The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) Evaluation:

Community Experiences (2021-2022)

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Report Prepared For
The Community of ECMHCI in San Francisco
The Joint Funders of ECMHCI in San Francisco

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Evaluation Partnership

This program evaluation is a collaborative effort between Clarity and Indigo Cultural Center. Clarity Social Research Group was initially brought in by joint funders to support meeting facilitation and for initial readiness planning for the overarching evaluation. Indigo Cultural Center was brought in for their expertise and breadth of experience in evaluating Infant and Early Childhood Mental Health Consultation Initiatives across the country. Together, they bring a well-balanced mix of local and national experience to this program evaluation.

Clarity Social Research Group

Clarity Social Research Group (Clarity) was founded in 2012 and grew from prior experiences in research and non-profit consulting that left us wanting for greater impact on issues of social justice and equity. Clarity is a small woman- and minority-owned organization, dedicated to uplifting vulnerable voices seldom heard and contributing to upstream, broad-based, inclusive, and community-supportive efforts. Led by founder and principal consultant Penelope Huang, PhD, Clarity draws from a close network of fellow consultants who share broad and deep experience working with government agencies, foundations, non-profit, and community-based organizations in program evaluation, needs assessment, and strategic planning to support children, families, and thriving communities.

Since 2009, Penny has worked in evaluation of San Francisco's early childhood education field, including conducting school readiness assessments in the San Francisco Unified School District, parent surveys, needs assessments, and program evaluations across a wide array of children-, youth-, and family-serving programs across the city.

Indigo Cultural Center

The Institute of Child Development Research and Social Change at Indigo Cultural Center is an action-research firm that specializes in infant and early childhood research and evaluation conducted with an anti-racist lens. Indigo Cultural Center (a BIPOC-led organization) is led by executive director Dr. Eva Marie Shivers and the Institute is directed by Jayley Janssen. Indigo Cultural Center's mission is to conduct rigorous policy-relevant research on infant and early childhood mental health, education, and development by partnering with community agencies and public agencies that are dedicated to improving the lives of children, especially those from low-income and historically marginalized communities.

Indigo Cultural Center and Dr. Shivers are considered national thought leaders of ECMHC as a result of numerous evaluations and research studies; training and keynotes throughout the country; organizational technical assistance; policy consultation; and advocacy efforts. Indigo Cultural Center has led Early Childhood Mental Health Consultation (ECMHC) in-depth evaluations in Arizona, New York, South Carolina, and Alameda County, CA. Indigo has consulted to ECMHC evaluations in Illinois, Colorado, Maryland, Oregon, and Washington.

Additionally, Indigo team members have authored peer reviewed publications and other briefs related to ECMHC. Dr. Shivers is a frequent national keynote speaker and often highlights the promising data that links ECMHC to reductions in racial disparities for young children in early care and education. For the past 12 years, she has been training mental health consultants and ECMHC supervisors throughout the country. Finally, Dr. Shivers and Indigo were affiliated with the federally-funded national Center of Excellence for IECMHC from 2016-2021.

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Executive Summary

This exploratory program evaluation of the Early Childhood Mental Health Consultation (ECMHC) initiative in San Francisco spans three years in the making, punctuated by the many disruptions caused by the COVID-19 pandemic. The design of this evaluation was developed with input from the joint funders of the initiative as well as from San Francisco's ECMHC workforce (i.e., mental health consultants, supervisors, and directors of the original five consultation agencies). Funder and workforce input was also solicited in the data collection, analysis, and interpretation phases of this work, as the evaluation team worked to maintain a transparent, inclusive process that would yield meaningful results.

Focus of Evaluation

This report presents findings from Phase 1 and Phase 2 of a broader ECMHC evaluation agenda in San Francisco. Phase 1 reports on the On-Call model and approach and Phase 2 explores experiences, impact, and feedback on the 'traditional' ECMHC model from the perspective of consultation partners (i.e., teachers and ECE site administrators/directors) as well as from the perspective of mental health consultants. Given that these are initial phases of a broader evaluation agenda in San Francisco, much of the work presented in this report is exploratory and will inform subsequent phases of the evaluation.

Methods

A mixed methods evaluation design was employed for phases 1 and 2 of the evaluation, exploring the On-Call consultation model and gathering feedback from consultees. Focus group conversations were utilized to collect qualitative data and surveys were used to collect quantitative data. Together, both methods illuminate nuances in consultation in San Francisco's initiative.

Data Collection

Phase 1: On-Call Evaluation	Phase 2: Feedback, Experiences and Impact Evaluation
Online Surveys 28 completed by consultees (response rate = 46%)	**Online Surveys** 99 online feedback surveys completed by consultees
Focus Groups 5 consultant focus groups; 2 teacher focus groups; 2 director focus groups	**Focus Groups** 2 consultant focus groups; 4 consultee focus groups

Summary of Findings

On-Call Findings:

The On-Call approach has limitations. Consultants and consultees shared several ways in which the On-Call approach was limited, highlighting issues around efficacy, ECMHC model fidelity, and the erosion of consultees' trust in their consultants.

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Tiering designations should not be static. High rates of turnover among ECE professionals, families migrating in and out of the city, and turnover among mental health consultants all impact site dynamics, rendering the need for a more flexible approach to tier designations.

Consultants suffer from burn-out. The On-Call approach increased feelings of guilt and burnout for consultants, as they held the burden of communicating and managing the reduction of hours to sites. Clear communication at the systems level about what the mental health consultation service is and is not will help to set expectations that will better position the initiative for success.

Without the supports in place, you don't just stay [at a high-quality rating]. You haven't arrived. Things shift, especially in programs. I am sure I shed a tear in the tier shift. Because consultation was a huge part of the program (when I was a director). There needs to be more flexibility in how it is thought about."

"Because consultation ... is about building rapport and getting to know people, rather than just jumping into a crisis without knowing anything. That is probably, to me, it didn't feel right coming particularly from a therapeutic background. That is not the way we work."

Previous exposure to consultation makes a difference. When sites were familiar with consultation, knew how to make it work, and were prepared in advance of their consultation meeting, the work of On-Call consultation went more smoothly. This offers insight into how to maximize the potential effectiveness of a truncated, triage-like service such as On-Call consultation.

Traditional Model: Feedback, Experiences, and Impact Findings

Consultees are satisfied and request more time with their consultant. Generally, consultees were very satisfied with their ECMHC consultant and services, with 74% of survey participants responding that they were ***satisfied*** or ***very satisfied*** with the consultation they received. Dozens of statements in the focus groups were categorized as success stories where consultation led to meaningful, positive change for children, educators, and the consultants themselves. Consultees' request for more hours was often accompanied by a request for more funding to alleviate consultants' caseloads and potential burnout.

When focus group participants were asked to think critically about the initiative, participants were slow to identify barriers and challenges in their experiences with ECMHC, though two central challenges emerged from focus groups and survey responses. Chief among these were calls to expand the initiative so that sites might benefit from more time with their consultants and more sites might utilize the service. Furthermore, consultees called for a renewed focus on cultural competence, hiring more Chinese- and Spanish-speaking consultants, more consultants of color, and enhancement of all consultants' literacy around culture and race.

Strong consultative relationships are the secret sauce! The most prominent themes that emerged from the feedback focus groups centered on the importance of the consultative relationship: the ***secret sauce,*** if you will. Cultural/linguistic match between consultant and site further strengthens the relationship through shared lived experiences, shared language, a deep understanding of cultural background, and the ability to counter unique, yet shared stigmas. In addition, consultants are often with an ECE site longer than the staff employed by the site, thereby becoming institutional knowledge holders of sites.

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There is a long arc of shifts that occur with consultation. By consultant and consultee accounts, within six to twelve months of engaging with consultation, the adults at a site begin to build capacities for reflection, gain greater understanding of child development, know how to access additional resources, and begin to implement strategies on their own. Beyond that initial year, a consultant begins addressing more systems-level issues and works with the site and its stakeholders to strategically support and sustain their mental health capacity building.

"...my magic wand would be that there's more, more folks being trained and more support for the [Spanish-speaking] community."-

Addressing racial equity issues takes trust and time. Consultants and consultees discussed the shifts that can happen related to culture and race when there is a strong consultative alliance, trust and time. Intentionally matching consultants with consultees by culture, race and language is also seen as a key mechanism to establishing and maintaining a strong consultative alliance.

Summary of Key Recommendations

Reimagine On-Call Services

- Expand collaboration in determining sites' Tier assignments
- Create, implement, and maintain a 'preparedness plan' for sites new to consultation.
- Generate more awareness about the ECMHC Initiative in general and about On-Call services in particular – this includes transparency about the Tier designation rationale and process.

Enhance the Traditional ECMHC Approach and Model

- Support and center consultant wellbeing to prevent burnout and turnover.

"They actually go to too many sites, they are very busy...they should extend the hours on specific sites..."

- Re-center San Francisco's initiative's history of community and consultant trust.
- Cultural alignment and responsivity are key. Work to deepen consultants' capacity to bring the strong lenses of anti-racism and decolonization to their everyday work. Continue to strengthen the workforce pipeline to increase the rates of cultural, racial and linguistic match with sites.

Next Steps

The next phase of this evaluation is currently in planning stages and will include exploration of pre/post changes among teachers and sites new to consultation to investigate what changes at the site/director level, teacher, consultant, classroom, and child levels.

Introduction and Background

What is Infant and Early Childhood Mental Health Consultation?

Infant and Early Childhood Mental Health Consultation (IECMHC) – also referred to as Early Childhood Mental Health Consultation (ECMHC) is a preventative and strengths-based approach that equips early childhood educators to provide supportive environments for children. An IECMHC consultant who specializes in infant mental health partners with adults in early care and educational settings (e.g., teachers, administrators, and parents) to build capacities and skills that strengthen and support children's development before formal intervention is needed.

IECMHC is an adult-focused intervention. Through the development of partnerships among ECE directors, teachers, and families, IECMHC builds their collective and individual capacity to understand the powerful influence of their relationships and interactions on young children's development. Children's well-being is improved, and mental health problems are prevented as a result of the consultants' work with teachers, directors, and parents through skilled observations, individualized strategies, and early identification of children with challenging behaviors which place children at risk for expulsion and suspensions (Center of Excellence for IECMHC, 2020).

IECMHC involves the collaborative relationship between a professional consultant who has mental health expertise and an early education professional. IECMHC is an adult-focused service – not a therapeutic service delivered directly to the child or family (Brennan et al., 2008). Consultation can focus on the emotional and behavioral struggles of an individual child (child-focused or 'case' consultation), the conditions and functioning of a classroom as they affect all the children in that environment (classroom-focused consultation), and/or work on a program's leadership to improve the overall quality of the early childhood program (program-focused consultation) (Center of Excellence for IECMHC, 2020).

The following 11 characteristics and components have been identified as describing IECMHC (Duran & Hepburn, ***n.d.***) Ideally, these characteristics and components of IECMHC are present in all early childhood settings where IECMHC is offered and are most apparent in the way mental health consultants implement this collaborative intervention. Hereinafter we refer to these 11 defining characteristics as the ***Threads of Consultation***. We refer to the ***Threads of Consultation*** throughout the remainder of this report.

Threads of Consultation:

Key Characteristics and Components

1. IECMHC delivers indirect support and builds internal capacity.
2. IECMHC is collaborative.
3. IECMHC is relationship-based.
4. IECMHC is individualized.
5. IECMHC is collaborative and relationship-based:
6. IECMHC is family-centered.
7. IECMHC is culturally and linguistically competent.
8. IECMHC is strength-based.
9. IECMHC is reflective.
10. IECMHC spans the continuum from promotion through intervention.
11. IECMHC is integrated with community services and supports.

Outcomes Related to Infant and Early Childhood Mental Health Consultation

The body of evidence to date suggests that IECMHC has a positive impact on many program, staff, and child outcomes (e.g., Brennen et al., 2008; Center of Excellence for IECMHC, 2020; Hepburn et al., 2013). To date, the strongest domains of outcomes in IEMCHC are 1) children's social and emotional well-being and 2) teachers' social-emotional support for young children (Center of Excellence for IECMHC, 2020). First, many evaluations of statewide IECMHC programs have found increases in children's emotional competency (e.g., self-regulation; social skills; adaptive behaviors; and other protective factors) and a reduction in children's challenging behaviors (e.g., hyperactivity, defiance, aggression) (Brennan et al., 2008; Conners-Burrow et al., 2012; Crusto et al., 2013; Hepburn et al., 2013; Gilliam et al., 2016; Perry et al., 2008; Shivers, 2015; Van Egeren et al., 2011; Williford et al., 2008).

A handful of studies also demonstrate that after exposure to IECMHC, children are less likely to be expelled (Brennan et al., 2008; Davis & Perry, 2016; Gilliam et al., 2016; Perry et al., 2011; Van Egeren, 2011). The second major domain of IECMHC findings with teachers includes increased outcomes such as self-efficacy in managing challenging behavior; increased sensitivity and responsiveness to children; and increased knowledge about children's social and emotional development (Beardslee et al., 2010; Crusto et al., 2013; Davis & Perry, 2015; Shamblin et al., 2016; Shivers et al., 2019). Additionally, a teacher's observed classroom emotional climate has been shown to increase after receiving IECMHC (Beardslee et al., 2010; Hepburn et al., 2013; Shivers, 2015; Raver et al., 2008).

The federal government and national policy leaders have issued several policy briefs highlighting IECMHC as an effective strategy for reducing child expulsion in general, and expulsion for boys of color specifically (e.g., Children's Equity Project, 2020; U.S. Department of Education, 2014). The emerging evidence for the effectiveness of IECMHC in promoting positive social and emotional outcomes for young children and in reducing racialized discipline disparities (Davis, Perry, & Rabinowitz, 2019; Davis, Shivers & Perry, 2018; Shivers, Farago, & Gal-Szabo, 2021) has been the impetus for many states to invest in IECMHC initiatives.

