in parent satisfaction of children who received child-specific consultation between Maryland (unlicensed) and Delaware (licensed); and (2) there is a difference in parent satisfaction of children who received child-specific consultation between Maryland (unlicensed) and Delaware (licensed). However, due to a small sample size, the researcher was unable to effectively test the null. It was also proposed that an independent samples t –test would be used to examine the differences between incomplete and complete cases

within each state as needed with the assumption that only 10% of the total available data would be missing. The researcher was unable to perform this analysis as well.

Summary

The descriptive statistics analysis provided a comparative overview of (1) the number of programs serviced, (2) the number of child specific consultation cases, (3) the average time it took to complete a case, (4) the average number of hours per case, and (5) the number of community based referrals made. Chi square was the initial test proposed to be used to test the first null hypothesis presented in this study. However, to correct for the small sample size and/or small number of expected frequencies, Fisher's exact test was used instead. Based on the results of this study, it was determined that there is no statistically significant difference in child-specific consultation expulsion rates between unlicensed (Maryland) and licensed (Delaware) ($p > .05$). Therefore, the first null hypothesis can be accepted. The null for the second hypothesis could not be tested due to missing data. The proposed independent samples *t*- test also could not be used to analyze missing data regarding parent satisfaction as the sample size was too low to do so.

Chapter five provides discussion about key findings, recommendations for future research, and social change implications.

Chapter 5: Discussion

Introduction

The purpose of this study was to examine child specific consultation expulsion rates and parent satisfaction of children who received child specific consultation of ECMHC services delivered by two states for the 2012 program year: one that uses unlicensed professionals (Maryland) and one that uses licensed professionals (Delaware). This study's aim was to lend to the growing literature of ECMHC services in efforts to address the current shortage of service professionals due to the lack of a general consensus regarding what skills and attributes an individual needs to have in order to be considered highly qualified and/or effective. While previous research has already shown how effective ECMHC at addressing expulsion among preschoolers, there are no previous studies that have sought to determine if there is a relationship between the licensure status of an ECMHC professional and the expulsion rates of preschool aged children.

Findings indicated that there is no statistically significant difference in child specific consultation expulsion rates between unlicensed (Maryland) and licensed (Delaware). Findings regarding whether or not there is a difference in parent satisfaction of children who received child specific consultation was undetermined due to the lack of or absence of required data. Additionally, findings resulting from incomplete data were also undetermined due to the data being too small.

Interpretation of the Findings

Expulsion rates

Previous research reveals that ECMHC is an effective approach to reducing expulsions of pre-school aged children. According to Gilliam (2008), research shows that children who experience challenging behaviors that lead to expulsion from pres-school programs (e.g., excessive tantrums, physical and verbal aggression, and/or poor social interactions) are at risk of developing long term and more chronic mental health issues if untreated. Children who received ECMHC had reductions in negative or challenging behavior frequency and duration (Carlson et al., 2012). This is an important outcome as the decrease in challenging behaviors equal to children avoiding expulsion from preschool settings. According to Gilliam (2008) and Duran et al (2009), there is a lack of available ECMHC services for young children due to the lack of qualified service providers.

This study's results echoed expulsion rate outcomes of previous studies in its comparison of two states that implement ECHMC services at the state level. Data for the 2012 year was examined and the results showed that both states were successful in reducing expulsion rates: Maryland (unlicensed) (N = 268; n = 17); and Delaware (licensed) (N = 119; n = 3). In other words, 268 young children avoided being asked to leave their childcare placements in Maryland (unlicensed) while 119 young children avoided being asked to leave their placements in Delaware (licensed). While this is true and important, this study's outcome showed that there is no statistically significant difference in outcomes between states. Additionally, it was concluded

that licensure status of a state cannot be associated with child specific consultation expulsion rates outcomes. Notably, there are no studies or research that relates to this current one.

Parent satisfaction

While this study's results were not statistically significant regarding the first hypothesis, the study's result regarding the second hypothesis was undetermined due to the sample size being too small to be analyzed. With data driven programs, parents are often tasked with having to complete a high volume of assessments before services begin and after they've ended. According to Bratton et al. (2012), although parent input are valuable and can contribute greatly to services and outcomes, actual participation is never forced (Bratton et al., 2012). While it is well documented that there are good effects when parents engage in their child's development, it is not always possible for them to do so (Crust et al., 2013), thus using strategies that will allow for good service outcomes for young children at risk of expulsion without reliance on parent engagement is worth investigating.

Cost effectiveness

Maryland is one of the premier states providing ECMHC services for young children. It helped to establish, through its own research, ECHMC characteristics and conceptual model currently being followed by those responsible for implementing ECMHC services in other states; namely, Delaware. One difference between the two states in terms of policy is that Delaware is a licensed state, or in other words, Delaware's hired ECMHC professionals are required to be licensed as mental health professionals in order to provide services, whereas Maryland's hired professionals are not. Specifically, unlicensed ECMHC professionals working in Maryland

(unlicensed) are required to have a minimum of a Bachelor's degree and experience and knowledge in early childhood development, and licensed ECMHC professionals working in Delaware (licensed) are required to have a minimum of a Master's degree in a human service discipline, licensed as a clinician in psychology or counseling, and experience and knowledge in early childhood development (University of Maryland School of Medicine, 2011).

Much of the research recognizes ECMHC as a collaborative approach where partnerships within the early childhood community work together to address challenging behavior that leads to expulsions of young children. The very nature of ECMHC services requires a sufficient amount of funding to be available in order to service the needs of the target population which consist of low income children and families that attend public preschool programs including Head Start. The funding that is obtained often comes from state and federal sources through block grants. Such funding provides some relief to ECMHC programs so that those hired to provide services can be paid whether those paid are unlicensed or licensed.

On the surface, from an overall financial perspective, it would make sense for states to hire unlicensed ECMHC professionals since funds for higher salaries are needed when licensed individuals are hired as licensed individuals have more to bring to the position that include clinical schooling and training as well as professional licensure. It is worth noting that despite Maryland employs a licensed mental health professional to provide case consultation supervision as well as a director of its program: one who typically is a licensed pediatrician (Allen et al., 2008). Unlicensed staff meets at least once a week for case consultation and mentoring (Duran et al., 2009). A few of the number of things Maryland (unlicensed) does for quality assurance is

conduct quarterly interviews and service logs that are designed to assess for areas of improvements (Perry, Trivedi, & Duran, 2009).

Relative to the hiring of licensed professionals, while more funding may be needed for supervisory staff to oversee the work of unlicensed professionals, less funding may be needed in this area in that licensed professionals have both the credentials and expertise to make an appropriate diagnosis and community referral if needed without the direct support of supervision (Kress, Hoffman, & Eriksen, 2010). Additionally, billing via third parting billing directly to the child's or families' insurance company can be an ideal option for states looking to fund their ECMHC programs (Kress, Hoffman, & Eriksen, 2010). So with this scenario as an option, programs could benefit by hiring a licensed professional as well.

Ethical boundaries

It is important to mention that from an ethical perspective, there are no immediate ethical concerns regarding the hiring of an unlicensed professional vs. a licensed professional for at least two reasons. First, the current ECMHC framework or model is one that indirectly supports the needs of a referred child by providing direct support services to the early childhood education program staff or teachers instead. In other words, it is the child's teacher that receives direct classroom support, management training, mentoring, and coaching for dealing with the behavior of the referred child throughout the consultation period. Second, at no time, based on this current model, does the ECMHC professional provide any direct one on one care treatment to a referred child. Conversely, programs within some states, such as: Massachusetts and California, are moving to include direct care services to expand funding options and are doing with the

understanding that only licensed professionals can be utilized (Capella, Kim, Hamre, Henry, Frazier, Atkins, & Schoenwald, 2012).

How covariates were controlled

The confounding variables for this study included SES, time spent in childcare, class size and ratios, teacher/child interactions, classroom management, and parenting style. This set of covariates do not impact or pose any threat to the finding that unlicensed professionals are not more or equally effective in reducing expulsion rates among preschool age children than licensed professionals. Regulations and rules governing childcare businesses for both Maryland and Delaware are quite homogeneous. Due to the homogeneity of early childcare licensing regulations shared by Maryland and Delaware, the homogeneity of qualifications for those receiving subsidized childcare assistance attending programs serviced by ECMHC professionals as well as the homogeneity of ECMHC support of families of children receiving ECMHC consultation, the covariates of this study were controlled for.

Limitations of the Study

One limitation of this study is that it used secondary data with the assumption that the data provided would be relevant to all research questions and allow for all research questions to be analyzed. Another limitation of this study is that it was limited in its ability to successfully address both research questions alike due to lack of sufficient amount of parent satisfaction data which was too small to do an adequate analysis. Further, this study employed a quantitative methodology to address the null hypotheses but a mixed methodology could have better addressed the research questions more efficiently.

Recommendations

Recommendation for future research is for this study to be replicated. The simplest approach for this would be to conduct data analyses of unlicensed and licensed professionals within the same state of those states that may currently be utilizing both to perform ecmhc services. Conversely, the benefit of using one state may allow for the reduction or minimization of confounding issues and concerns that may arise; however, this could pose a problem where there would be an imbalance of unlicensed to licensed ratio (e.g., 12 unlicensed professionals: two licensed professionals) as it related to the number of child-specific consultation cases that were referred. This, of course, would have an impact on the sample size or the available cases that could actually be analyzed. For this reason, a multi-state, multi-year, longitudinal study – using secondary data- could be best applied.

This study would include the same key variables that were used for the current study in addition to pre and post test behavioral assessment scores to determine if there were noticeable changes in challenging behaviors of children that received child specific consultation services. Controlled variables would also include child specific consultations performed in preschool settings, early childhood education facilities that provide services to families that received subsidized childcare, teacher and parent training and support, just to name a few.

Broadening this study to include multiple states over a multi-year period had a few advantages: (1) it allows for a greater number of child specific cases to be included, increasing the sample size needed when doing a longitudinal study (Farrington, 1991); (2) a longitudinal, multi-state approach better details outcomes performed by both service professional types as it

relates to behavior improvements; (3) this approach may also show, overall, if expulsion rates increased, decreased or merely stayed the same; and (4) this approach would allow the isolation of rates of improvements specific to unlicensed professionals and licensed professionals.

The disadvantages to using this type of approach may include the amount of available or unavailable data due to improper collection processes. Additionally, this type of study could be extremely time consuming and costly (although available research grants are an option of pursuit where available). Another factor would be the capacity to manage larger amounts of data appropriately. Besides these, a change in the variables being collected by states during the time periods being analyzed by the study could also be a disadvantage to using this type of approach.

Aside from using a longitudinal approach, a replicated study could also benefit from using a mixed method approach. Using a combined approach may provide more validity to the study's results (Farrington, 1991). Measurements for this type of study would include the pre and post behavioral assessments or tests used by states to determine baseline or severity of behavior at the start of ecmhc services, and the post test assessments that are used to assess the reduction of challenging behavior once services have concluded. While each state may likely use different types of pre/post test assessments, they all rely on baseline behavior scores and the post assessment scores at the completion of services to determine service effectiveness.

An interview survey of parents may be a better approach to get services satisfaction. Questions would include: (1) Overall, were you pleased with services? And (2) Would you refer this service to anyone else? Response options would be "yes" or "no". Such surveys would be done via electronically.

Advantages to using this approach would be that it is less structured yet very commonly used, it saves both time and money, it allows for multiple surveys to be sent at one time, and because it is a short survey, the likelihood of parents not responding decreases (Meho, 2006). The disadvantages, however, are that they limit responses to only those able to utilize a computer with working internet (Wright, 2006). This approach also requires IRB's to have a more sophisticated understanding of such methods in that this approach is not any more harmful to participants than traditional approaches when collecting data when the same appropriate safe guards are in operation. Notably, according to Wright (2006), some IRB's lack such experience.

Social Change

The findings of this study, despite its limitations, do invoke conversation regarding social change as it relates to policy. States that are currently providing services can consider a few things. First, services can be expanded by using unlicensed professionals. As previously mentioned, the advantages of hiring unlicensed professionals are that salary costs may not be as high allowing for more professionals to be hired to address the expulsion issue as well as the shortage issue at the national level. While more professionals can be hired, one disadvantage or counter problem that may develop as a result of hiring more unlicensed professionals is that more licensed professionals would also have to be hired to provide the necessary clinical supervision. Second, developing and implementing a national ECMHC credentialing process can help to identify qualified professionals. Last, having a credentialing system in place could help to also address current shortages in ECMHC services thereby providing more support for both children that display challenging behavior that lead to expulsion and early childhood education programs that service them. In other words, based on study findings, states could

consider broadening their services to support the reduction of expulsion rates among young children.

Summary

This study adds to the growing literature of ECMHC services that continues to help to reduce expulsion rates of preschool aged children. More importantly, the findings of this study do show that the licensure status has no affect expulsion rate outcomes. While findings regarding parent satisfaction of services are yet to be determined, the impact of ECMHC services, whether unlicensed or licensed professionals are used, can greatly influence the trajectory of how well young children perform both socially, behaviorally, and academically when support is provided to help address challenging behavior that lead to expulsion.

References

Allen, M.D., Brennan, E.M., Green, B. L., Hepburn, K. S., & Kaufmann, R. K. (2008). Early childhood mental health consultation: a developing profession. Focal Point: Research, Policy, & Practice in Children's Mental Health. Portland, OR: Portland State University Research and Training Center on Family Support and Children's Mental Health. Retrieved from http://www.rtc.pdx.edu /pdf/fpW0809.pdf

Aunola, K. & Nurmi, J.-E. (2005). The role of parenting styles in children's problem behavior. *Child Development, 76*(6), 1144–1159. doi:10.1111/j.1467--8624.2005.00840.x-i1

Azzi-Lessing, L. (2010). Meeting the mental health needs of poor and vulnerable children in early care and education programs. *Early Childhood Research and Practice, 12*(1), 1-14. Retrieved from http://ecrp.uiuc.edu/v12n1/azzi.html

Baillargeon, R., Tremblay, R. & Williams, J. D. (2002). Physical aggression among toddlers: does it run in families? In vulnerable children: findings from Canada's longitudinal study of children and youth, J. D. Williams (Ed.), University of Alberta Press. Retrieved from http://www.community.nsw.gov.au/docswr/_assets/main/documents/aggressiondiscussionpaper.pdf

Bandura, A. (1971). Social learning theory. New York, NY: General Learning Press. Retrieved from http://www.jku.at/org/content/e54521/e54528/e54529/e178059/Bandura_SocialLearningTheory_ger.pdf

Benson, M. J. & Buehler, C. (2012). Family process and peer deviance influences on adolescent aggression: Longitudinal effects across early and middle adolescence. *Child Development, 83*(4), 1213–1228. doi:10.1111/j.1467-8624.2012.01763.x

Bolger, K.E., Patterson, C. J, Thompson, W.W. & Kupersmidt, J.B. (1995). Psychosocial adjustment among children experiencing persistent and intermittent family economic hardship. *Child Development, 66*(4), 1107-1129. doi:10.2307/1131802

Bornstein, M. H., Hahn, C-S., & Haynes, O. M. (2010). Social competence, externalizing, and internalizing behavioral adjustment from early childhood through early adolescence: Developmental cascades. *Development and Psychopathology, 22*(4), 717-735. doi:10.1017/S0954579410000416

Boslaugh, S. (2007). An introduction to secondary data analysis. In secondary data sources for public health: a practical guide (pp. 2-10). Retrieved from http://sfcs.cals.arizona.edu/azsearch/sites/sfcs.cals.arizona.edu.azsearch/files/Boslaugh,% 202007.pdf