These many positive outcomes hinge on the work of the mental health consultant and the relationship the consultant forms with their consultees. The noted strengths and hallmarks of IECMHC as an individually-tailored approach includes fluidity, flexibility and responsivity. It is also important to highlight guidelines, competencies, and frameworks that are central to the delivery of effective IECMHC services. One such seminal framework was developed by San Francisco's own Kadija Johnston and Charles Brinamen. Their book, ***Mental Health Consultation in Child Care: Transforming Relationships with Directors, Staff, and Families*** (2006) identified 10 elements needed for consultants to deliver effective mental health consultation. Together, these elements are known as the ***Consultative Stance*** and are embodied as the consultants engage with their consultees. The elements of the Consultative Stance are widely viewed and accepted by practitioners, supervisors, agency administrators, policy makers and funders as foundational to the practice of IECMHC.

Ten Elements of the Consultative Stance
(Johnston & Brinamen, 2006)

1) **Mutuality of endeavor.** Early childhood mental health consultation can be effective only when the consultee contributes to and participates in the process.
2) **Avoiding the position of sole expert.** In accepting that the work is a collective effort between consultant, providers, and parent, the expertise of others is valued as equal to the consultant's own.
3) **Wondering instead of knowing.** "Wondering with, not acting upon" (J. Pawl, personal communication, 1997) the caregivers with whom the consultant is working elicits their involvement in the process and properly preserves the sense of the consultee as the holder of the essential information and knowledge as the agent of change.
4) **Understanding another's subjective experience.** The consultant introduces the importance of "not knowing" by demonstrating curiosity about internal experience of the other.
5) **Considering all levels of influence.** In addition to the personal histories of caregivers, there are numerous other influences on their views of a child and on their ability to respond effectively.
6) **Hearing and representing all voices-especially the child's.** Eliciting the voices of everyone involved, the consultant is dedicated to hearing about and from each individual.
7) **The centrality of relationships.** Because development is transactional and mental health is promoted through interactions between child and caregivers, the centrality of relationships underlies all beliefs about ECMHC.
8) **Parallel process as an organizing principle.** The consultant's way of being emanates from their conviction that the ways in which people are treated affect how they will feel about themselves and treat other people.
9) **Patience.** Just as consultants encourage and attempt to foster patience in caregivers' relationships with children, consultants must also be patient with the caregivers and family.
10) **Holding hope.** Consultees often lose hope in the face of daily crises and persistent challenges. The consultant must maintain a belief in change in a slowly shifting system.

Historical Background: Early Childhood Mental Health Consultation Initiative in San Francisco

Looking back to move forward

The Early Childhood Mental Health Consultation Initiative (ECMHCI) has enjoyed a long history in San Francisco. We thought it important to remember, record, and report this history to provide important insight and context for understanding how and why ECMHC continues to scale across San Francisco and across the country. Additionally, we seek to center and ground this current evaluation with a strong racial equity focus. As such, we acknowledge the importance of the 'Sankofa Effect' – looking back to move forward. As ECMHC continues to grow, evolve, and expand not only in San Francisco but around the country, there are four central questions that have influenced the design of this current evaluation approach and study: Who are we? Why are we here? Where did we come from? Where are we going? In our case, the collective 'WE' in the previous questions could refer to this sub-specialty known as Infant and Early Childhood Mental Health Consultation (IECMHC / ECMHC). The next section attempts to lay out the distinct histories of ECMHC in San Francisco which came to fruition in parallel time tracks. The telling of any history is ever-evolving and such is the case in the San Francisco story. According to our gathering of the stories from our 'history holders' and other historical documents, there seem to be three separate, but parallel origin stories. They start to all converge in the 90's.

Three Parallel Histories of IECMHC in San Francisco

Chinatown Child Development Center & Richmond Area Multi-Services	Infant-Parent Program & Jewish Family Children's Services	Instituto Familiar de la Raza's Early Intervention Program
The earliest stories of ECMHC in San Francisco date back to the 1970's, The Chinatown Child Development Center (CCDC) which recently celebrated its 50th anniversary was established in 1972 by San Francisco's Department of Public Health. This behavioral health clinic was established in the heart of Chinatown and serves children, youth and their families in the neighborhood, and many	For more than four decades, agencies within San Francisco have provided mental health consultation to early care and education programs throughout the city. Two of the most well-known originating agencies that first received significant funding to develop and deliver ECMHC were: 1) Jewish Family and Children's Services (JFCS)/Parents Place; and 2) Day Care Consultants, a program of the Infant-Parent Program (embedded within	Instituto Familiar de la Raza (Instituto) is a non-profit, community-based mental health and social service agency that has focused on meeting the diverse needs of the Chicano/Latino community and other multicultural communities in San Francisco for 45 years. Instituto offers a range of services including mental health promotion and prevention services, early intervention,

of them are immigrants from Asia, mostly from China. Those influential in those early days with CCDC were Sai-Ling Chan-Sew, Wei Lew, and Nancy Lim-Yee, among others.

In the 1970's many Chinese families who immigrated to the United States depended on child care in order to go to work at minimum-wage paying jobs. Consultation activities began as a response to young Chinese children being kicked out of preschool and child care settings because of challenging behavior. Sai-Ling Chan-Sew (former Director of CCDC, and later Director of SFDPH-CYF-SOC) tells the story that there was a lot of concern from many Chinese families because there was such a strong value of educational attainment, and the implications of a young child struggling with school at such an early age were confusing and problematic. Other families were also making use of drop-in playgroups at CCDC and there was also an expression of concern about young children's challenging behavior. At first referrals were made by CCDC staff. Then upon reflecting that many children were spending their days in child care, there

UCSF) and housed at San Francisco General Hospital in the Mission District. Later on, with seed funding from the Miriam and Peter Haas Fund, these two programs worked together early on in the history of ECMHC in San Francisco to articulate an approach, model and create an infrastructure for inter-agency collaboration.

Foremost among the early childhood mental health pioneers to bring ECMHC to life was Jeree Pawl, Ph.D., former Director of the University of California San Francisco's (UCSF) Infant-Parent Program (IPP) and a past president of the Board of Directors of Zero to Three: National Center for Infants, Toddlers and Families. As Director of IPP, Dr. Pawl created Day Care Consultants in 1987 to address relational wellbeing in child care for young children and their caregivers. The genesis of bringing mental health into child care settings was an extension of the ongoing, community-based, home visiting mental health programs where therapists were invited into homes to meet with caregivers and very young children. Dr. Pawl was instrumental in shaping the work of ECMHC that is now replicated and scaled in states, communities and tribal nations across the country we call the United States. Day Care Consultants, a program within the

case management, psychological and psychiatric services, mentoring services and cultural/spiritual reinforcement.

In 1986, Instituto began providing mental health consultation through its ***Proveedora Program***, which was the first program in San Francisco to provide consultation to Latinx family child care providers. During that time in the 1980's, the Latinx community had a significant influx of people from Central America who were in the middle of civil wars that were funded financially and politically supported by the US. These communities were not accustomed to send their children to the care of "strangers" at a young age and so they primarily depended on child care provided by friends, family members and other trusted people in their community. Additionally these communities / families were experiencing the consequences of war trauma and immigration trauma. Family relationships were significantly impaired, and the system was overwhelmed.

Over the years, Instituto expanded its consultation services to include early

was an attempt to bring training and referrals to Chinese child care providers.

There was such a welcoming of this new information and support that the child care providers wanted more of their support and time. Sai-Ling Chan-Sew decided that CCDC should bring their mental health expertise into their relationships with child care providers on a regular basis, and yet it was tailored to the needs of the providers. Some only needed referrals, and other providers needed and wanted more ongoing support.

Since the 1980's, Richmond Area Multi-Services, Inc. (RAMS), a non-profit organization that provides mental health services with an emphasis on Asians, provided mental health services on-sites at San Francisco Unified School District. The two agencies came together in 1998 to propose and in 1999 started a partnership that became the Fu Yau Project. Thanks to the leadership of Gene Chen, then director of CCDC, and Dr. Roger Wu, the collaboration solidified CCDC's over two decades of mental health consultation to child care settings, and early intervention to

Infant-Parent Program was launched in 1988. Its mission was to provide relationship-based and culturally-informed consultation to early care and education sites. Gradually, therapeutic groups and access to IPP psychotherapy services were added to further support higher levels of need. Their collective experience was backed by the growing body of brain development and early childhood educational research. This research supported their growing hypotheses that promoting the emotional wellness of young children and fostering secure warm relationships with care providers was facilitated by attending to the dynamic internal experiences, which are critical to healthy early development and greater success rates for children once they started attending school.

At JFCS, their strategy for helping children and families by working with elementary school teachers started prompting more curiosity. JFCS wondered whether an even earlier mental health consultation intervention at child care centers would succeed. In theory, such an approach would be even more beneficial because it could address social, developmental, and emotional issues during the crucial first five years of life. JFCS conducted one of the first

care and education settings and schools. In 1993, Instituto established the Early Intervention Program (EIP) to integrate the agency's various mental health consultation efforts into one program. At that time, Instituto was still a fairly young agency (only 7 years old). The individual chosen to lead EIP was a clinician, Germán Walteros, who sought out partner agencies to develop overall expertise in ECMHC. He ended up working with Kadija Johnston who was in a leadership position with Day Care Consultants (Infant-Parent Program at UCSF). Germán developed Instituto's consultation model with the same relationship-based orientation as the Infant-Parent Program, while infusing a strong cultural framework to meet the needs of Instituto's largely Latinx immigrant service population in the Mission District.

Instituto Familiar de la Raza (Instituto) in San Francisco has a long history of supporting and engaging Latinx family child care providers. By attending to the unique culture of family child care as well as the Latinx/Chicano/a culture, Instituto has built and maintained strong ties to this community.

children 0-5 and their families and providers. Fu Yau Project created an opportunity to train more culturally competent mental health consultants at RAMS. Christina Shea, first Coordinator, was instrumental in strengthening the experiences and ideas of both organizations and making Fu Yau a reality in providing relationship based, culturally and linguistically relevant mental health consultation services to the child care communities and the family resource centers.

After 15 years of partnership, and leadership and priorities changes, Fu Yau Project moved out of CCDC in 2014, and continues to grow under the sole leadership of RAMS. RAMS and CCDC (and Fu Yau) continue our relationship as community partners in many other ways.

To learn more about the work of the Fu Yau Project, visit: www.ramsinc.org/fy.html

evaluations of mental health consultation to help guide their continued efforts.

Between 1995 and 1999, funding from the Miriam and Peter Haas Fund enabled both JFCS and IPP to collaboratively provide mental health consultation to elementary schools and child care centers. Laurel Kloomok who was with JFCS at the time and Kadija Johnston who was with IPP at the time emerged as local leaders during this period and helped to shape the ongoing collaborative efforts that continued to expand.

At the writing of this report JFCS no longer provides ECMHC services. But The Infant Parent Program through Daycare Consultants continues to provide case and programmatic consultation and milieu-based therapeutic shadowing and therapeutic playgroups for toddlers and preschoolers who are exhibiting behavioral concerns in a group care setting.

To learn more about the work of the Infant Parent Program, visit: https://psych.ucsf.edu/zsfg/ipp

Over the years Instituto's long term work with ECE centers (particularly Head Start) has resulted in deep partnering, collaboration and leveraging community relationships. They have implemented a strong programmatic and child/family case consultation model that embeds a cultural/worldview perspective that recognizes the role of power and privilege on marginalized communities.

Not surprisingly, almost all of Instituto's staff and leadership identify as Chicano/a, Latino/a /Latinx/Latine. They have fostered relationships with local child care providers through genuine collaboration that reinforces mutual expertise and effectively meets the needs of early educators in a culturally responsive manner.

To learn more about the work of Instituto Familiar La Raza, visit: https://www.ifrsf.org/?locale=en

Photo courtesy of Instituto

Convergence, collaboration, community-building

In the 90's the Carnegie Starting Points Initiative—a local collaboration of public and private agencies focusing on the zero to five populations in San Francisco—began to take note of the consultation approach. As more child care centers sought assistance, the City and County of San Francisco moved to fund mental health consultation through its Department of Public Health, Division of Community Mental Health Services. This funded collaboration work laid the groundwork for a city-wide community-based mental health consultation initiative that began in April of 1999. This collective impact approach brought together nine mental health community agencies[1]. Those original grantee-agencies included: Children's Council of San Francisco; Family Service Agency of San Francisco**; Fu Yau Project (Richmond Area Multi-Services/Chinatown Child Development Center); Homeless Children's Network; Instituto Familiar de la Raza;** San Francisco Psychoanalytic Institute, Parents Place- Jewish Family and Children's Services; **Day Care Consultants (Infant Parent Program at University of California, San Francisco);** and Westside Community Mental Health Center. Each grantee works with its own network of local child care centers and family child care providers.

Over the past 34 years there have been many foundations and public funders that have believed in consultation and in the outcomes of the work to create and implement a service in San Francisco to improve the long-term prospects for the city's most vulnerable children and families. A special acknowledgement must be made to Sai-Ling Chan-Sew. As noted earlier, she was instrumental in developing ECMHC at Chinatown Child Development Center and then later creating Wu Yee Children's Services to address the dearth of child care available to Chinese-American families in San Francisco. And finally, without the backing of Sai Ling Chan-Sew who went on to work as the Director of Child, Youth and Family Section of Community Mental Health Services at DPH, the County of San Francisco would never have considered adopting ECMHC as its primary model of early intervention with families of young children.

Although our recounting of the history of ECMHC is far from complete and exhaustive, we hope that by now it is clear that the development of a strong, collaborative infrastructure has been in place from inception. It included an emphasis on community-building and establishing trust and cooperation among the grantee-agencies and the various funders who regularly came to the same table to share and learn from one another.

1 Bolded names indicate that they are still currently ECMHCI grantees as of the writing of this report.

Philosophy and approach

One of the most enduring foundations of ECMHC is the understanding that young children develop best in a setting that promotes positive relationships between teacher and parents, among staff, and between the child and their teacher. This relationship parallels the potency of the relationship between children and parents. The quality of child care is improved as teachers become better able to observe, understand and respond to children's needs. The work of mental health consultation is to help the teachers develop an increased awareness and understanding of the impact of their interactions with children.

From the very beginning more than 30 years ago, the seminal ECMHC approach was and still is based upon the following assumptions:

Learning is a complex process that occurs over time.	Due to the interpersonal nature of caregiving, the teacher's performance will improve as they are better able to recognize, accept and understand their own emotional reactions to children	The teacher's emotions are tools for understanding the child's experiences.