Box, F., & Joan D. (1987). Guinness, Gosset, Fisher, and small samples. *Statistical Science 2*(1), 45–52. doi:10.1214/ss/1188013437

Bratton, S. C., Ceballos, P. L., Sheely-Moore, A. I., Meany-Walen, K., Pronchenko, Y., & Jones, L. D. (2013). Head start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. *International Journal of Play Therapy, 22*(1), 28-42. doi:10.1037/a0030318

Brendgen, M., Boivin, M., Vitaro, F., Bukowski, W. M., Dionne, G., Tremblay, R. E., & Pérusse, D. (2008). Linkages between children's and their friends' social and

physical aggression: Evidence for a gene–environment interaction? *Child Development, 79*(1), 13–29. doi:10.1111/j.1467-8624.2007.01108.x

Brennan, E. M., Bradley, J. R., Allen, M., & Perry, D. F. (2008). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. *Early Education and Development,19*(6), 982-1022. doi:10.1080/10409280801975834

Brown, E. D., Ackerman, B. P., & Moore, C. A. (2013). Family adversity and inhibitory control for economically disadvantaged children: Preschool relations and associations with school readiness. *Journal of Family Psychology, 72*(3), 443-452. doi:10.1037/a0032886

Brown, J.L., Jones, S.M., LaRusso, M.D., & Aber, J.L. (2010). Improving classroom quality: Teacher influences and experimental impacts of the 4Rs program. *Journal of Educational Psychology*, *102*(1), 153-167. doi:10.1037/a0018160

Bulotsky-Shearer, R. J., Dominquez, X., & Bell, E. R. (2012). Preschool classroom behavioral context and school readiness outcomes for low-income children: A multilevel examination of child- and classroom- level influences. *Journal of Educational Psychology*, *104*(2), 421-438. doi:10.1037/a0026301

Campbell, C. (2011). Adapting an evidence-based intervention to improve social and behavioral competence in head Start children: Evaluating the effectiveness of teacher-child interaction training. Theses, Dissertations, and Student Research: Department of Psychology. Paper 37. Retrieved from http://digitalcommons.unl.edu/psychdiss/37

Cappella, E., Hamre, B. K., Kim, H. Y., Henry, D. B., Frazier, S. L., Atkins, M. S., & Schoenwald, S. K. (2012). Teacher consultation and coaching within mental health practice: Classroom and child effects in urban elementary schools. *Journal of Consulting And Clinical Psychology*, *80*(4), 597-610. doi:10.1037/a0027725

Carlson, J. S., Mackrain, M. A., van Egeren, L. A., Brophy-Herb, H., Kirk, R. H., Marciniak, D., & ... Tableman, B. (2012). Implementing a statewide early childhood mental health consultation approach to preventing childcare expulsion. *Infant Mental Health Journal*, *33*(3), 265-273. doi:10.1002/imhj.21336

Cohen, E., & Kaufmann, R. (2005). Early childhood mental health consultation. DHHS Pub.No.CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved from http://store.samhsa.gov/shin/content//SVP05-0151/SVP05- 0151.pdf

Conners-Burrow, N. A., Whiteside-Mansell, L., Mckelvey, L., Virmani, E., & Sockwell, L. (2012). Improved classroom quality and child behavior in an Arkansas early childhood mental health consultation pilot project. *Infant Mental Health Journal*, *33*(3), 256-264. doi:10.1002/imhj.21335

Cooper, J., Masi, R., & Vick, J. (2009). Social-emotional development in early childhood: what every policymaker should know. New York, NY: National Center for Children in Poverty (NCCP). Retrieved from http://www.nccp.org/publications/pdf/text_882.pdf

Cox, E., Martin, B. C., Van Staa, T., Garbe, E., Siebert, U., & Johnson, M. L. (2009). Good research practices for comparative effectiveness research: Approaches to mitigate bias and confounding in the design of nonrandomized studies of treatment effects using

secondary data sources. *International Society for Pharmacoeconomics and Value In Health (Wiley-Blackwell), 12*(8), 1053-1061. doi:10.1111/j.1524-4733.2009.00601.x

Crane, J. & Barg, M. (2003). Do early childhood intervention programs really work? Washington Coalition for Evidence Based Policy. Retrieved from http://coalition4evidence.org/wp-content/uploads/2012/12/Do-Early-Intervention-Programs-Really-Work7.pdf

Crusto, C. A., Whitson, M. L., Feinn, R., Gargiulo, J., Holt, C., Paulicin, B., & ... Lowell, D. I. (2013). Evaluation of a mental health consultation intervention in preschool settings. *Best Practices In Mental Health: An International Journal, 9*(2), 1-21.

Deeming, P. & Johnson, L. (2009). An application of Bandura's social learning theory: A new approach to deaf-blind support groups. *Journal of The American Deafness & Rehabilitation Association*, 203-209. Retrieved from http://content.ebscohost.com.ezp.waldenulibrary.org/pdf

Delacare: rules for early care and education and school age centers (2007). Retrieved from http://www.kids.delaware.gov/occl/occl_resources.shtml#occlregs

Diamond, A., & Lee, K. (2011). Intervention shown to aid executive function development in children 4-12 years old. *Science, 333*(6045), 959-964. doi:10.1126/science.1204529

Dodge, K.A., Petit, G. S., & Bates, J. E. (1994). Socialization mediators of the relation between socioeconomic status and child conduct problems. *Child development, 63*(2), 649-665. doi: doi:10.1111/j.1467-8624.1994.tb00774.x

Dodge, K. A., Coie, J. D. & Lynam, D. (2007). Aggression and antisocial behavior in youth. *Handbook of Child Psychology, 3*(6), 719-788. doi:10.1002/9780470147658.chpsy0312

Dornfeld, M. & Kruttscnitt, C. (1992). Do the stereotypes fit? Mapping gender-specific outcomes and risk factors. Criminology, 30(3), 397-419. doi:10.1111/j.1745-9125.1992.tb01110.x

Dufrene, B., Doggett, R. R., Henington, C., & Watson, T. T. (2007). Functional assessment and intervention for disruptive classroom behaviors in preschool and head start classrooms. *Journal of Behavioral Education, 16*(4), 368-388. doi:10.1007/s10864-007-9048-8

Dunlap, W. P., Burke, M. J., & Smith-Crowe, K. (2003). Accurate tests of statistical significance for r-sub (WG) and average deviation interrater agreement indexes. *Journal Of Applied Psychology,88*(2), 356-362. doi:10.1037/0021-9010.88.2.356

Duran, F., Hepburn, K., Irvine, M., Kaufmann, R., Anthony, B., Horen, N., & Perry, D. (2009). What works? a study of effective early childhood mental health consultation programs. Washington, DC: Georgetown University Center for Child and Human Development. Retrieved from http://www.gucchdtacenter.georgetown.edu/publications/ECMHCStudy_Report.p df

Early Childhood Mental Health Consultation Brochure. (n.d.). Retrieved from http://www.healthychildcare.org/PDF/ECMHC_BrochureDE.pdf

Eyberg, S.M., Boggs, S.R., & Algina, J. (1995). Parent-child interaction therapy: A psychosocial model for the treatment of young children with conduct problem behavior and their families. *Psychopharmacology Bulletin, 31*(1), 83-91.

Fabes, R. A., Gaertner, B. M., & Popp, T. K. (2006). Getting along with others: Social competence in early childhood. In K. McCartney & D. Phillips (Eds.), Blackwell

handbook of early childhood development. Blackwell Publishing, Ltd. pp. 297-316. doi:10.1002/9780470757703.ch15

Farrington, D. P. (1991). Longitudinal research strategies: Advantages, problems, and prospects. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(3), 369-74. doi: http://dx.doi.org/10.1097/00004583-199105000-00003

Farrington, D. P., Jolliffe, D., Loeber, R., Stouthamer-Loeber, M., & Kalb, L. M. (2001). The concentration of offenders in families, and family criminality in the prediction of boys' delinquency. *Journal of Adolescence, 24*(5), 579-596. doi:10.1006/jado.0424

Fewell,Z., Smith, G. D., & Sterne, J. A. C. (2007). The impact of residual and unmeasured confounding in epidemiologic studies: A simulation study. *American Journal of Epidemiology,166*(6), 646-655. doi:10.1093/aje/kwm165

Fox, L., Hemmeter, M.L., Snyder, P., Artman, K., Griffin, A., Higgins, A.;. . . Shepcaro, J. (2009). Teaching pyramid observation tool for preschool classrooms (TPOT) manual research edition. Retrieved from http://www.pbisnetwork.org/wpcontent/uploads/2012/10/TPOT_Manual_Revised _7_01_09.pdf

Faul, F., Erdfelder, E., Buchner, A., & Albert-Georg, L. (2009). Statistical power analyses using G*Power 3.1. *Behavior Research Methods, 41*(4), 1149-1160. doi:10.3758/BRM.41.4.1149

Gambino, B. (2012). The validation of screening tests: Meet the new screen same as the old screen? *Journal of Gambling Studies, 28*(4), 573-605. doi:10.1007/s10899-011-9285-6

Gilliam, W. S. (2008). Implementing policies to reduce the likelihood of preschool expulsion. FCD Policy Brief: Advancing PK-3, No. 7. Retrieved from http://medicine.yale.edu/childstudy/zigler/publications/34772PreKExpulsionBrief 2.pdf

Gilliam, W. S. (2008). Implementing practices to reduce the likelihood of preschool expulsion. (Foundation for Child Development Policy Brief, Advancing PreK-3, No.7). Retrieved from http://www.fcd-s.org/sites/default/files/ExpulsionBriefImplementingPolicies.pdf

Gilliam, W. S. (2007). Early childhood consultation partnership: Results of a random - controlled evaluation. Retrieved from http://www.chdi.org/admin/uploads/5468903394946c41768730.pdf

Gilliam, W. S. (2005). Prekindergartners left behind: Expulsion rates in state kindergarten systems. Yale University Child Study Center. Retrieved from http://www.fcd-us.org/PDFs/NationalPreK ExpulsionPaper03.02_new.pdf

Gillam, W.S. & Shahar, G. (2006). Preschool and childcare expulsion and suspension: Rates and predictors in one state. *Infants & Young Children, 19*(3), 228-245. Retrieved from http://www.researchgate.net/publication/232198215_Preschool_and_Child_Care_ Expulsion_and_Suspension_Rates_and_Predictors_in_One_State

Goodman, G. & Aber, J. L. (2010). Predictors of representational aggression in preschool children of low-income urban African American adolescent mothers. *Infant Mental Health Journal, 31*(1), 33–57. doi: doi:10.1002/imhj.20241

Gormley Jr., W. T., Phillips, D. A., Newmark, K., Welti, K., & Adelstein, S. (2011). Social-emotional effects of early childhood education programs in Tulsa. *Child Development, 82*(6), 2095-2109. doi:10.1111/j.1467-8624.2011.01648.x

Graves, S. r., & Howes, C. (2011). Ethnic differences in social-emotional development in preschool: The impact of teacher child relationships and classroom quality. *School Psychology Quarterly, 26*(3), 202-214. doi:10.1037/a002411

Green, B. L., Everhart, M., Gordon, L., & Gettman, M. G. (2006). Characteristics of effective mental health consultation in early childhood settings: Multilevel analysis of a national survey. *Topics in Early Childhood Special Education, 26*(3), 142-152. Retrieved from, Retrieved from http://www.rtc.pdx.edu/PDF/pbMHConsultHS.pdf

Green, B., Malsch, A., Kothari, B., Busse, J., & Brennan, E. (2012). An intervention to increase early childhood staff capacity for promoting children's social-emotional development in preschool settings. *Early Childhood Education Journal, 40*(2), 123-132. doi:10.1007/s10643-011-0497-2

Green, B. L., Simpson, J., Everhart, M. C., Vale, E., & Gettman, M. G. (2004). Understanding integrated mental health services in head start: Staff perspectives on mental health consultation. NHSA Dialog, 7(1), 35–60. doi:10.1207/s19309325nhsa0701_5

Griffin, J. (2009). Professional development and preschool intervention research: I would rather have a talking frog. *Early Education and Development, 20*(3), 373-376. doi:10.1080/10409280902967367

Grining, C., Raver, C., Champion, K., Sardin, L., Metzger, M., & Jones, S. M. (2010). Understanding and improving classroom emotional climate and behavior management in the "real world": The role of head start teachers' psychosocial stressors. *Early Education & Development, 21*(1), 65-94. doi:10.1080/10409280902783509

Harwood, M. D., O'Brien, K. A., Carter, C. G., & Eyberg, S. M. (2009). Mental health services for preschool children in primary care: A survey of maternal attitudes and beliefs. *Journal of Pediatric Psychology, 34*(7), 760-768. doi:10.1093/jpepsy/jsn128

Hayes, L., Giallo, R., & Richardson, K. (2010). Outcomes of an early intervention program for children with disruptive behaviour. *Australasian Psychiatry, 18*(6), 560-566. doi:10.3109/10398562.2010.498047

Hemmeter, M., Fox, L., Jack, S., & Broyles, L. (2007). A program-wide model of positive behavior support in early childhood settings. *Journal Of Early Intervention, 29*(4), 337-355. doi: doi:10.1177/105381510702900405

Hepburn, K. S., & Kaufmann, R. K. (2005). A training guide for the early childhood services community. DHHS Pub. No. CMHS-SVP0152. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://www.caheadstart.org/2011HI/ABaileyTrainingGuilde.pdf

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; Portland State University, Research and Training Center on Family Support and Children's Mental Health. Retrieved from http://eclkc.ohs.acf.hhs.gov

IBM Corp. Released 2013. IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp.

Jones, K., Daley, D., Hutchings, J., Bywater, T, & Eames, C. (2008). Efficacy of the incredible years programme as an early intervention for children with conduct problems and adhd: long-term follow-up. *Child: Care, Health & Development, 34*(3), 380-390. doi:10.1111/j.1365-2214.2008.00817.x

Johnson, K., Knitzer, J., & Kaufmann, R. (2002). Making dollars follow sense: Financing early childhood mental health services to promote healthy social and emotional development in young children. Policy Paper No. 4. National Center for Children in Poverty, Columbia University Mailman School of Public Health. Retrieved from http://www.nccp.org/publications/pdf/text_483.pdf

Kaufmann, R. K., Perry, D. F., Hepburn, K. S., & Duran, F. (2012). Assessing fidelity for early childhood mental health consultation: Lessons from the field and next steps. *Infant Mental Health Journal, 33*(3), 274-282. doi:10.1002/imhj.21337

Kress, V. E., Hoffman, R. M., & Eriksen, K. (2010). Ethical dimensions of diagnosing: Considerations for clinical mental health counselors. *Counseling & Values, 55*(1), 101-112. http://dx.doi.org/10.1002/j.2161-007X.2010.tb00024.x

Laible, D., Panfile, T. & Makariev, D. (2008). The quality and frequency of mother-toddler conflict: Links with attachment and temperament. Child Development, 79(2), 426–443. doi:10.1111/j.1467-8624.2007.01134.x

Lakes, K., Vargas, D., Riggs, M., Schmidt, J., & Baird, M. (2011). Parenting intervention to reduce attention and behavior difficulties in preschoolers: A cuidar evaluation study. *Journal of Child and Family Studies, 20*(5), 648-659. doi:10.1007/s10826-010-9440-1

Loeber, R., Keenan, K., & Zhang, Q. (1997). Boys' experimentation and persistence in developmental pathways toward serious delinquency. *Journal of Child and Family Studies, 6*, 321-357. Retrieved from https://www.ncjrs.gov/pdffiles/169595pdf

Low, C., & Shepard, S. (2010). Early childhood mental health consultation in early care environments: An introduction. *Brown University Child & Adolescent Behavior Letter, 26*(3), 1-6. doi: doi:1002/cbl.20111