Inherent in the history of ECMHC in San Francisco is also the strong sense of collaboration, community, and culture that is infused into the infrastructure, approach, philosophy, training, supervision, and the way in which mental health consultants embody the Consultative Stance. Indeed, Instituto and Fu Yau's approaches to consultation have both historically integrated a strong focus on addressing mental health needs within a cultural and clinical framework. For example, at Instituto the mental health consultants foster a sense of community in each program to support high quality learning environments. As an essential first step in implementing these strategies, consultants historically and continue to put considerable effort toward cultivating their own relationships with programs, providers and parents through mutual respect and collaboration. A central element of fostering these relationships is establishing "confianza" (i.e., the belief that the consultant will respect an individual's private self and exercise compassion).

Early activities of ECMHC

From the early stages, ECMHC was designed to improve the overall quality of early care and education for the Bay Area's low-income children, specifically addressing the teacher-child relationship, and to promote children's mental health by building the community's capacity to provide high quality child care and early childhood mental health services. The model seeks to improve overall care and also to target the developmental needs of individual children. To achieve this aim, two primary activities are pursued: 1) Providing on-site mental health consultation services to early care and education staff, including child- and program-level consultation as well as didactic training; and 2) Providing intensive training and supervision for mental health professionals in the provision of consultation and individual/group treatment of young children, their families and teachers.

Historical theory of change still holds true.

The success of consultation depends on the consultant's ability to develop an alliance with teachers. Within this alliance, they work to understand what children need and how best to provide it. A hallmark of the effort is respect for teachers, children and families. However, forming an alliance with teachers takes time and depends on the establishment of a predictable, protective atmosphere of learning. Not only must the consultant understand concerns about particular children or programs, they must also strive to understand the educator's subjective experience, appreciate the stresses experienced by staff members, cultivate their readiness to engage in the learning process, and work to authentically understand their particular professional and cultural views about child-rearing, and work to understand the systemic issues and cultures of each child care program.

An additional element to San Francisco's ECMHCI's theory of change is to strive to provide services in a manner that reflects and is respectful of the collective culture being served. Through their work with colleagues and reflective supervisors, mental health consultants seek to engage in cultural self-reflection and consideration of how culture affects one's worldview. This introspection, coupled with a heightened awareness and understanding of the cultures of the community being served, helps lead to more appropriate and effective services. Given that a majority of San Francisco's consultant workforce culturally and linguistically match the communities they serve, there is a greater likelihood of awareness of and respect for the cultural norms and traditions within various San Francisco cultural communities.

Current-day perceptions of ECMHC in San Francisco.

San Francisco is perceived as trail blazers in ECMHC. Many of the key foundations for the ECMHC approach and model were established in San Francisco and this approach continues to inspire and inform the continued scaling of IECMHC across the country. At the writing of this report, Kadija Johnston (formerly the director of the Infant-Parent Program) is nationally celebrated and respected as a thought leader, policy influencer, and advocate. The book she and Charles Brinamen published in 2006 (where the Consultative Stance framework is first introduced to the field) continues to be the sole, seminal work that influences our collective, current-day approach to IECMHC.

San Francisco has a strong grounding in cultural communities and in cultural clinical practice. From the very inception of ECMHC in San Francisco there was an intuitive 'knowing' that child care providers needed more mental health support in a way that attends to and uplifts community- and family-held cultural values. When the nine community mental health agencies finally all came together in 1999, Fu Yau and Instituto both brought a more expansive and social-justice oriented world-view to the initiative that was inclusive of marginalized communities who were not initially at the 'funded table' when this effort began in the 80's. From the periphery, Instituto brought in an experiential diversity that enhanced the "Consultative Stance" to include a broader socio-cultural and socio-political dimension of the communities being served. Likewise, Fu Yau and Instituto both brought in a keen understanding and adaptations to ECMHC that call into question the strong focus of individuality and independence in dominant, western approaches to infant mental health versus an approach to infant mental health that is more aligned with a familism world-view embraced by many traditional cultural communities wherein the family is at the center of mental health approaches. Familism prioritizes interdependence and right relationships through the meaningful rituals of being family. Currently all programs center a

strong cultural lens and grounding in the development and support of the workforce (e.g., leadership development, development, recruitment, workforce pipeline, etc.). This results in an approach to consultation whereby consultants embody curiosity and cultural humility in their day to day work in communities.

Long, lasting relationships with consultees. Historically, there has been some tension among both the community mental health agencies and funders not always agreeing on the longevity of ECMHC with ECE sites.. From the early beginnings of ECMHC in San Francisco there was – and still is – a strong vision of long-term collaboration. There is the idea that mental health consultation should be part of the fabric of early care and education programs – much like school counselors are part of elementary schools' fabric. The world-view held by the community mental health agencies that provide ECMHC emphasizes collaboration and interdependence. In mainstream society interdependence is often pathologized. However, current mental health consultants as well as those who were around in the early days of ECMHC in San Francisco understand the power of long-term collaborative relationships and the depth of capacity building that can happen over the longer arc of consultation. There is a belief that this is what it takes for meaningful capacity building within communities. An additional theme that was explored with the 'ECMHC history holders' in San Francisco highlights the constant turnover that happens among directors, teachers, families and children at ECE sites. In this way there are always those who are new to consultation. But when a site has a history of receiving ECMHC over the years and there is 'institutional knowledge and trust' that has built up over time at that site, the consultative alliance that is developed between consultant and a consultee (who may be new to consultation) has an easier time being leveraged in a way that leads to better outcomes for teachers and children.

Strong workforce infrastructure. From the beginning of the initiative, the community mental health agencies benefitted from funding that supported collective impact development., which resulted in a shared infrastructure for workforce development and support. For example, each grantee-agency sought to create and currently seeks to maintain a robust workforce pipeline to ensure that San Francisco is attracting and supporting professionals into the field who come from the communities they serve and who are culturally and linguistically matched with many of the diverse ECE sites around the city.

Braided funding and strong collaboration with funders. The ECMHC Initiative in San Francisco still benefits from a strong collaboration with a group of funders. Early on in the initiative, a group of funders (public and private) regularly met together with community mental health grantee-agencies who provided ECMHC to the city. There was a deep intention from the funders to learn from the agencies (e.g., What is ECMHC? How does it work? How can we leverage and collaborate with other early childhood programs and systems?) and to support the expansion of ECMHC. Over the years, some of the individuals who were originally in the ECMHC workforce went on to work with the funding agencies. Additionally, there were several funders who were actual recipients of ECMHC earlier in their careers! A notable achievement among the funders was the creation of a single RFP so that agencies would not be required to submit multiple proposals and reports to all the various funding organizations.

ECMHC Evaluations in San Francisco

Over the years there have been several independent evaluations conducted that have taken place in various configurations: across many ECMHC sites/agencies (SF's DPH); agency specific (Johns & Rassen, 2003); and as part of larger national evaluation initiatives (e.g., What Works; What's Working – both studies led by Georgetown University).

Going back to the mid-1980s, Jewish Family and Children's Services (JFCS) / Parents Place, backed by foundation funding and in partnership with a local university and the San Francisco Unified School District—undertook a four-year service and research project to find out which consultation methods worked best and why. They wanted to investigate how their new intervention model helped children and teachers and whether the emotional and academic well-being of children could be improved by providing mental health services to elementary school personnel.

Their research project provided several key insights:

1. The support and expertise provided by onsite mental health consultants enabled teachers to address a wide range of mental health problems facing children and families.
2. Teachers' sense of efficacy improved if they had a fuller understanding of the issues facing children. Further, this understanding could translate into more effective classroom interventions.
3. As teachers used more mental health consultation and developed a more effective set of classroom interventions, children's self-esteem, motivation to learn and academic performance improved.

(Johns & Rassen, 2003)

Since 2001, San Francisco's Department of Public Health has coordinated the evaluation effort by publishing several ECMHCI evaluation reports and by continuing to gather data from all the ECMHC grantee-agencies. This data gathering typically has focused on units and reach of service; assessing the impacts of consultation on social development and challenging behaviors among children; enhancing providers' skill development; and satisfaction with services among providers and families. Over the years, DPH's evaluation efforts have employed a number of different empirically validated tools, employing designs that have included a pre/post design and a comparison group. The number and selection of tools typically varies based on current priorities.

Past evaluation findings from San Francisco's Department of Public Health (2005) demonstrate (via pre-post-comparison data) the following:

- Children whose teachers received ECMHC services showed significant gains in their social development;
- Children whose teachers received ECMHC services showed significant decreases in their problem behaviors;
- Families felt very positive about mental health consultation;
- Teaching staff felt that services were helpful; and
- Early care and education program directors felt that consultants improved their sites in a number of ways, such as heightening family involvement and addressing issues of cultural competence and diversity.

(Duran et al., 2009 - What Works Study)

A year later, San Francisco's Department of Public Health conducted another county-wide evaluation effort that utilized a pre- post-evaluation design but with an added comparison group component (intervention group = 27 children; comparison group = 21 children). Findings demonstrated that children in the treatment group receiving ECMHCI services showed:

- Greater improvements in social skills than children not receiving services;
- Statistically significant reductions in externalizing problem behaviors; and
- Greater improvements in age-appropriate play than children not receiving services.

(Duran et al., 2009 - What Works Study)

ECMHC in San Francisco has a long history evolving and learning from these various evaluation efforts. Our hope is that this current study will also contribute to the understanding of the power and potential of ECMHC to shape experiences for the early care and education community and the children they serve.

In 2018, a process evaluation of the City's Early Care and Education Training & Technical Assistance (T&TA) initiative commissioned by First 5 San Francisco and the San Francisco Office of Early Care and Education examined user experience with the host of City-funded services that support and enhance the city's early care and education field, including mental health consultation. This inquiry found that while teachers and directors agreed that they could use more mental health consultation support at their sites, some of their reviews of the service itself was mixed, depending on how seasoned their consultant was. Those whose consultants were interns or new to the profession had less-positive reviews of their experience than others who had more veteran professionals at their service. Nonetheless, the feedback from that evaluation was that more of the service was desired across the field of early educators (both family child care providers as well as center-based directors and educators).

The San Francisco ECMHC Initiative today.

Over the years, the philosophy and approach have stayed fairly consistent, and consultation services have expanded into other settings where there are young children, including pediatrician offices, homeless shelters, doula programs, and family resource centers. In the face of limited resources and growing needs however, the funders of the ECMHC initiative in San Francisco are working to leverage resources to meet an ever-increasing need and demand for more services.

Introducing a new model and approach to ECMHC in San Francisco: On-Call

Most states and communities are currently searching for additional funding for ECMHC. However, while states are getting creative with how to procure additional funding, they are also exploring how to leverage and do more with the limited ECMHC resources. For example, the state of Arkansas has developed a preschool expulsion prevention support system designed to coordinate key technical assistance and ECMHC resources (Conners Edge, Kyzer, Abney, Freshwater, Sutton, Whitman, 2020). As of 2016, Arkansas started implementing a multi-tiered service approach. In Arkansas, Tier 1 includes behavioral health support over the phone or email. Tier 2 includes short-term assistance from a team of developmental / social-emotional experts. Tier 3 includes services from Project PLAY mental health consultants (Conners Edge et al., 2020).

In response to a recognition that resources for mental health consultation are limited amidst a growing need for supportive services, a tiered model of consultation was piloted, which offered a new, "On-Call" level of services at the Tier 1 designation, as explained in this excerpt from the Request for Qualifications issued in April 2018:

> ***"In the past, each City-designated ECMHCI site was guaranteed a specific number of program consultation hours per month. This resulted in consultation hours not being fully utilized at some sites, while higher need sites were not receiving the level of consultation required to effectively support the social and emotional development of children they serve.***
>
> ***To better allocate limited program consultation resources, the ECMHCI joint funders have adopted a site tiering system which will allocate program consultation services based on a site's anticipated need for consultation services. Need will be determined based on a site's emotional domain scores, environmental rating scale (ERS) scores, Quality Rating Improvement System (QRIS) Level, program administration stability, and whether or not the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) framework is used. [See chart below]***
>
> ***Upon request, all ECMHCI sites will be able to access ECMHCI consultation, early intervention and treatment services for young children and their parents and caregivers regardless of whether the site is designated as Tier 1, Tier 2, or Tier 3 without limitation on the type, intensity, and dosage of the service.***

Consultants will assess the specific behavioral health needs of each young child referred and the specific consultation, coaching, training and service access needs of their parents and caregivers, working in collaboration with service site staff.

Based on the assessment of need, appropriate ECMHCI services will be identified and reflective of services that could be expected to best support the social and emotional development of a young child, in consultation with his or her parent or caregiver. ECMHCI are intended to be short-term, limited interventions, especially for Category 1 and Category 2 services. It is the expectation that ECMHCI services be assessed at regular intervals for their effectiveness in improving the emotional health and well-being of children and building the capacity of families to support the emotional health and well-being of themselves and their children".

ECMHCI Program Consultation Service Frequency by Program Tier

ECMHCI Service	Tier 1* Characteristics: **Low Need,** High Quality Environment/ Interactions w/All Children	Tier 2 Characteristics: **Moderate Need,** Adaptation, Small Group, Individualized Instruction for Some Children	Tier 3 Characteristics: **High Need,** Specialized Instruction for a Few Children
Program Observation	As needed, On-Call	Once per month	At least weekly
Individual Consultation with Site Director/Designee	As needed, On-Call	Once per month	At least weekly
Group Consultation with Site Staff or Family Child Care Providers	As needed, On-Call	Once per month	At least weekly
Site Staff Training	None	None	Quarterly as needs arise

**** Tier 1 sites are considered high functioning sites with low program capacity needs and low child and family needs, having the following characteristics: a) Emotional domain score > 6; b) ERS > 5; c) QRIS Level > 4; d) stable administration; and 5) uses CSEFEL.***

[End excerpt]

Implementing On-Call services during COVID

Initial roll-out and implementation of the new tiered system was met with considerable confusion and upset. In an effort to more effectively allocate limited resources to the highest-need sites, some sites that had been accustomed to the full level of service (i.e., the traditional model of ECMHC) had their hours with their consultants drastically reduced. This model change put a strain on consultants' relationships with sites and was the source of considerable consternation in the early months of implementation. It must be noted, too, that due to the COVID-19 pandemic and other factors, changing conditions on the ground meant that consultation agencies needed to be more flexible in their allocation of hours to meet the changing and varying needs of sites during this time. For example, one consultant noted that many Tier 2 sites had expectations of having their consultant 5.5 hours per week, rather than one visit per month. In addition, Tier 2 sites also receive some staff training. Thus, actual implementation of the new Tiered model was flexible and varied.