Ludwig, J., & Phillips, D. A. (2008). Long-term effects of head start on low-income children. *Annals of The New York Academy Of Sciences*, 1136257-268. doi:10.1196/annals.1425.005

Lyons, J. J., True, W. R., Eisen, S. A., Goldberg, J., Meyer, J. M. Faraone, S. V., Eaves, L. J., & Tsuang, M. T. (1995). Differential heritability of adult and juvenile antisocial traits. Archives of *General Psychiatry*, 52i, 906-15. doi:10.1001/archpsyc.1995.03950230020005

Lyon, A., Gershenson, R., Farahmand, F., Thaxter, P., Behling, S., & Budd, K. (2009). Effectiveness of teacher-child interaction training (TCIT) in a preschool setting. *Behavior Modification, 33*(6), 855-884. doi:10.1177/0145445509344215

Mackrain, M. (2011). A day in the life of an early childhood mental health consultant: A series of real life vignettes illustrating the early childhood mental health consultation process. Center for Early Childhood Mental Health Consultation: Georgetown

University Center for Child and Human Development. Retrieved from http://www.ecmhc.org/documents/Day_in_the_Life_MH_Consultant.pdf

Mackrain, M., Perry, D., Yates, D. & Pell, K. (2011). Early childhood mental health consultation (ECMHC) guide: Standards, rationale, and guidance for the state of Maryland. Maryland Department of Education. Retrieved from http://www.marylandpublicschools.org

Maryland State Department of Education (MSDE). (2009). Fact sheet on the Maryland model for school readiness. Retrieved from http://mdk12.org/instruction/ensure/MMSR/MMSRFA1.html

Mashburn, A. J., & Pianta, R. C. (2006). Social relationships and school readiness. *Early Education and Development, 17,* 151-176. doi:/10.1207/s15566935eed1701_7

McCabe, P. C., & Altamura, M. (2011). Empirically valid strategies to improve social and emotional competence of preschool children. *Psychology in the Schools, 48*(5), 513-540. doi:10.1002/pits.20570

McCarthy, J., Hemmings, C., Kravariti, E., Dworzynski, K., Holt, G., Bouras, N., & Tsakanikos, E. (2010). Challenging behavior and co-morbid psychopathology in adults with intellectual disability and autism spectrum disorders. *Research in Developmental Disabilities, 31*(2), 362–6. doi: doi:10.1016/j.ridd.2009.10.009

McGencey, S. (2011). The time is now: Creating opportunities for young children to succeed. *National Civic Review, 100*(4), 56-58. doi:10.1002/ncr.20088

McGilloway, S., Mhaille, G., Bywater, T., Furlong, M., Leckey, Y., Kelly, P., & ... Donnelly, M. (2012). A parenting intervention for childhood behavioral problems: A

randomized controlled trial in disadvantaged community-based settings. *Journal of Consulting and Clinical Psychology, 80*(1), 116-127. doi:10.1037/a0026304

Meho, L. (2006). E-mail interviewing in qualitative research: Methodological discussion. *Journal of the American Society for Information Science and Technology, 57(*10):1284–1295. doi: 10.1002/asi.20416

Morrison, M. O., & Bratton, S. C. (2010). Preliminary investigation of an early mental health intervention for head start programs: Effects of child teacher relationship training on children's behavior problems. *Psychology in The Schools, 47(*10), 1003-1017. doi:10.1002/pits.20520

Murray, C., Murray, K. M., & Waas, G.A. (2008). Child and teacher reports of teacher-student relationships: Concordance of perspectives and associations with school adjustment in urban kindergarten classrooms. *Journal of Applied Developmental Psychology,29*(1), 49-61. doi: doi:10.1016/j.appdev.2007.10.006

Nadiv, S., (2013). Early childhood mental health consultation outcomes monitoring system (OMS) manual. The Institute for Innovation & Implementation University of Maryland, School of Social Work. Retrieved from https://theinstitute.umaryland.edu/topics/ebpp/ecmhc.cfm

NAEYC. (n.d.) Position statements. Retrieved from www.naeyc.org/positionstatements

Newland, R. P., Crnic, K. A., Cox, M. J., Mills-Koonce, W. R., & Family Life Project Key Investigators. (2013). The family model stress and maternal psychological symptoms: Mediated pathways from economic hardship to parenting. *Journal of Family Psychology, 27(*1), 96-105. doi:10.1037/a0031112

Nyberg, L., Henricsson, L. & Rydell, A.-M. (2008). Low social inclusion in childhood: Adjustment and early predictors. *Infant and Child Development, 17*(6), 639–656. doi:10.1002/icd.590

Ohio Department of Education. (2012). An analysis of high quality heat start programs : Recommendations from the Lucas County Head Start Task Force. Retrieved from http://www.ci.toledo.oh.us

Olchowski, A. E., Foster, E., & Webster-Stratton, C. H. (2007). Implementing behavioral intervention components in a cost- effective manner: Analysis of the incredible years program. *Journal Of Early & Intensive Behavior Intervention, 3-4*(4-1), 284-304. Retrieved from http://www.eric.ed.gov/PDFS/EJ805573.pdf

Parens, H., Rose-Itkoff, C., Pearlman, M., Reid, K., Turrini, P., Fallon, T., Singletary, W. and Scattergood, E. (2006). Into our fourth decade of prevention via parenting education: Where we have been – where we are going. *International Journal of Applied Psychoanalytic Studies, 3*(1), 17–38. doi:10.1002/aps.44

Parente, M. E. & Mahoney, J. L. (2009). Residential mobility and exposure to neighborhood crime: Risks for young children's aggression. *Journal of Community Psychology, 37*(5), 559–578. doi: doi:10.1002/jcop.20314

Peisner-Feinberg, E. S., Burchinal, M. R., Clifford, R. M., Culkin, M. L., Howes, C., Kagan, S. L., & Yazejian, N. (2001). The relation of preschool child-care quality to children's cognitive and social developmental trajectories through second grade. *Child Development, 72*(5), 1534-1553. doi:10.1111/1467-8624.00364

Perry, D.F. (2005). Evaluation results for the early childhood mental health consultation pilot sites. Washington, DC: Georgetown University Center for Child & Human development. Retrieved from http://mdchildcare.org/mdcfc/pdfs/consultation_pilot_sites.pdf

Perry, D. F. (2011). The evidence base for early childhood mental health consultation. USDHS Pub No. 90YD0268. Georgetown University Center for Child and Human Development. Retrieved from http://familymedicine.uams.edu

Perry, D. F., Dunne, M. C., McFadden, L., & Campbell, D. (2008). Reducing the risk for preschool expulsion: Mental health consultation for young children with challenging behavior. *Journal of Child and Family Studies, 17*(1), 44–54. doi:10.1007/s10826-007-9140-7

Perry, D.F., Holland, C., Darling-Kuria, N., & Nadiv, S. (2011). Challenging behavior and expulsion from child care: The role of mental health consultation. *Zero to Three, 32*(2), 4-11. Retrieved from http://main.zerotothree.org/site/DocServer/32-2_Perry.pdf?docID=12901

Perry, D., & Kaufmann, R. (2009). Policy brief: Integrating early childhood mental health consultation with the pyramid model. Tampa, FL: Technical Assistance Center on Social Emotional Intervention for Young Children. Retrieved from http://www.challengingbehavior.org/do/resources/briefs.htm

Perry, D. F., & Linas, K. (2012). Building the evidence base for early childhood mental health consultation: Where we've been, where we are, and where we are going. *Infant Mental Health Journal*,*33*(3), 223-225. doi:10.1002/imhj.21331

Perry, D., Trivedi, P., & Duran, F. (2009). Early childhood mental health consultation (ECMHC) standards for the state of Maryland. Georgetown University, Center for Child and Human Development. Retrieved from http://www.marylandpublicschools.org/NR/rdonlyres/5B3956EA-2AB2-43CF-BBEB-A310BF739236/28066/ECMHstand093009.pdf

Pianta, R, Howes, C., & Burchinal, M., (2005). Features of pre-kindergarten programs, classrooms, and teachers: Do they predict observed classroom quality and child-teacher interactions? *Applied Developmental Science*, *9*(3), 144-159. doi:10.1207/s1532480xads0903_2

Raver, C., Blair, C., Willoughby, M., & The Family Life Project Key Investigators. (2012). Poverty as a predictor of 4-year olds' executive function: New perspectives on models of differential susceptibility. Developmental Psychology, 49(2), 292-304. doi:10.1037/a0028343

Raver, C., Jones, S., Zhai, F., Metzger, M., & Solomon, B. (2009). Targeting children's behavior problems in preschool classrooms: A cluster-randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *77*(2), 302-316. doi:10.1037/a0015302

Rentzou, K., & Sakellariou, M. (2011). The quality of early childhood educators: children's interaction in Greek child care centers. *Early Childhood Education Journal*, *38*(5), 367-376. doi:10.1007/s10643-010-0403-3

Resource Details. (2011). ZERO TO THREE: National Center for Infants, Toddlers and Families. Retrieved from

http://policy.db.zerotothree.org/policyp/view.aspx?InitiativeID=853&origin=results&QS='&union=AND&viewby=50&startrec=1&tbl_Public_InitiativeYMGHFREStateTerritoryTribe=DE&tbl_Public_InitiativeYMGHFREDescription=&top_parent=164

Roane, H. S., Ringdahl, J. E., Vollmer, T.R., Whitmarsh, E. L., & Marcus, B. A. (2007). A preliminary description of the occurrence of proto-injurious behavior in typically developing children. *Journal of Early and Intensive Behavioral Intervention, 3*(4), 334–47. Retrieved from http://www.eric.ed.gov/PDFS/EJ805535.pdf

Royston, P., Altman, D. G., & Sauerbrei, W. (2006). Dichotomizing continuous predictors in multiple regression: A bad idea. *Statistics in Medicine, 25*(1), 127-141. doi:10.1002/sim.2331

Ruchkin, V., Gilliam, W. S., & Mayes, L. (2008). Developmental pathway modeling in considering behavior problems in young Russian children. *Child Psychiatry & Human Development, 39*(1), 49-66. doi:10.1007/s10578-007-0070-9

Rutter, M. (1997). Nature-nurture integration: The example of antisocial behavior. *American Psychologist, 52*, 390-398. doi:10.1037/0003-066X.52.4.390

Sandstrom, H. (2012). The characteristics and quality of pre-school education in Spain. *International Journal of Early Years Education, 20*(2), 130-158. doi: IO.1080/09669760.20l2.715012

Schultz, B. L., Richardson, R., Barber, C. R., & Wilcox, D. (2011). A preschool pilot study of connecting with others: Lessons for teaching social and emotional competence. *Early Childhood Education Journal, 39*(2), 143-148.doi:10.1007/s10643-011-0450-4

Shaw, D. S. & Bell, R. Q. (1993). Developmental theories of parental contributors to antisocial behavior. *Journal of Abnormal Child Psychology, 21*(5), 493-518. doi:10.1007/BF00916316

Stadelmann-Steffen, I. (2012). Education policy and educational inequality: Evidence from the Swiss laboratory. *European Sociological Review, 28*(3), 379-393. doi:10.1093/esr/jcq071

Stanton-Chapman, T.L., Kaiser, A.P., Vijay, P., & Chapman, C. (2008. A multicomponent intervention to increase peer-directed communication in head start children. *Journal of Early Intervention, 30*(3), 188-212. doi:10.1177/1053815108318746

State of Delaware. (n.d.) Child Care Subsidy Program. Retrieved from http://regulations.delaware.gov/AdminCode/title16/

Ştefan, C. A., & Miclea, M. (2010). Prevention programs targeting emotional and social development in preschoolers: Current status and future directions. *Early Child Development and Care, 180*(8), 1103-1128. doi:10.1080/03004430902830263

Stoiber, K., & Gettinger, M. (2011). Functional assessment and positive support strategies for promoting resilience: Effects on teachers and high-risk children. *Psychology in the Schools, 48*(7), 686-706. doi:10.1002/pits.20587

Thorpe, K., Staton, S., Morgan, R., Danby, S., & Tayler, C. (2012). Testing the vision: Preschool settings as places for meeting, bonding and bridging. *Children & Society, 26*(4), 328-340. doi:10.1111/j.1099-0860.2010.00336.x

U.S. Department of Commerce, United States Census Bureau (n.d.). Delaware: state and county quickfacts. Retrieved from http://quickfacts.census.gov/qfd/states/10000.html

U.S. Department of Commerce, United States Census Bureau (n.d.). Maryland: state and county quickfacts. Retrieved from http://quickfacts.census.gov/qfd/states/10000.html

U. S. Department of Education (2007). Teacher shortage areas nationwide listing: 1990-91 thru 2006-2007. U. S. Department of Education Office of Postsecondary Education Policy & Budget Development Staff (USDOE). Retrieved from http://www2.ed.gov/about/offices/list/ope/pol/tsa.pdf

U.S. Department of Health & Human Services. (2013). 2013 Poverty Guidelines. U.S. Department of Health & Human Services: Office of the Assistant Secretary for Planning and Evaluation. Retrieved from http://aspe.hhs.gov/poverty/faq.cfm

University of Maryland School of Medicine. (2011). Maryland's early childhood mental health consultation evaluation: Final report. Retrieved from http://theinstitute.umaryland.edu/topics/ebpp/docs/ECMHC/ECMHC%20Final%20Report.pdf

Thompson, R.A. (1994). Emotion regulation: A theme in search of definition. *Monographs of the Society for Research in Child Development, 59*(2/3), 25-52. Retrieved from http://dx.doi.org/10.2307/1166137

Viding, E. (2004). On the nature and nurture of antisocial behavior and violence. *Annals of the New York Academy of Sciences, 1036*(1), 267–277.doi:10.1196/annals.1330.017

Waliski, A. D., & Carlson, L. A. (2008). Group work with preschool children: Effect on emotional awareness and behavior. *Journal for Specialists in Group Work, 33*(1), 3-21. doi:10.1080/01933920701476714

Ward, E. C., & Heidrich, S. M. (2009). African American women's beliefs about mental illness, stigma, and preferred coping behaviors. *Research in Nursing & Health, 32*(5), 480-492. doi:10.1002/nur.20344

Wat, A., & Gayl, C. (2009). Beyond the school yard: pre-k collaboration with community-based partners. The PEW Center: Nellie Mae Education Foundation. Retrieved from http://www.nmefoundation.org/getmedia/c9544bc4-2128-4ec5-8446-d7858f12868b/BeyondtheSchoolYard?ext=.pdf

Webster-Stratton, C., Gaspar, M., & Seabra-Santos, M. (2012). Incredible years parent, teachers and children's series: Transportability to Portugal of early intervention program for preventing conduct problems and promoting social and emotional competence. *Psychosocial Intervention/Intervencion Psicosocial, 21*(2), 157-169. Retrieved from http://dx.doi:10.5093/in2012a15

Webster-Stratton, C., & Hammond, M. (1998). Conduct problems and level of social competence in head start children: Prevalence, pervasiveness and associated risk factors. *Clinical Child Psychology and Family Psychology Review, 1*(2), 101-124. doi:10.1023/A:1021835728803

Webster-Stratton, C., Reid, M., & Beauchaine, T. (2011). Combining parent and child training for young children with adhd. *Journal of Clinical Child & Adolescent Psychology, 40(*2), 191-203. doi:10.1080/15374416.2011.546044

Webster-Stratton, C., Reid, M., & Stoolmiller, M. (2008). Preventing conduct problems and improving school readiness: Evaluation of the Incredible Years Teacher and Child