Photo courtesy of Instituto

Photo courtesy of Instituto

In an effort to better understand the impact of the ECMHC initiative, as well as the effects of the new On-Call approach, this program evaluation was launched in January, 2020, roughly one year into implementation of the new consultation model with an initial convening of all five mental health consultation agency directors and leads, as well as the joint funders representing four City departments that jointly contribute to ongoing funding of the initiative. At this convening, initiative funders and consultation agency directors were invited to contribute to a timeline activity, marking significant initiative milestones. Notably, the ECMHCI timeline that the collaborative constructed started in the mid-80s when the current-day-funders of the initiative were then early childhood education (ECE) center directors and recipients of the service.

Almost immediately following this initial evaluation kickoff meeting, the COVID-19 pandemic dramatically changed the early childhood landscape via shelter-in-place orders, site closures and the transition to virtual support. The evaluation was temporarily put on hold as the world braced for the onslaught of the pandemic.

Introduction

The early weeks and months of the pandemic put great strain on the early care and education community, as sites initially closed, then reopened intermittently to service essential workers' needs for childcare so that they could go back to work as the doctors, nurses, grocery clerks, plumbers, and other service providers critical to the maintenance of safety, sanitation, and essential operation of residences, businesses, hospitals, and congregate care settings while the pandemic wreaked havoc. Consultants scrambled to find personal protective equipment, set up ECE sites with appropriate ventilation and COVID-19 safety protocols, and then, increasingly, consultants scrambled to find adequate mental health resources to attend to the growing and soon-to-become overwhelming need that engulfed the City's ECE community over the first year and a half of the pandemic. In response to the unfolding crisis, mental health consultants did their best to continue to provide support to their sites virtually and quickly innovated by providing Zoom and other video-based consultation and online group support meetings for ECE providers, directors, parents, and caregivers.

As COVID-19 infection rates slowed and the world began to attempt resuming some semblance of normalcy, evaluation efforts resumed. In November 2021, plans for the ECMHCI evaluation were officially announced to the early care and education community at an ECE center directors meeting. In December, protocols were developed for the On-Call phase of the evaluation, and outreach for participation began. Just as the evaluation was finally kicking off, the joint funders received notice from one of the consultation agencies, Edgewood Center for Children and Families, that they would no longer be able to provide services under ECMHCI. As one of only five providers of consultation services in the city, this came as a blow to the whole ECE system. Having struggled to establish services with their newly assigned sites, Edgewood had not been able to bill for services and this deficit eventually led to their withdrawal from the initiative. This left their current caseload in need of absorption into other consultation agencies' caseloads. However, in the context of the COVID-19 pandemic crisis and the Great Resignation, characterized by elevated rates of resignation while observing high labor demand, there was heightened demand for mental health services, leading to severe burnout of the healing professions, coupled by struggles with staffing shortages well before Edgewood's exit. Transferring Edgewood's caseload to other consultation agencies would not be an easy task without adequate clinical staff to service the caseloads.

Photos courtesy of RAMS/Fu Yau

The joint funders worked closely with each of the four remaining agencies to prioritize active Edgewood cases for reassignment, while also providing agencies with additional funding to support the additional work and hiring of new clinical staff that would be needed to service the new cases. As of this writing, all sites have been reassigned, even as the four remaining consultation agencies continue to struggle to hire adequate clinical staff.

The configuration of joint funders has also shifted over this time, as the San Francisco Mayor's Office of Early Care and Education (OECE) and First 5 SF have come together as the newly minted San Francisco Department of Early Childhood (DEC). In order to expand capacity and funding more effectively, and to better integrate the City's early childhood resources, these two organizations merged under the direction of the Mayor's Office to become the City's largest funder of early childhood programs and services. DPH and DCYF continue to jointly fund the initiative and in the next RFP cycle, the holder of contracts with the consultation agencies will move from DPH to DEC.

Meanwhile, in July 2021, the California State Department of Social Services began to oversee the state's Infant and Early Childhood Mental Health Consultation Initiative and is providing additional funding for expanded services such as workshops and training, as well as preparing a new workforce of mental health consultants. This evaluation was launched amid the backdrop of all these events unfolding, which continue to unfold.

As of this writing, the ECMHC initiative is funded by three City departments, supporting four agencies that provide consultation services.

Joint funders of the SF ECMHC

- SF Department of Early Childhood (DEC)
- SF Department of Public Health (DPH)
- SF Department of Children, Youth, and Their Families (DCYF)

Early Childhood Mental Health Consultation Initiative Agencies

- Homeless Children's Network (HCN)
- Instituto Familiar de la Raza (IFR)
- Richmond Area Multi-Services (RAMS) Fu Yau Project
- University of California San Francisco Infant-Parent Program (IPP)

Current reach of the ECMHC Initiative in San Francisco

These agencies are the heart of the initiative and maintain relationships with 229 different sites across the city to support their mental health needs. As demonstrated in the following table, while all consultation agencies serve a number of early care and education centers, which is what this evaluation focuses on, each agency has a slightly different emphasis with respect to the type of agencies they serve. For example, HCN and IPP have a greater presence in homeless and domestic violence shelters and in substance use treatment programs; HCN and IFR carry the bulk of family child care home providers; and RAMS carries the majority of the ECE center-based care sites.

Number of Sites Served, by Agency							
Agency	Family Resource Centers	FCCQN Licensed Family Child Care Home	Homeless and Domestic Violence Shelters	Licensed Early Care and Education Centers	SUD Treatment Programs	SFUSD	Grand Total
HCN	4	20	3	6	4	10	47
IFR	4	25	0	21	0	12	62
RAMS	8	11	0	40	0	15	74
IPP	8	4	6	23	3	2	46
Grand Total	24	60	9	90	7	39	229

The incredible breadth and depth of the reach of the initiative can be surmised from the billable units of service. Each agency provides an annual report of the total units of services and persons served. In the 2021-22 fiscal year, 41, 638 total hours of service were provided by 46 consultants. The initiative served 1,599 care providers, 4,403 parents/caregivers, and 6,151 children across six different types of sites, as shown in the table below.

Number of Participants							
	Licensed Early Care and Education Centers	Family Resource Centers	Homeless and Domestic Violence Shelters	FCCQN Licensed Family Child Care Home	SUD Treatment Programs	SFUSD	Grand Total
Care Providers	866	196	93	145	39	260	1,599
Children	2,592	1,892	183	221	34	1,229	6,151
Parents/Caregivers	1,086	2,862	110	42	42	261	4,403
Grand Total	4,544	4,950	386	408	115	1,750	12,153

Each agency serves a unique set of sites and consultees. For example, HCN served 32% Black/African American and 32% Latino/a consultees with the majority speaking English (61%). IFR served primarily Latino/a (71%) consultees who spoke Spanish (55%). RAMS primarily served Asian consultees (54%) and Cantonese was the primary language (40%). Finally, IPP served mostly Latino/a consultees (54%) who spoke Spanish (53%).

Additional information describing who was served, the types of consultation services provided, and demographics of the consultants who provided the services can be viewed in the ECMHI Dashboard. The dashboard also provides descriptions by each agency. The dashboard is available in Appendix F or at the following link: SF IECMHC Data Dashboard.

Evaluation Approach

The current evaluation of San Francisco's ECMHC Initiative is ongoing and this document reports on the first two of a four-phase effort. The broad purposes driving this overarching evaluation are listed below.

Broad Objectives for 4-Phase ECMHC Evaluation in San Francisco

- Understanding whether and how ECMHC impacts outcomes
  - For whom and under what conditions?
- Quality assurance and program design implications
- Influencing policy (example: school readiness or preschool expulsions)
- Contributing to the national base of knowledge about ECMHC (e.g., what is SF's unique contribution?)

Central research questions driving the multi-year, 4-phase evaluation

1) What are sites' feedback and experiences with ECMHC? Does this vary by racial, linguistic, and/or ethnic match between consultant and center demographics?
2) What changes at the site level, teacher level, and for the consultant?
3) What is the impact of ECMHCI on ECE center and classroom climate?

Evaluation Approach

A summary table with an overview of the overarching plan for the 4-phase ECMHC evaluation in San Francisco is included below.

SF ECMHC EVALUATION OVERVIEW

Phase 1: On Call Consultation Exploration			
Research questions	Who?	Data	When?
• How is On-Call consultation defined? • Where does it fit in San Francisco's traditional consultation model and approach? • What has been useful about this service? • What is needed to make On-Call services more useful and more effective? • What are sites' experiences and feedback regarding On-Call services?	• ECE program directors • Teachers • Mental health consultants	Focus groups Online survey	January/Feb 2022 March - May 2022
Phase 2: Feedback from ECMHCI Long-Time Partners			
Research questions	Who?	Data	When?
• What have been the experiences with IECMHC? What has been the impact of working with an IECMHC partner over time? • What feedback do directors, teachers and providers have for their IECMHC partners? • Are there any background factors that impact consultees' experiences with IECMHC?	• ECE program directors • Teacher • Mental health consultants	Focus groups (long time partners) Online surveys	May/June 2022 July/Aug 2022
Phase 3: Outcomes / Pre-Post ECMHCI Evaluation			
Research questions	Who?	Data	When?
• For sites and teachers new to consultation… • What changes at the site/director level, teacher level, consultant level, and/or child level (outcomes)? • What is the impact of EMCHC on classroom emotional climate and suspension/expulsion?	• ECE program directors • Teachers • Mental health consultants	Pre/post surveys Pre/post classroom observations	2023-2024

Data Collection Strategies

A mixed methods evaluation design was employed for phases 1 and 2 of the evaluation, exploring the On-Call consultation model and gathering feedback from consultees. Focus group conversations were utilized to collect qualitative data and surveys were used to collect quantitative data. Together, both methods illuminate nuances in consultation in San Francisco's initiative.

Focus Groups

Focus groups are a well-suited methodology in situations where a concept or area has little to no research and where the evaluation is likely to gain much from involvement of the interested community (Edmunds, 1999).

On-Call Focus Groups

Consultants
5 Focus Groups
17 participants

Directors/Educators
4 focus groups
11 participants

Consultants who provide Tier 1, or On-Call consultation were invited to join a 1-hour focus group to share their experiences. A total of five consultant focus groups were conducted, one focus group per agency (i.e., IFR, Edgewood, RAMS, IPP, HCN). Edgewood was gracious to participate in these focus groups even as they exited from the initiative. A total of 17 consultants participated in the On-Call focus groups

ECE center-based directors and educators who received On-Call consultation in the 2021-22 fiscal year were invited to join a 1-hour focus group to share their experiences with the service. A total of four focus groups were conducted: Two with early education center directors and support staff and two with ECE center-based educators. A total of 11 consultees participated in the On-Call focus groups.

All On-Call focus groups were transcribed and content-analyzed using Dedoose, a software designed for qualitative data analysis. Based on our understanding of the current IECMHC literature, our experiences conducting IECMHC evaluations with other communities around the country and based on theoretical frameworks that inform IECMHC implementation and effectiveness, an On-Call codebook was constructed a priori to facilitate content analysis. The On-Call codebook is displayed in Appendix A.

Feedback Focus Groups

Consultants
2 Focus Groups
14 participants

Long-Term Partners
4 focus groups
25 participants

Consultation agency directors were invited to join a 1.5-hour focus group and were asked to invite up to three of their longest-standing consultants to join as well (e.g., those who have been working as consultants for 10+ years). Focus group questions encouraged agency directors and consultants to share their experiences with consultation over the course of their career. A total of 14 consultants participated across two focus groups, with representation from each of the four agencies (i.e., HCN, IPP, IFR, RAMS/Fu Yau; Edgewood had exited the initiative before feedback focus groups were conducted). Given the rich conversations that occurred in these groups, we did not have time to address all questions during the focus group meeting. Thus, agency directors and consultants also provided open-ended responses to questions via Survey Monkey. We incorporate these responses as qualitative data and do not consider these "***survey responses"*** per se**.**

Agency directors and consultants identified up to 10 consultees they considered to be ***long-time partners*** of mental health consultation**.** These consultees were invited to join a 1.5-hour focus group of their own to examine early educators' experiences with consultation over time. Four groups were conducted: two in English, one in Chinese, one in Spanish. A total of 46 long-time consultees were identified across the four agencies and 25 ultimately participated in focus groups, including teachers (n=3), family child care providers (n = 7), directors (n = 12), and other site administrators and supports (e.g., site advocates, program managers; n=15). Focus groups were not segmented by role (e.g., director, teacher).

All feedback focus groups were transcribed and content-analyzed with Dedoose. Given this focus group exploration was largely to gather feedback about San Francisco's ECMHCI over the years, we utilized an inductive coding approach which creates codes that emerge from the content. In other words, we allowed the voices of the agency directors, consultants, and consultees to direct our coding. After reading through each focus group, the research team noted themes that emerged and added them to a codebook. The coding process was led by an Indigo team member with previous experience in the IECMHC workforce as a clinical and reflective supervisor. The Feedback Codebook is available in Appendix B.

Photo courtesy of Instituto

Surveys

On-Call Survey (N=28)

An online survey was administered via email between March and May 2022 and was offered in Chinese, English, and Spanish to all directors and educators who had received On-Call consultation in the past year. Respondents were directed to answer questions based only on their experiences in the last 12 months. Questions probed dosage, duration, and perceived quality and effectiveness of their On-Call experience. A total of 28 consultees participated in the On-Call survey (response rate of 46%).

Survey participants were center-based educators, some of whom had utilized On-Call consultation services and some of whom had not. Most respondents were teachers (54%), followed by directors (32%), and site supervisors (11%; 3% did not provide their role). Respondents identified as Asian (61%), White (14%), Latino/a (11%), multi-racial (7%), and Black (4%) and the majority were female (96%). Respondents were from 23 unique child care sites. The majority of the sites used English for instruction (64%).