Training Programs in high-risk schools. Journal of Child *Psychology & Psychiatry, 49*(5), 471-488. doi:10.1111/j.1469-7610.2007.01861.x

Welshman, J. (2010). From head start to sure start: Reflections on policy transfer. *Children & Society, 24*(2), 89-99. doi:10.1111/j.1099-0860.2008.00201.x

Wilder-Wilson, M., Vogul. D. A., & Edwards, B. M. (2007). State licensure, national certification, and continuing education. *Seminars in Hearing, 28*(1): 024-035. doi:10.1055/s-2006-958909

Williams, J. L., Armstrong, K. H., Agazzi, H., & Bradley-Klug, K. L. (2010). Helping our toddlers, developing our children's skills (HOT DOCS): A parenting intervention to prevent and address challenging behavior in young children. *Journal Of Early Childhood And Infant Psychology, 6*,1-20. Retrieved from http://content.ebscohost.com.ezp.waldenulibrary.org/pdf2526/pdf/2010/B7RL/01May10/58031270.pdf

Williams, S. T., Conger, K. J. & Blozis, S. A. (2007). The development of interpersonal aggression during adolescence: The importance of parents, siblings, and family economics. *Child Development, 78*(5), 1526–1542. doi:10.1111/j.1467-8624.2007.01081.x

Williford, A. P., & Shelton, T. L. (2008). Using mental health consultation to decrease disruptive behaviors in preschoolers: Adapting an empirically-supported intervention. *Journal of Child Psychology And Psychiatry, 49*(2), 191-200. doi:10.1111/j.1469-7610.2007.01839.x

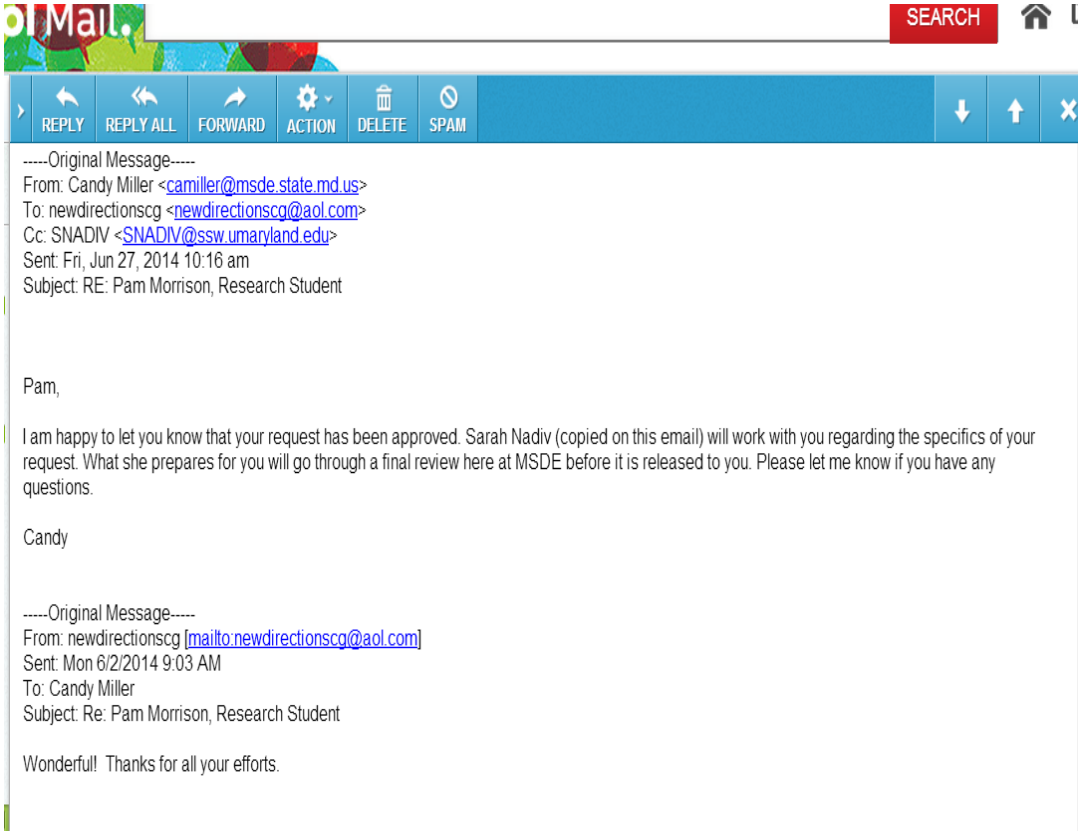
Wishmann, A., Kates, D., & Kaufmann, R. (2001). Funding early childhood mental health services and supports. Washington: Georgetown University Child Development Center. Retrieved from http://gucchd.georgetown.edu/products/FundingECMHS.pdf

Wright, K. B. (2006). Researching internet-based populations: Advantages and disadvantages of online survey research, online questionnaire, authoring software packages, and web survey services. *Journal of Computer-Mediated Communication, 10*(3). doi:10.1111/j.1083-6101.2005.tb00259x

Zaghlawan, H. Y., & Ostrosky, M. M. (2011). Circle time: An exploratory study of activities and challenging behaviors in head start classrooms. *Early Childhood Education Journal, 38*(6), 439-448. doi:10.1007/s10643-010-0431-z

APPENDIX A

MARYLAND DATA AGREEMENT



SEARCH

REPLY | REPLY ALL | FORWARD | ACTION | DELETE | SPAM

-----Original Message-----
From: Candy Miller <camiller@msde.state.md.us>
To: newdirectionscg <newdirectionscg@aol.com>
Cc: SNADIV <SNADIV@ssw.umaryland.edu>
Sent: Fri, Jun 27, 2014 10:16 am
Subject: RE: Pam Morrison, Research Student

Pam,

I am happy to let you know that your request has been approved. Sarah Nadiv (copied on this email) will work with you regarding the specifics of your request. What she prepares for you will go through a final review here at MSDE before it is released to you. Please let me know if you have any questions.

Candy

-----Original Message-----
From: newdirectionscg [mailto:newdirectionscg@aol.com]
Sent: Mon 6/2/2014 9:03 AM
To: Candy Miller
Subject: Re: Pam Morrison, Research Student

Wonderful! Thanks for all your efforts.

APPENDIX B

DELAWARE DATA AGREEMENT

SEARCH

REPLY | REPLY ALL | FORWARD | ACTION | DELETE | SPAM

RE: FOLLOW UP FROM PAM MORRISON

Moor, Mary M (DSCYF) (DSCYF) to you show details Mar 20

Data_Usage_Agreement.pdf (802 KB)

Pam,

Please see attached data usage agreement form signed by Susan Cycyk. I hope this provides you with what you need to move your research project forward. Once it is signed on your end, please provide me with a copy. Thanks.

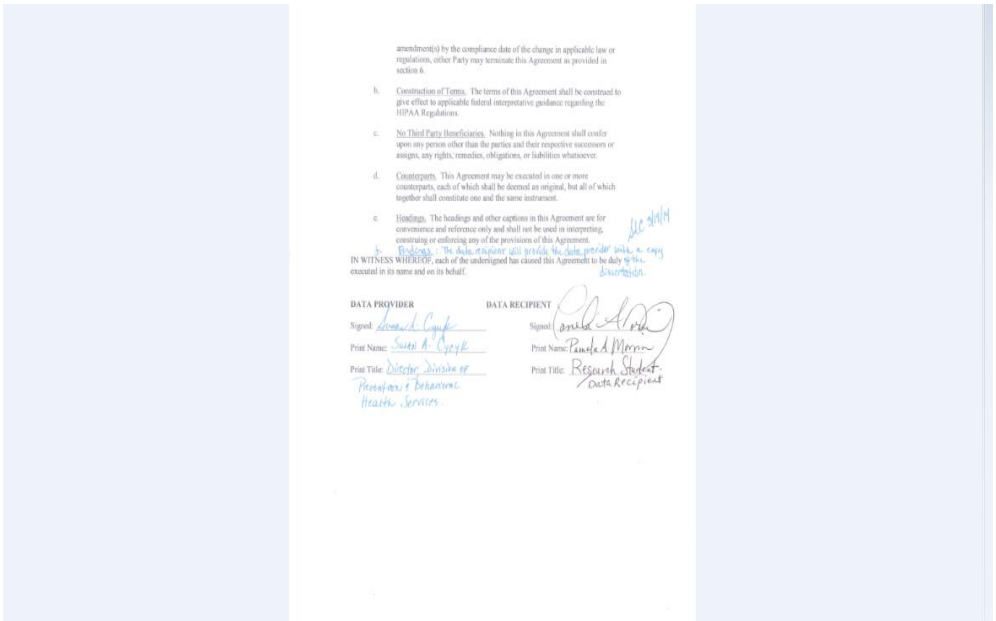
Mary

Mary M. Moor

Delaware's B.E.S.T. Project Director

Delaware Children's Department

Division of Prevention and Behavioral Health Services



amendment(s) by the compliance date of the change in applicable law or regulations, either Party may terminate this Agreement as provided in section 6.