Feedback Survey (N=99)

An online survey was administered via email between August and October 2022 and was offered in Chinese, English, and Spanish. This survey explored the effectiveness of the traditional approach and model of consultation. All Tier 2 or Tier 3 consultees were asked to complete the survey which asked about the dosage, duration, quality, and effectiveness of traditional consultation. A total of 99 consultees participated in the traditional consultation survey (we could not calculate response rate).

Traditional consultation participants were teachers (44%), followed by directors (29%; 27% did not provide their role). Respondents identified as Asian (33%), Latino/a (14%), White (7%), Black (6%), Multiracial (6%), Arab/Middle Eastern (1%), and 2% preferred not to disclose, and the majority were female (65%). Respondents were from 11 unique child care sites. Over half of the sites utilized multiple languages for instruction (51%), followed by English (11%), and Chinese (2).

Findings

This report presents findings from Phase 1 and Phase 2 of this evaluation effort separately. Phase 1 reports on the On-Call model and approach and Phase 2 explores experiences, impact, and feedback from the perspective of consultation partners (i.e., teachers and ECE site administrators/directors) as well as from the perspective of mental health consultants. Given that these are initial phases of a broader evaluation agenda in San Francisco, much of the work presented in this report is exploratory and will inform subsequent phases of the evaluation. Key themes and findings from Phases 1 and 2 are described. Select, exemplary quotes are included for each major finding to center the voices of the participants. Additional quotes can be viewed in Appendix C.

Key ECMHC Definitions (Johnston, 2022)

ECMHC **Model**
The term 'model' connotes factors related to frequency or service, dosage, intensity, etc.

ECMHC **Approach**
The key frameworks that guide how ECMHC is implemented. It includes the way in which consultants embody and convey (through practices and relationships) a particular stance, philosophy and worldview (e.g., integration of the Pyramid Model; centrality of the Consultative Stance; building capacity with adults in early childhood settings (as well as building consultees' organizational or program capacity) vs. direct work or short-term work that is focused more on finding triaged solutions on behalf of young children).

Phase 1: What is the On-Call model and approach of mental health consultation?

This evaluation of the On-Call approach of ECMHC in San Francisco was primarily exploratory, which included data collected in 2022 as well as preliminary in-depth foundational conversations with joint funders and grantee-agency directors over the course of a year to articulate research purposes, goals, design, methods, and implementation plans. The primary research questions driving the Phase 1 On-Call inquiry include:

Research Questions for Phase 1: On-Call Model and Approach:

1. What is the On-Call model approach and model of mental health consultation?
    a. Who provides the service?
    b. Why On-Call?
    c. How is it implemented?
2. How is On-Call experienced by consultees and consultants?
3. How does the On-Call approach fit in the context of our collective understanding of the traditional ECMHC model and approach?
4. How is On-Call different from the traditional approach and model?
5. How effective is On-Call? What are its limitations?
6. How can the On-Call model and approach be improved?

Exploration of the On-Call model and approach provided greater understanding of consultants' and consultees' perception of the model, their implementation and experience with it. Their input offers opportunities to consider where the model fits in the overarching consultation methodology and how it might be augmented and put to greater effect.

Who provides On-Call services?

Sites designated for On-Call consultation are not evenly distributed across San Francisco's ECMHC grantee-agencies, as illustrated in the table below. And importantly, some sites had previously received mental health consultation under the traditional model, whereas other sites had no prior experience with consultation and knew of mental health consultation only through their On-Call experience.

Agency	Number of On-Call Sites	Sites with previous consultation	Sites new to consultation
Edgewood	23 (17 inactive)	0%	100%
Homeless Children's Network	2	100%	0%
Instituto Familiar de la Raza	3	100%	0%
Infant Parent Program	3	100%	0%
RAMS/Fu Yau	13	77%	23%

Of the 23 survey respondents that had utilized On-Call in the past year, they typically met with their consultants for 30-minute sessions monthly, or on an as-needed basis.

How did participants understand the rationale for providing an On-Call service?

Focus group discussions gauged consultant and consultees' working understanding of the On-Call intervention and why it was developed. Five different groups discussed this, with a total of 34 statements defining it. Both consultants and consultees determined that On-Call consultation was created to provide greater access to mental health consultation services. A total of 11 statements defined the On-Call service as an effort toward more equitable access to ECMHC. However, these statements also mentioned the nuances of equity-based services and pointed to the tension between the need for services in the community and the limited funding available to provide for it:

> ***"The way that it was described to start was that tiers were designed, and the idea was that everyone within SF could have access to these consultation services regardless of where they were at. So that the On-Call sites were the ones that had the least amount of need."***

> ***"I just want to speak to that issue, in terms of how important this is and how much we invest into the mental health of our children and those who care for them… I think that's the hard part: more schools should have mental health consultants, but it shouldn't be at the expense of another school."***

ECE site directors noted,

> ***"I just wanted to talk a little about when we learned about the tier system from the Office of Early Care and Education. I think there was a survey and that was how they determined our tiers…I think the idea that they wanted to provide services to additional schools that were in high demand or high need of consultants. That felt right, everyone needs it and there's schools and neighborhoods that need it more, so that felt right. But the part that was hard was that rather than seeking more funding to provide services for everyone, it's just taking the same amount of funding and spreading it thinner. When it's already thin."***

How was On-Call perceived by San Francisco's ECHMC community?

Focus group participants noted that On-Call seemed more like crisis triage, as opposed to traditional consultation; three different groups mentioned this (12 statements were characterized by this code).

> ***"I feel like mainly what I'm called to do now is child crisis family work…This On-Call feels very different than even when I used to go to sites for a few hours at a time. I don't think On-Call is putting out fires, it is triage. We have to address the crisis first and then maybe we will get to the other stuff."***

> ***"Very specific things that are seen as the problem of the child. They want me to come in and fix it. That is when I get called."***

> ***"Because consultation as a regular consultation model is more about building rapport and getting to know people, rather than just jumping into a crisis without knowing anything. That***

is probably, to me, it didn't feel right coming particularly from a therapeutic background. That is not the way we work."

How is On-Call implemented?

Focus groups explored how the new On-Call approach and model was implemented to gain a better understanding of whether and how well it achieves its aims of providing lighter-touch consultation services to a broader community.

On-Call Designation

A recurring theme in the focus groups was confusion and frustration around the metrics used to designate a site as On-Call. Five focus groups discussed this (a total of 10 statements were characterized by this code). Participants surmised that a site was designated as On-Call based on their available resources and their current capacities, but these were believed to be poor proxies for a site's need for consultation.

Regardless of the metrics designating On-Call sites, participants emphasized that sites' resources and operational capacities are not static, thus rendering any point-in-time metrics unreliable and increasingly so over time. In addition, consultants and consultees noted that their high-functioning sites had developed capacities and became higher-functioning as a ***result*** of the consultation support they had previously relied on.

> ***"So, my understanding I think was that these sites were supposed to be sites that were in some way having less need. So, they were given less time per week. I think I found in my experience that even with more resources, maybe in some ways whether that is parents who are more resourced or like schools with more money or something, all of my sites had similar needs to other sites."***

> ***"They don't measure the quality of relationship among staff and that is huge and that is what trickles down to the kid and that is what we do! Yeah, … it is huge. Obviously, staff dynamics trickle down and that is so much a part of the consultation and that is not measured."***

> ***"[Transitioning from full-service consultation to On-Call] feels really not great for the consultant and it feels like a punishment for the site. We did good and scored high and now we don't have resources when the reason they scored high is because of the resources. Without the supports in place, you don't just stay there. You haven't arrived. Things shift, especially in programs. I am sure I shed a tear in the tier shift. Because consultation was a huge part of the program (when I was a director). There needs to be more flexibility in how it is thought about. We need more about why is this happening and when can it change."***

Further highlighting the dynamic nature of child care settings, focus groups revealed that sites experience frequent and sometimes radical transitions as families move in and out of sites and turnover among center staff remains high across the profession. Further, COVID upended the ECE community, leaving many sites, teachers, directors, and families quite unsettled. Focus group participants saw the On-Call designation as unable to accommodate such dynamic site changes as they occur.

> ***"In my mind, there is an arbitrary distinction. I don't think about my On-Call site much differently because it is not the static demographic or capacity that this distinction expects. Contextually this pandemic is not static. The need fluctuates and of course, there also needs to be an interest to keep engaging. So, I don't think of the needs in a different way from my other sites."***

> ***"The result has been that I have this sense that there was a wish to be really strategic about where to invest the funds and that maybe there was the assumption made that if a site scored well on certain metrics and an element of the demographics of the families in the site, I'm not sure, some magic algorithm. They decided which sites were less needy and under-resourced then there was an assumption embedded in there that these things are static and measured well. My On-Call site the demographics of the families they serve have really shifted a lot because the organization and their funding has shifted. So even on the certain metrics they are looking at, the sites changed."***

Rollout

Consultants reflected on how the On-Call model and approach was introduced and expressed frustration around how the change impacted their consultative relationships, as communicating the reductions in hours to sites designated as On-Call was primarily left up to the consultants and sometimes was not communicated at all (six statements were characterized by this code).

> ***"It was really hard to go into those sites and say that their hours had been cut. It wasn't communicated, to be completely honest. Yeah, I went into one site, and it was just, "why, what did we do that made us have these hours cut?" So, I had a lot of feelings around it in terms of why do I have to be the messenger? It wasn't me, it wasn't my decision, and it wasn't our organization. That was so, so tough. That is one site that, when they became an On-Call site we haven't heard from them again."***

> ***"Even my current [On-Call] site, I saw familiar faces and I was a familiar face to them. Even that was hard. I received a warm handoff from the other agency, we were there together and spoke and all of that. But when it became On-Call I would hear "[the teachers] are asking why you aren't coming back" ... That has been really difficult, in either understanding the message or did they ever actually get the message that they are now On-Call and it is 2 hours – from whoever made this decision to happen. So that has been a challenge. What bothers me about it is that there was a rupture in the relationship because of that basically. Sure, because [the previous agency] could have told them or maybe they got an email, but I was the one who stopped showing up. So, I was the one, "well why doesn't she come anymore, why isn't she here". The principal wants to know when my name comes up is "when is she coming and how long". That is all she wants to know basically. This means to me there is no communication. If it was communicated (that they shifted to On-Call) it needs to be communicated again."***

Implementation

Particularly during the peak of the COVID-19 outbreak, there was considerable variability and flexibility in how agencies administered their On-Call hours. Initially intended to provide two or fewer hours per site, funders provided for greater flexibility in billing to enable consultants to respond more nimbly to the changing and growing needs around COVID-19. This created opportunities for some On-Call sites to receive service hours that looked more like the traditional model. Consultants were quick to reshuffle their total allocated On-Call hours to respond to their recognition that some sites needed more time and others were underutilizing their hours, by pooling their total On-Call hours to better serve the sites with greater needs.

One consultant mentioned that this flexible and collaborative process of distributing hours based on needs, as opposed to static site metrics, is a more equitable way to distribute hours throughout the system; to allow educators and consultants to negotiate which sites need more hours and which sites can get by with fewer hours.

> ***"So, the funders told us to treat this as a bank of hours. So, we have 1.5 hours for each On-Call site. But since not all of them are going to use it up, so we put it in a bank."***
> ***"So… we took our two hours a week at some of these sites and we coupled it to our existing sites that we knew we needed extra hours."***

Burnout & Guilt

Though not hypothesized a priori, our analysis of focus group transcripts revealed that consultants developed a sense of guilt in administering On-Call. Consultants could see that services were needed at their sites, they knew how to provide needed support, but were constrained by the limited hours. The guilt this created was specifically named in one consultant focus group:

> ***"Something unmentioned is that the consultants have this guilt. They want to provide services they were trained to provide, and they can't because of the limited hours. That is a struggle. They aren't getting to do the job they were hired to do in On-Call. This needs to be revisited."***

Though this quote explicitly mentions the negative impacts of the On-Call approach on consultant's own mental health and wellbeing, there were other covert indications of negative impacts with respect to consultants' sense of 'self-efficacy' (e.g., how well consultants believe they are doing their jobs, and/or feeling they were letting their clients down).

> ***"Because of the On-Call, I don't think I can do any of the relationship building to make it work. I don't even remember the kids' names. I feel so bad. Every time I walk in I just remember the one or two children that they keep talking about with behavior issues. But then like the rest of the class I can just say: the red t-shirt girl, you are really doing a good job, you know? I'm like, wait, what am I doing here? You know? It is really hard. The teacher is noticing that I am just learning the kids' names at this point. We are halfway through the year; they are like what are you doing here? I just feel so bad."***

> ***"Teachers' feelings have been abandonment in many ways. I think going from regular team meetings and regular parent groups and really having a high number of child cases and parent cases to be reduced to what can we do with a couple of hours made people feel like they didn't***

have access. We went from a very robust consultation to: "What happened to [our consultant]? How can we use her?"

"I was the one who stopped showing up. So, I was the one, 'well why doesn't she come anymore, why isn't she here.'"

COVID-19 Complications

It is difficult to disentangle the heightened challenges that were brought by COVID-19 and those that came with the introduction of On-Call. Nonetheless, child care center administrators shared their struggles with the On-Call model and approach, particularly when it dovetailed with COVID-19:

"If any funders might hear this, I wonder how they would feel if they imagined that in the past 10 years, they don't need mental health services and then in 2021 and 2022 the pandemic hits and then they really need services and therapists. I tell them, 'Oh I can only see you once a month. Maybe you can try someone else to help you more.' Would that funder want to utilize this service? Would they come back to that therapist? This is what the site struggles with. The system is telling them they can't have more hours and more services. They are telling them what they are supposed to need/get. I wonder how the funder would feel."

"Well actually, the pandemic hit in March 2020, and we reopened in June 2020. So, we weren't closed very long and then it was just like through email. [Our consultant] would check in here and there but with all the changes in the program because of the pandemic, going to smaller pods and all of that, like sitting down and having to type an email to her and responding to her questions was like extra work and it was really hard. She did make efforts, but it was just really difficult and to have the teachers come out of their classrooms to talk to her online and to explain whatever behaviors they are seeing in the classroom, yeah it was just… [we only have] 5 hours a month that she's giving us. So, it has kind of just fallen off."

However, some found the COVID-19 pivot to online services to actually work well with on-ramping On-Call services (8 statements were categorized by this code):

"So, we started that process and when everything got online, it was a great time to actually be able to meet with our consultant and have that time, because we weren't in a classroom. So, we were just scheduling meetings throughout the day because everyone was technically working from home. So, we were able to really get in a lot of those introduction meetings. Which I feel was important because the teachers were able to meet the person and get to know her. She offered individual consultations as well, which was very helpful. So, I feel like in terms of being able to move on, it was a little bit, smooth, we were able to navigate around that, and there wasn't as much classroom observation that had to be done."

Being able to meet virtually also worked well for some parents:

"I think one of the things even though we were in a pandemic, the ability to meet virtually really was helpful to parents. We had parents throughout the pandemic that could talk at 8 o'clock at night or 8:30 at night and that's worked for me, and it's worked for our consultants

to show up at that time and for them to show up at the end of their day to participate in a parent group, you know, that was helpful. You know the ability to have parent meetings as a group because then they can also build a relationship with their consultant that is amongst a group and they are really talking about developmental stuff, and if you are all talking about the child can't sleep or your child can't you know parents are able to chime in and help each other and over the pandemic it was also a good way for parents to build relationships with each other because they were not allowed in school. We were not having any events at school where they could nourish relationships amongst each other, and I think that was helpful."

How is the On-Call approach different from the traditional ECMHC approach?

An underlying objective of this evaluation was to explore the circumstances under which On-Call could be considered mental health consultation. Could the ECMHC model and approach be understood as a continuum, of which On-Call is one component? Themes identified in this section advance the exploration of a larger issue with which communities and states around the country are currently grappling as policymakers, funders, advocates, and programs strive to stretch resources.

Gaining more clarity around the boundaries of ECMHC is also relevant to researchers and evaluators of ECMHC initiatives in understanding the theory of change and pathways of change that lead to positive child outcomes and closing racial disparities. Exploring the nuances in a community's ECMHC approach (philosophy; worldview; integration of the Consultative Stance) and ECMHC model (frequency, intensity, and duration of services) can help the broader IECMHC field refine our understanding of the conditions of IECMHC implementation most likely to lead to positive outcomes for children, teachers, and families.

The following quote questions head-on whether the On-Call service is actually delivering mental health consultation as defined by the literature, policy makers, thought leaders, and other states' initiatives:

Three focus groups of consultants discussed the On-Call approach as clearly distinct from their current understanding of 'mental health consultation' (a total of 13 statements were characterized by this code).

Several consultants' comments highlighted the challenge of relationship building and providing consultation under time constraints.

"Tried to build relationships with that amount of time and the way we go about relationship building, what it really takes to get to a place where teachers will sit down and talk about their own triggers toward kids and biases, there just wasn't any way that that would happen. So, you are just dealing with the top of the pyramid, the most painful moment of the day- the adult stress moment or a kid or parent or outside something. So, you can really just touch on that, but cannot go deeper on it. It was just, we aren't implementing a consultation model by any means"

"It is just really hard to say I am doing mental health consultation in 2 hours."

"May I just say using mental health consultation and On-Call in the same sentence because it just is not. It is really hard to say that…. with my two sites, it really is a relationship that I hold with them, which is why it is even effective…. I feel like a case manager sometimes …the whole space to pause and reflect is just really difficult to do; to be completely honest."

"It is hard to know about the families. I have no connection with families. I cannot be family centered. I cannot be strengths-based. It takes time to find strengths. We can't talk about or ask about this. We can't find what they feel or think. I try to build internal capacity but It is hard and I don't see much. If I am the only person with resources, who can I collaborate with? On-Call is missing so many of these things."

What is the **APPROACH** to On-Call Services?

Focus group conversations were also coded using two tools: 1) the 11 Threads of Consultation (See this report's Introduction section; Duran & Hepburn, n.d.) and 2) the 10 Elements of the Consultative Stance (Johnston & Brinamen, 2006). Both tools harken to the **APPROACH** (which connotes philosophy, frameworks, etc.) of ECMHC versus the **MODEL** (which connotes frequency, intensity and duration of services). Well-known IECMHC researchers like Dr. Annie Davis and Dr. Deborah Perry have published studies which hypothesize that it is the APPROACH of IECMHC that makes it particularly effective at reducing exclusionary disciplinary practices and negative outcomes for children.

In the present study, when participants mentioned that a domain from the two tools described above was present or possible in the On-Call approach, it was coded as a positive mention. If participants mentioned the domain was not possible or present in On-Call consultation, it was coded as negative. In addition, if a consultee mentioned that they wanted the consultant to perform in a way that was contradictory to the embodiment of these threads and elements, it was coded as a negative mention. There were also situations in which these domains were mentioned in a neutral way. As such, the positive and negative will not add up to the total category number of mentions.

In total, 62 statements were categorized by the Consultative Stance. In each element of the Stance, there were more negative mentions than positive. For example, when examining ***avoiding the position of the sole expert,*** seven statements mentioned this element in a negative way and no statements mentioned this element in a positive way. We found that On-Call consultees expected consultants to come into their

sites and provide solutions in the short number of hours allocated. For the Consultative Stance, the highest disproportionality between positive and negative coding was for ***mutuality of endeavor.*** This element was negatively mentioned in 26 statements and only nine statements positively mentioned ***mutuality of endeavor.***

A total of 79 statements were categorized by the Threads of Consultation. Statements categorized by the Threads were more evenly distributed between negative and positive mentions. For example, focus group participants mentioned On-Call consultation as ***collaborative*** in 20 statements (positive coding) and mention On-Call as lacking collaboration in 23 statements (negative coding). Further examination into these codes revealed that On-Call consultation could be collaborative to one ***type*** of consultee: teachers, directors, or parents. However, given the limited hours, the collaborative process of consultation could not be extended to all potential consultees at the site. For example, if teacher-focused consultation was occurring, parents and directors might not be able to access the consultant.

In summary, the majority of the 10 elements of the Consultative Stance were either not mentioned as being present in the On-Call experience at all or the elements were mentioned in a predominantly negative way. The elements of the Stance that was discussed the most frequently as being negative was 'mutuality of endeavor,' which has been considered a central tenet in mental health consultation for decades.

There were slightly more positive reflections about the extent to which the 11 Threads of Consultation felt present in the On-Call approach and model. The 'threads' that were mentioned the most were 'collaborative,' 'family-centered,' 'individualized' and 'relationship based.' The rest were either not mentioned or barely mentioned. Out of the 3 threads that were mentioned the most, only 'individualized' had more positive mentions. This is not surprising given the hyper-focused nature of triaged services for children within the On-Call approach and model.

For more details about the results of coding the themes related to the '11 Threads of Consultation' and the 10 elements of the Consultative Stance, please refer to the data table in Appendix D.

Quantitative Exploration of On-Call as Distinct from Traditional Consultation

As noted in the section "Who Experiences On-Call", an important distinction among On-Call participants is those with "previous exposure" to the traditional model of consultation and those with "no previous exposure". Survey data (N=127) were examined for three sub-groups of consultees:

Traditional Model Consultees.
Includes consultees who experience full consultation of ranging from 5.5 hours to 10 hours per week (N=99);

On-Call Consultees with previous exposure to ECMHC.
Includes consultees who experienced a reduction of hours from traditional consultation to the On Call model (N=19);

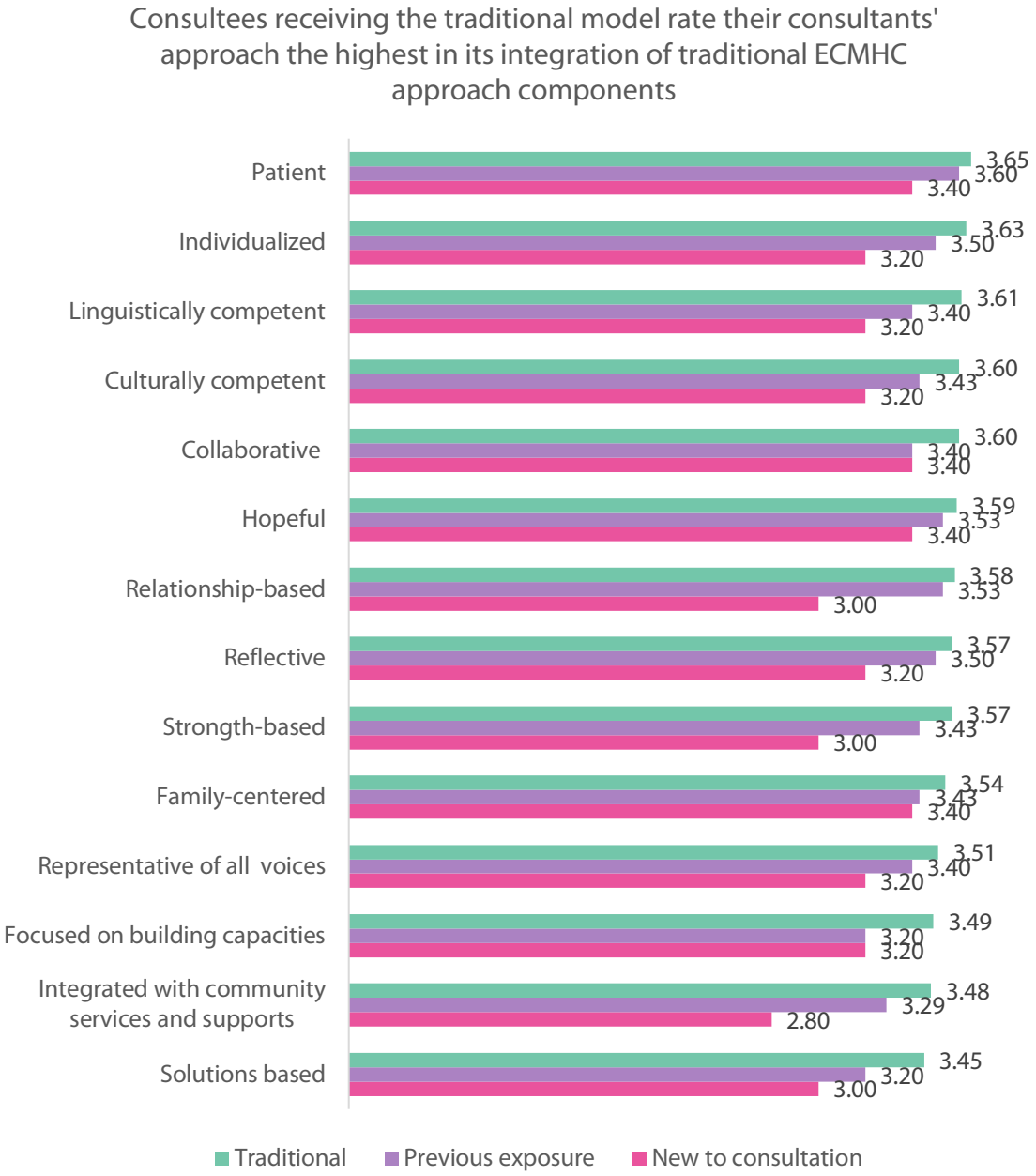
On-Call Consultees with NO previous exposure to ECMHC.
Includes consultees who experienced the On Call model as their first exposure to mental health consultation (N=9).

Mean scores were compared between these sub-groups. Statistical tests for significant differences were not conducted due to small sample sizes.

Respondents were also asked to rate the extent to which elements from the ***Consultative Stance*** (Johnston and Brinamen, 2006) and the components from the ***Threads of Consultation*** (Duran & Hepburn) are present in their consultant's approach to understand the quality of the consultative alliance and how closely aligned their consultant's approach is to widely accepted ECMHC components and ways of embodying the Consultative Stance. Respondents rated each element using a 4-point Likert from 1 = Strongly disagree to 4 = Strongly agree (see the callout table on the next page).

Compared to both On-Call groups, the traditional consultation group rated their relationships higher across consultative components. That is, consultees who were receiving the traditional model reported their consultation relationships as most closely aligned with the Consultative Stance definitions. This finding also suggests that consultative relationships may be more difficult to achieve within the limitations of the On Call approach.

Moreover, when the two On-Call consultee sub-groups are compared, we find the consultation relationship was more aligned with the 11 Threads of Consultation as well as the Consultative Stance for the sub-group with 'previous exposure to traditional consultation.' These consultees reported relationships ***more*** aligned to the traditional IECMHC approach than their counterparts with no prior consultation experience. This suggests that it may be helpful to build the consultative relationship under traditional consultation prior to a reduction of hours in a transition to On-Call.

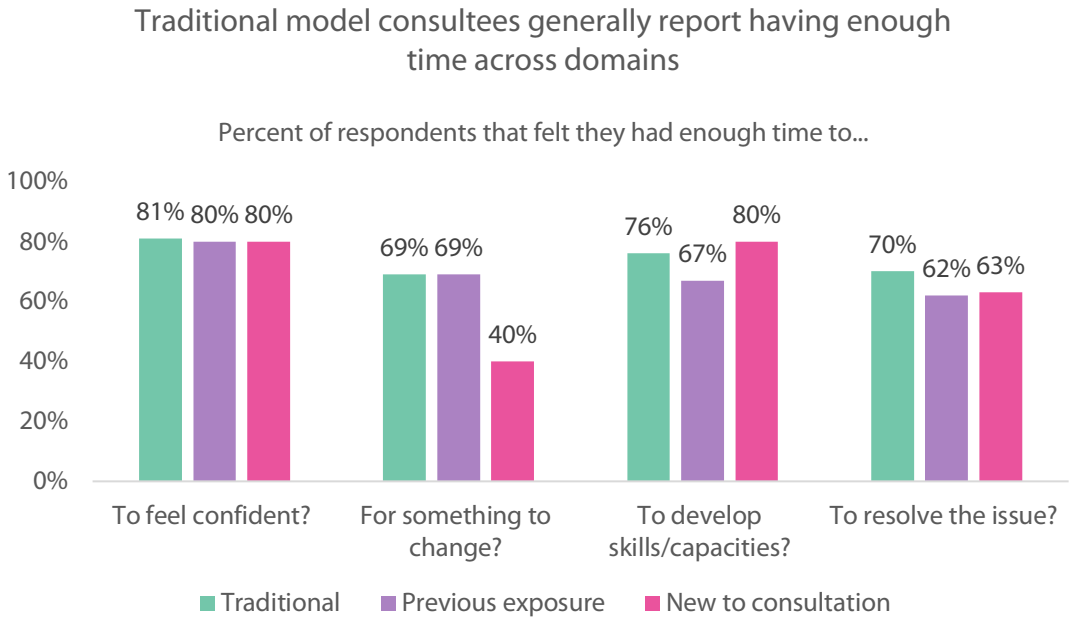


Note. Sample sizes across the variables in this chart are Traditional (N = 53 to 71), On-Call: New to Consultation (N=5) and On-Call: Previous exposure to consultation (N= 14 to 15).