b. Construction of Terms. The terms of this Agreement shall be construed to give effect to applicable federal interpretative guidance regarding the HIPAA Regulations.

c. No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

d. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

e. Headings. The headings and other captions in this Agreement are for convenience and reference only and shall not be used in interpreting, construing or enforcing any of the provisions of this Agreement.

f. Reporting. The data recipient will provide the data provider with a copy

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

DATA PROVIDER	DATA RECIPIENT
Signed:	Signed:
Print Name: Susan A. Cycyk	Print Name: Pamela A. Morrison
Print Title: Director, Division of Prevention & Behavioral Health Services	Print Title: Research Student Data Recipient

APPENDIX C

MARYLAND DATA REQUEST LETTER

October 10, 2014

Candy Miller, Specialist Early Learning
Division of Early Childhood Development
200 W. Baltimore Street 10th floor
Baltimore, MD 21201

RE: **Request to Release/Receive Data**

Dear Candy Miller

Thank you for the decision to approve my use of Maryland's data in the fulfilling of my capstone project. You will recall through previous correspondence that I am a graduate student at Walden University. For my dissertation project, I have chosen to do research on *Early Childhood Mental Health Consultation* (ECMHC). Specifically, I will be doing a comparative study of outcomes across states (Maryland and Delaware) that offer ECMHC services.

Since my last communication with your office, I have applied to Walden University's IRB, and it has granted its approval for me to complete this study. My approval number is: **#10-07-14-0086565**. Please accept this correspondence as my formal request for release of data referred to below.

As previously shared, data being requested is specific to the 2010 program year. The variables of this study, as previously requested, are the following:

-total cases of child specific consultations
-number of child specific consultation expulsions
-number of parents satisfied with services/satisfaction rates
-the number of centers/facilities serviced
-number of hours per child specific consultation
-number of community based referrals made
-average time to complete a child specific consultation

It is acknowledged that Sarah Nadiv will be working with me regarding the specifics of my request and that what she prepares will go through a final review at MSDE before it is released to me.

Please don't hesitate to contact me by phone at (302) 674-5200 or by email at pamela.morrison@waldenu.edu should you need any further information or have any questions.

Thank you for your attention and support regarding this matter.

Respectfully,
Pamela A. Morrison, Graduate Student
Walden University

APPENDIX D

DELAWARE DATA REQUEST LETTER

March 11, 2015

Susan A. Cycyk, Me.d., Director
Division of Behavioral Health Services, Delaware
1825 Faulkland Road
Wilmington, DE 19805

RE: **Request to Release/Receive Data**

Dear Susan A. Cycyk

Thank you for the decision to approve my use of Delaware's data in the fulfilling of my capstone project. You will recall through previous correspondence that I am a graduate student at Walden University. For my dissertation project, I have chosen to do research on *Early Childhood Mental Health Consultation* (ECMHC). Specifically, I will be doing a comparative study of outcomes across states (Maryland and Delaware) that offer ECMHC services.

Since my last communication with your office, via Mary Moor, I have applied to Walden University's IRB, and it has granted its approval for me to complete this study. My approval number is: **#10-07-14-0086565**. Please accept this correspondence as my formal request for release of data.

As previously shared, data being requested is specific to the 2010 program year. The variables of this study, as previously requested, are the following:

-total cases of child specific consultations
-number of child specific consultation expulsions
-number of parents satisfied with services/satisfaction rates
-the number of centers/facilities serviced
-number of hours per child specific consultation
-number of community based referrals made
-average time to complete a child specific consultation

It is acknowledged that Delaware has requested a copy of this study's findings upon completion. I will ensure that this occurs in addition to being available, via face to face meeting or teleconference, to discuss any questions regarding outcomes upon request.

Please don't hesitate to contact me by phone at (302) 674-5200 or by email at pamela.morrison@waldenu.edu should you need any further information or have any questions.

Thank you for your attention and support regarding this matter.

Respectfully,
Pamela A. Morrison, Graduate Student
Walden University

APPENDIX E

WALDEN UNIVERSITY IRB APPROVAL

On Tue, Oct 7, 2014 at 4:46 PM, IRB <IRB@waldenu.edu> wrote:

Dear Ms. Morrison,

This email is to notify you that the Institutional Review Board (IRB) confirms that your study entitled, "Early Childhood Mental Health Consultation: A comparison of Unlicensed and Licensed Professionals," meets Walden University's ethical standards. Our records indicate that you will be analyzing data provided to you by the State of Maryland Department of Education, Division of Early Childhood and State of Delaware Department of Services for Children, Youth, and Their Families, and Division of Prevention and Behavioral Health Services as collected under their oversight. Since this study will serve as a Walden doctoral capstone, the Walden IRB will oversee your capstone data analysis and results reporting. The IRB approval number for this study is 10-07-14-0086565.

This confirmation is contingent upon your adherence to the exact procedures described in the final version of the documents that have been submitted to IRB@waldenu.edu as of this date. This includes maintaining your current status with the university and the oversight relationship is only valid while you are an actively enrolled student at Walden University. If you need to take a leave of absence or are otherwise unable to remain actively enrolled, this is suspended.

If you need to make any changes to your research staff or procedures, you must obtain IRB approval by submitting the IRB Request for Change in Procedures Form. You will receive confirmation with a status update of the request within 1 week of submitting the change request form and are not permitted to implement changes prior to receiving approval. Please note that Walden University does not accept responsibility or liability for research activities conducted without the IRB's approval, and the University will not accept or grant credit for student work that fails to comply with the policies and procedures related to ethical standards in research.

When you submitted your IRB materials, you made a commitment to communicate both discrete adverse events and general problems to the IRB within 1 week of their occurrence/realization. Failure to do so may result in invalidation of data, loss of academic credit, and/or loss of legal protections otherwise available to the researcher.

Both the Adverse Event Reporting form and Request for Change in Procedures form can be obtained at the IRB section of the Walden web site:
http://researchcenter.waldenu.edu/Application-and-General-Materials.htm

Researchers are expected to keep detailed records of their research activities (i.e., participant log sheets, completed consent forms, etc.) for the same period of time they retain the original data. If, in the future, you require copies of the originally submitted IRB materials, you may request them from Institutional Review Board.

Both students and faculty are invited to provide feedback on this IRB experience at the link below:

http://www.surveymonkey.com/s.aspx?sm=qHBJzkJMUx43pZegKlmdiQ_3d_3d

Sincerely,
Libby Munson
Research Ethics Support Specialist
Office of Research Ethics and Compliance
Email: irb@waldenu.edu
Fax: 626-605-0472
Phone: 612-312-1341
Office address for Walden University:
100 Washington Avenue South
Suite 900
Minneapolis, MN 55401

Information about the Walden University Institutional Review Board, including instructions for application, may be found at this link: http://researchcenter.waldenu.edu/Office-of-Research-Ethics-and-Compliance-IRB.htm