Perceptions of 'Enough Time' in On-Call versus the Traditional Model and Approach

Given the differences in time offered per week in the On-Call versus traditional consultation approaches, we developed survey questions that probed if consultees felt they had enough time with their consultant on four domains that were prominent in focus group conversations (0 = No or 1 = Yes; see the table below). Results are presented as the percentage of each group that indicated, "Yes, they had enough time". For example, 81% of traditional consultation and 80% of both On-Call groups felt they had enough time to feel confident. Overall, all groups felt they had enough time to feel confident, suggesting that confidence can be fostered even within the limited On-Call approach.

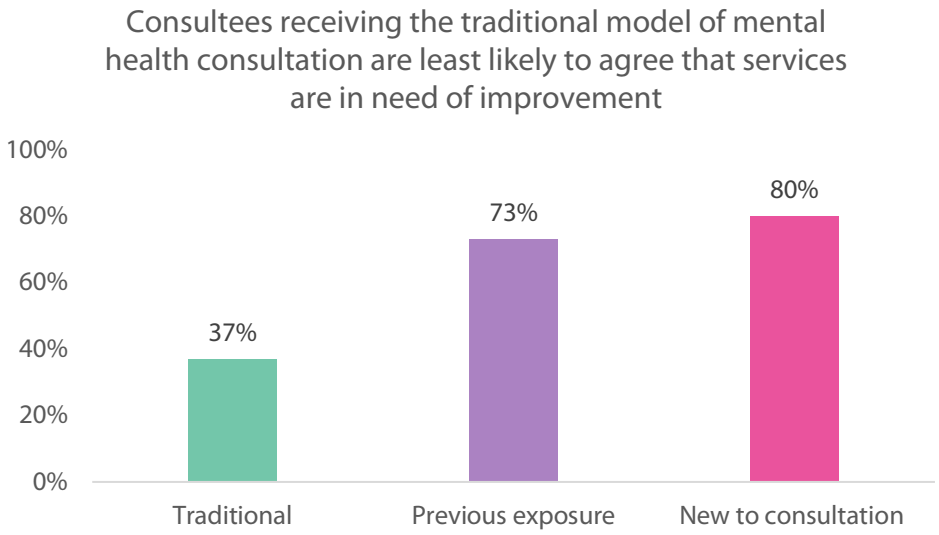
Consultees receiving the traditional model generally reported the highest agreement that they had enough time for each domain, followed by the previous exposure group, with the no exposure group demonstrating the lowest agreement that they had enough time. This relationship is particularly evident for questions asking if there was enough time for something to change and if there was enough time to resolve the issue.



Note. Sample sizes across the variables in this chart are Traditional (N = 67 to 72), On-Call: Previous Exposure (N= 15 to 16), and On-Call: New to Consultation (N=5).

Effectiveness of On-Call versus the Traditional Model

Consultees were asked to rate their level of agreement with the following statement, "Our mental health consultation services and approach are in need of improvement". Traditional model consultees were least likely to agree that improvements are needed. Respondents receiving the On-Call approach to consultation were most likely to agree that services are in need of improvement. Those with no prior exposure indicated greatest dissatisfaction, with 80% agreeing that improvements are needed.



Note. Sample sizes across the variables in this chart are Traditional (N = 61), On-Call: Previous Exposure (N= 15), and On-Call: New to Consultation (N= 5).

Consultees' perceived effectiveness of consultation services was explored by probing common issues addressed by mental health consultation. Respondents used a 5-point Likert scale to indicate:

1) The amount of stress a particular aspect of ECE work causes the consultee;
2) The respondent's perception of their consultant's impact on that particular issue;
3) Respondent's current capacity to address that issue.

The research team developed this question series based on focus group conversations with the consultants and the consultees. Consultees' responses to these three elements across six domains for each of the three consultation groups are presented in the following figure, which examines perceived effectiveness relative to perceived stress.

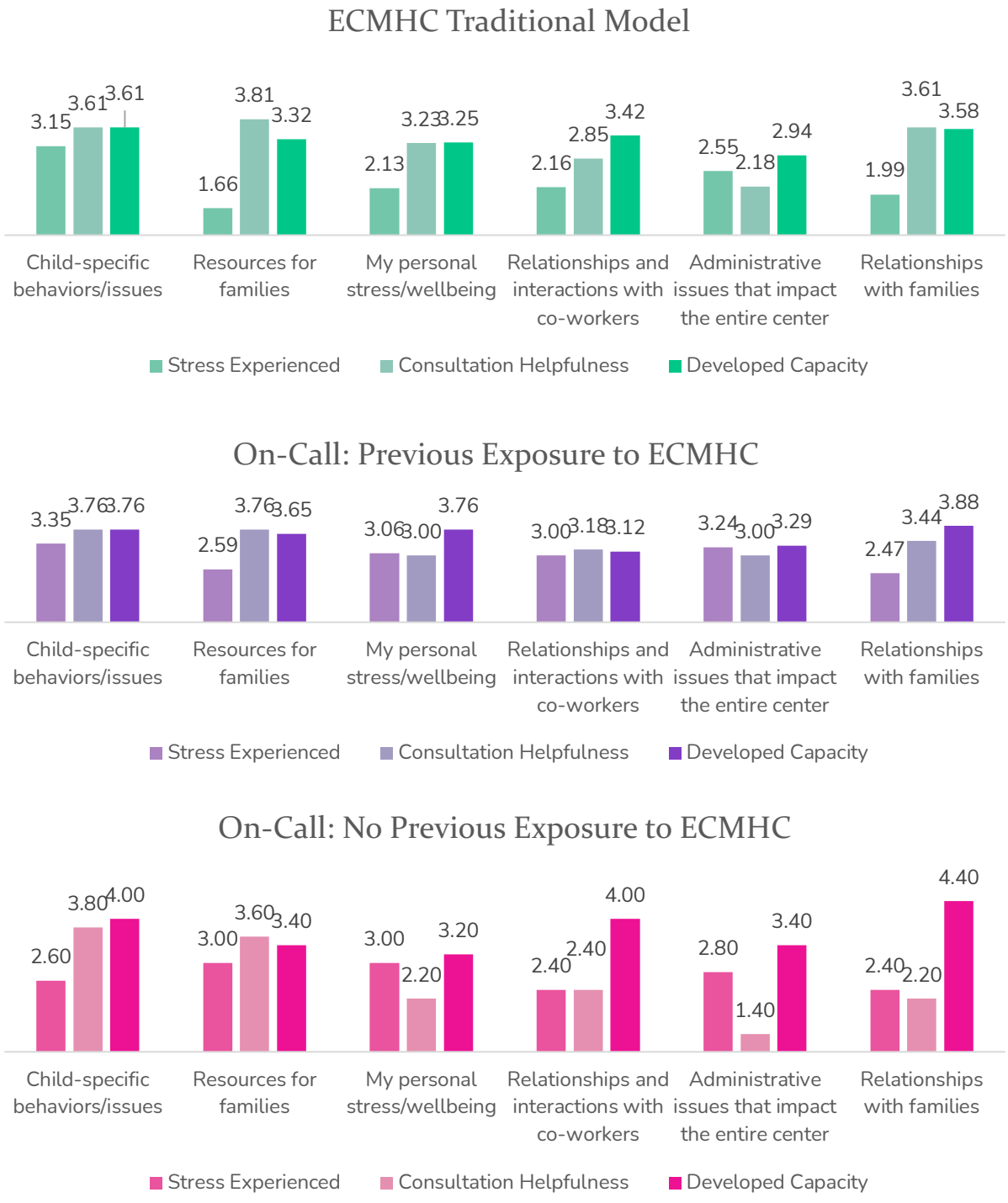
For example, respondents with previous exposure to the traditional consultation model reported a moderate level of stress caused by child-specific behaviors/issues (M =3.35), rated their consultants' helpfulness for such behaviors as slightly higher (M=3.76), and rated their current capacity to manage such behaviors as slightly elevated (M=3.76). This indicates that for the previous exposure group, consultation was helpful and increased consultees' capacity to address child-specific behaviors.

Perceived stress. When comparing stress caused by child-specific behaviors/issues across groups of consultee respondents, the 'previous exposure' On-Call group experiences higher stress (M=3.35) compared to the 'no previous exposure' On-Call group (M=2.60) and to the traditional model group (M=3.15). Across each of the six domains, the consultees receiving the traditional model of consultation rated themselves as having lower stress when compared to both On-Call groups, and the On-Call with previous exposure group had generally the highest stress levels. It may be that the On-Call respondents who had previously had greater access to their mental health consultation support feel greater stress and now perceive their On-Call experience as lacking in comparison to what they once enjoyed. In comparison, those who have had no prior experience with consultation may feel a more immediate sense of decreased stress and increased capacity as a result of their new experience with a consultant.

Perceived helpfulness of consultation. Those in the On-Call group with no prior exposure to mental health consultation generally rated their consultation as the least helpful, with helpfulness being particularly low in domains of the consultees' personal well-being, relationships with co-workers and families, and with administrative issues that impact the center, both within the no exposure group, as well as in comparison to other groups. These are precisely the types of issues that focus group participants discussed as the most challenging to address in short spurts of consultation. These are the kinds of issues that consultants and consultees indicated requiring deeper relationships and embeddedness in order to really have an impact.

Perceived current capacity to address needs. In addition, the 'no prior experience' group generally rated their current capacity as high or higher than other consultation groups. This finding could be a function of the On-Call designation, that is – the site itself has a baseline level of capacity already established. However, this interpretation may not be accurate given the finding does not extend to the On-Call cases with previous exposure, who by tier-designation metrics, should have the same developed capacities. An alternative explanation could be that sites who have never had exposure to consultation were given the space to reflect on their capacities for the first time and were able to realize their abilities to address these domains even within the On-Call time constraints.

Perceived stress and efficacy vary by consultation modality



Note. Sample sizes across the variables in this chart are Traditional (N = 36 to 39), Previous Exposure (N= 16 to 17), and New to Consultation (N=5).

How effective is the On-Call model and approach to ECMHC?

The effectiveness of the On-Call approach was explored in focus group conversations with consultees. Three statements were categorized as discussing effectiveness and 15 statements identified problems that could be addressed with On-Call consultation. Consultee-participants shared examples of some of the ways in which On-Call was effective.

> ***"We were having a child who was having a lot of emotional irregularities. And then a mom was having a hard time supporting a child at home as well. So, they helped the mom. And the teachers help regulate this child. And she's doing really well now." -Child Care Administrator***

> ***"I had a staff member who lost like a total of five or six family members. The mental health consultant had the resources, she was actually able to go to a group and have conversations around that grief and it was super helpful. It's really valuable that, you know, we're able to kind of offer it to individual staff members as well, who might need it." -Child-Care Administrator Consultee***

> ***"We have a family who lost the dad and what can I say? Her emotion is very, very harsh. She comes to school, she cries, and we talk. We give her the information about the mental health consultant and then she talked to the mental health consultant. And then we get ideas, you know, create a story for the kids and how we pay more attention to the kids and that helped her a lot. And then she's doing much, much better after like two weeks." -Early Educator Consultee***

Limitations of On-Call Consultation

Despite a few success stories and a general sense of gratitude for the service in any form it might be made available, focus group participants noted that On-Call consultation is limited. A total of 20 statements raised questions of the effectiveness of the On-Call approach and 20 statements identified problems beyond the scope of On-Call consultation. That is, without the ability to develop deep trusting relationships, the On-Call approach's efficacy felt limited to both consultants and consultees.

> ***"We aren't magic, it takes time to build relationships. I think On-Call is a different service with different training. Because I have worked in the past at an organization where we had someone who would go out and provide… other On-Call type of service, I know how to work with those people, it is a different lens. I don't want to throw the baby out with the bath water, I don't want to be a negative Nelly. I'm trying to understand where it came from and honor that, but then can we make sure that we set up for success with this initiative and also address those gaps? There clearly are gaps and there are systems of care who are ready to utilize consultation and that is a whole 'nother conversation." –Consultant***

> ***"Before they were here every week so the parents would see [our consultant] at the drop-off and know who she was, so it's, now it's we've lost that parent referral because how do I introduce? Do you want to speak to this person? So that has been challenging. So I just focus on the children and what the teachers need if there's challenging behavior they go to her" – Child Care Administrator Consultee***

> ***"Unfortunately, because of the limited hours the parents don't have too much contact with our consultant and so a lot of the questions were asked through email. It's just a lot of surface general resources that were provided to the parents. Our consultant hours are just very limited, her hands are tied. And so she wasn't able to provide more in-depth service to parents or family who are in need. Which really kind of blows for sure." -Child Care Administrator Consultee***

Importantly, consultees' overall perception of the effectiveness of On-Call may have varied based on their previous exposure to consultation. That is, consultees who had received full model hours and then had their hours reduced in transitioning to On-Call may have more acute perceptions of On-Call as ineffective. This hypothesis about previous exposure to mental health consultation was qualitatively explored in the focus groups and corroborated by the survey data reported above.

How can the On-Call approach be more effectively employed?

While focus groups revealed areas where the On-Call approach was limited, suggestions for improvement were also offered (24 statements were categorized as opportunities for improvement). One prominent suggestion was to implement a flexible model of consultation that centers the consultee-site's ability to **voice the amount of support needed.**

> ***"I don't have a solution, but one of the things that I bump into quite a bit is the concept of time. I'm wondering if there is ever a way to measure if a person is going to need services versus not. Humans are flexible and sometimes we need help and sometimes we don't. The 1.5 hours, it didn't jive well for me. I don't think it jives well for sites either. Sometimes regular sites need 24-hour support and others are like, "Great. I'm doing totally fine." That concept of time is not jiving well." -Consultant***

> ***"I hope they would find a different way to understand centers' needs. How it was defined to us doesn't make sense. If they are lower needs in 2019 doesn't mean they are lower needs in 2022. How do you adjust for needs for the families when there are so many changes? Even if we didn't have the pandemic, things change, even month to month. The equity part comes into play. How can we give someone 1.5 hours if they have these large needs?" -Consultant***

> ***"More opportunities to connect. Getting a sense before starting services to see what people want. The ability to brainstorm and collaborate. In my regular sites we make goals together and brainstorm. That would be a huge starting place." -Consultant***

Some suggested that there might be a way to **implement a gradual reduction in hours** over time. That is, time to develop a strong relationship and a sense of stability and reliability may be necessary to build foundational support before transitioning to fewer hours. This recommendation hinges on the idea that capacities can be fostered initially that allow for the eventual intentional reduction of hours and that this would be the most optimal On-Call situation.

> ***"There is this sweet spot where consultation has worked long enough in certain centers and there is stability, if we ever get to that place where you have the relationship, and they know how to utilize you and they understand the role of a mental health consultant that you could shift a little bit towards fewer hours. In an ideal world that could happen, but our system isn't set up for consistent teachers and staffing and training and leadership. It is constantly changing." -Consultant***

> ***"I feel like a felt presence is part of it. To know that we are there no matter if it is two hours or six hours. Knowing that you are available to them. I think part of being available is feeling known, seen, and held. I feel that idea very hard in fewer hours. But I imagine that would be the center." -Consultant***

> ***"An internalization of a sense of efficacy or a felt sense of feeling that they can approach this. I know who I can talk to think about this together. But when something comes up and it knocks them off-center then they can re-regulate or co-regulate and come to a place where they can respond or react. For On-Call when there is not a system or relationship, then that becomes really hard. We have a history and relationship. For example, [my site] has been with us for 25 years. That felt consultation and relationship helps us to benefit from that. There is a challenge for doing On-Call when the relationship doesn't get to develop. If the relationship is there it may be okay, but if the relationship isn't there then getting it to develop is really hard." -Consultant***

Others strategized around how to make maximal use of the limited time available by having ECE center administrators and educators do some **preparation work** before the consultant visits each week/month and convening meetings as a team.

> ***"I think one thing that helps On-Call work with fewer hours is that they seem to come into meetings, they have the capacity and practice to come together to decide what they want to use the consultation time to talk about. …I use the time to meet with the team and one individual staff. When I meet with the individual, they have already worked through what they need to bring up by themselves or with the director. Why this is the case, I'm not sure. But they do this to utilize me with the fewer hours. I also do see that things come up and I spend extra hours." -Consultant***

> ***"I think having a team meeting with my whole team and meeting with the consultant, I think that's helpful because at least we have time together and kind of explain what's going on. And then I hear what a consultant has to say so that I don't have to like if it's just me. And that my team is able to speak their thoughts and also hear what she has to say. So, I think that's a good strategy." -Child Care Administrator***

Some comments highlight the barriers that arise when directors are not collaborative:

> ***"My shift to On-Call also coincided with a new director who had ideas about consultation. My site switched to Tier 1 and they had a short-lived director. There were a lot of hard feelings from this director. Another director came in and invited me to participate more freely. We have a much better experience." -Consultant***

> ***"The new director got very involved in gatekeeping. This was also a very different experience for people. They used to get to talk to me [the consultant] whenever. So, I became more restricted, and it complicated the relationships."***

Others envisioned alternative ways in which a more holistic system of support for teacher, family and child wellbeing could be created as a complement or set of complements to the ECMHC model to provide a cohesive system of care.

> ***"I felt there was a deep intention to make sure that no kid falls through the cracks in our city, despite what system of care they are in. That there are families that access some of these private and non-profit places. I know that our leaders deeply care and don't want any kids to fall through the cracks. They want access too. My sense is that we create a different model for that. Because that is a different kind of service going in when you are targeting a child. You are already targeting a child. Look at the words I am using. You have identified a child, right? So how do we develop a different kind of service that can really be a consultation to a family and to a director to figure out what is happening in a given moment and what we could do together to try to figure out what the next step or direction this is? People need outside consultants."***

> ***"[We could create] just like a portal where there's lots of different resources for social anxiety, grief, separation anxiety, whatever the topics that are very important and have it all in one place so that parents, teachers can just access it and even videos would be helpful too in that portal with the limited resources that we have in that portal yeah."***

> ***"Well, I don't know if this is even something you would be able to facilitate but you know this parent kind of group I don't know if it could be a combination of a therapist that offers it or maybe somehow sharing resources. It feels like we are sharing them now. But in a more global, thoughtful way where parents can do drop-ins, developmental groups, like having a resource center where they could drop into, something like that, that parents can access."***

Another suggestion was that additional efforts be expended on community outreach to increase awareness and uptake of On-Call consultation.

> ***"From a financial administrative perspective, this model is not sustainable. … They want us to be On-Call, but they don't pay us for being On-Call. …We don't have relationships with our On-Call sites. Our funders have relationships with them. The funders have the relationships. I think if First 5 and OECE would put more effort into helping us or educating about On-Call then [sites] would really use it."***

Summary of Key Findings from Phase 1 Evaluation: On-Call Model and Approach

COVID-19 shaped experiences. Implementation of On-Call consultation was heavily impacted by the reality of having to find ways to provide consultation while COVID-19 cases were high and more deadly. As such, it is difficult to truly tease apart difficulties with the On-Call implementation and pandemic challenges.

The On-Call approach has limitations. Based on findings from survey data and focus groups with consultees and consultants, it is clear that the On-Call model and approach has limitations as a method of consultation service delivery that must be acknowledged, and then worked around to intentionally maximize the reach of the ECMHC initiative in San Francisco. Reducing hours for many ECE sites in San Francisco eroded trust among many of the ECMHC stakeholders. Consultants and consultees shared many ways in which the On-Call approach was limited, highlighting issues around efficacy, ECMHC approach fidelity, and the erosion of consultees' trust in their consultants.

Tiering designations should not be static. The metrics and procedures used to categorize sites by tiers are not adequately capturing the dynamic needs and nuances of a site. High rates of turnover among ECE professionals, families migrating in and out of the city, and turnover among mental health consultants all impact site dynamics, rendering the need for a more flexible approach to tier designations. Given the ever-changing nature and composition of the ECE ecosystem, procedures might be put in place to revisit site needs on an ongoing basis. In addition, sites expressed interest in being included in a systematic way in the tier-assignment process.

Consultants suffer from burn-out. The On-Call approach increased feelings of guilt and burnout for consultants, as they held the burden of communicating the reduction of hours to sites. Moving forward, clear communication at the systems level about what the mental health consultation service is and is not will help to set expectations that will better position the initiative for success. In addition, it is important for the initiative to consider the impact that system changes have on consultants' well-being and feelings of burnout that often lead to turnover. There is an abundance of literature citing the well-established connection between feelings of burnout and turnover.

Previous exposure to consultation makes a difference in perception of services. Despite the articulated limitations, consultees generally felt their time with their consultants was enough to build some capacities, to gain confidence, and in some cases, to resolve issues, and this was even true for consultees new to consultation. When consultees/sites were familiar with consultation, knew how to make it work, and were prepared in advance of their consultation meeting, the work of On-Call consultation went more smoothly. These findings offer insight into how to maximize the potential effectiveness of a truncated, triage-like service such as On-Call consultation. Namely, On-Call consultees who were new to consultation were least likely to feel they had adequate time to see effective improvement.

We advance several hypotheses to help explain this finding. It is important to note that On-Call sites are designated as such based on a site's level of need.

Hypothesis #1: Perhaps lower-needs sites have fewer changes to undergo, and so one would expect stability and not expect to see much change.
Hypothesis #2: On-Call consultees new to consultation may not be as familiar as those with prior consultation experience and are perhaps less apt to recognize changes as they occur due to their engagement with consultation services.

Hypothesis #3: The On-Call approach was perceived as most effective when the following conditions were present: 1) sites had previously received the full consultative model from their consultant; 2) consultees already understood how ECMHC works; and 3) the site and the consultant worked together to maximize their consultation time and to leverage other available supports/services AND the site had additional supports and services necessary to leverage limited consultation hours.

There are some conditions under which the On-Call approach could be made more effective. It is noteworthy that On-Call consultees who had prior experience with traditional consultation indicated having enough time to see changes to the same extent as those receiving traditional consultation. This suggests that an On-Call service holds at least some promise in achieving outcomes, albeit perhaps with a population that has a different need and 'preparedness profile (e.g., understands the ways in which consultation can be utilized and possesses a set of key capacities).

While questions may remain as to what a 'preparedness profile' looks like and what an assessment tool might be to support this determination, focus groups provided insights as to how the On-Call approach might be applied more effectively:

1. Generate more awareness about what ECMHC is and how changes happen. Then provide more transparent information about the rationale for the tiered system and how it works.
2. Implement a flexible model of consultation that centers the consultee-site's ability to voice the amount of support needed so that hours might be more effectively allocated.
3. Implement a gradual reduction in hours over time, once foundational support has been established and the site has gained some internal capacity.
4. Make maximal use of the limited hours by having sites do some preparation work and convening meetings as a team, and helping sites leverage additional supports that may be available to them.
5. Build out the On-Call approach as one part of a more holistic system of care.

It must be noted, however, that additional funds and planning money would be needed to implement and sustain this type of 'preparedness plan.'

Findings Continued

Phase 2: How Does the SF ECE Community Experience ECMHC? Reflections on Relationships, Impacts and Barriers

The second phase of this multi-phased evaluation endeavor in San Francisco was to explore experiences with the traditional ECMHC model and approach. We sought to capture consultants' and consultees' experiences and success stories and gather suggestions for improving the initiative. The following research questions guided the development of this evaluation phase.

Phase 2 Research Questions: San Francisco Community's Experiences with ECMHC:

1) How do the nationally touted long-term relationships in San Francisco's ECMHC initiative develop and sustain over time?

2) What is the impact of San Francisco's traditional model and approach of consultation?
    a. What are the impacts over time (e.g., after one year, two years, etc.)?

3) What role does race, language and cultural responsivity play in the initiative?

4) What challenges have consultees faced? What improvements are needed?

What is the "secret sauce" of mental health consultation?

The most prominent themes that emerged from the feedback focus groups centered on the importance of the consultative relationship. The consultative relationship was mentioned in all six focus groups across 81 statements, emphasizing that relationships are the root of mental health consultation: the ***secret sauce,*** if you will.

Though the importance of relationships has been highlighted in previous explorations of ECMHC, consultative relationships are unique in San Francisco given their longevity. On average, consultees reported in focus groups and surveys that they have worked with a mental health consultant for nine years and have had relationships with a single consultant for an average of three years. However, many consultees revealed they had consultant relationships that extended well beyond a decade, with some sustained to over 20 years! Most consultees reported even longer partnerships with MHC agencies. Approximately 80% of survey respondents had worked with multiple consultants over the years.

The uniqueness of the consultative relationships in San Francisco is also apparent from the consultation grantee-agency side. On average, consultants had 6 years of experience providing consultation, with some having provided 28 years consultation. Further, relationships between a consultative agency and a single ECE site reached back to the origins of the initiative in San Francisco; nearly 30 years. The longevity of these consultation relationships means that at many sites, the consultant and/or consultation agency has been a presence at the ECE site longer than the tenure of many of the current educators or administrators.

Developing Long-Term Relationships

In exploring the timeline of relationship development, it seems that the primary objective is for the consultant to begin creating connections and building trust with the site. As more adults at the site become engaged, the consultant can begin fostering connections among the adult caregivers at the site. For example, the consultant might foster teachers' relationships with parents, they may facilitate teachers' connections to each other, and support connections among other staff at the site.

Focus group participants shared that these deep, connected relationships are strengthened by the following:

- Time at the center strengthens relationships by allowing the consultant to develop consistency in conducting observations and creating connections with all staff.
- Cultural/linguistic match strengthens the relationship through shared lived experiences, shared language, a deep understanding of cultural background, and the ability to counter unique stigmas.
- Director, staff, teacher, and parent involvement strengthen the relationship, as all ***actors*** collaborate and work towards common goals. This unity facilitates structural changes that support children.
- Flexibility strengthens the relationship when strategies can be modified, there are few scheduling restrictions, and hours can be provided based on need.
- Sharing personal experiences strengthens the relationship because it introduces vulnerability, builds trust, and establishes confidentiality.

In addition, focus group participants revealed important consultant and consultee dispositions that foster relationship development and successful consultation. Important dispositions or strategies were identified across focus groups and summarized in the following table.

Themes: Effective CONSULTANT Dispositions/Strategies		
The ability to strike a balance between avoiding the position of the expert but bringing in knowledge that is needed "Understanding that I am not the expert but rather a facilitator. Leveraging and showcasing the strengths of the providers I work with. Implementing horizontal management to build rapport and trust." - Consultant Categorized by 29 statements	**Sharing a language and cultural match and/or knowledge and expertise with the consultee and with the overall site.** "Our mental health consultant has a good chemistry with our parents because they share the same ethnic background, they understand what Chinese culture is about, it is easier for parents to communicate with them"-Consultee "We've had examples of, if a black baby is exhibiting the same behaviors as his white peer, the black baby is like receiving punitive consequences…So, we have a lot of conversations within cultural context too."- Consultee Categorized by 27 statements	**The ability to meet the consultee where they are without judgment** "[The consultants] were meeting us where we were and supporting the work we were doing…there's always there's so often messages about what we're doing is never good enough or correct…So having a consultant that comes in and is not trying to make you do something different."- Consultee "They meet us where we are at. And the same with families."- Consultee Categorized by 19 statements

Being curious about the entire program (e.g., the child, families, the teacher, relationships among staff, organizational procedures/policies).	**Being a neutral, in-person presence in the site/center (emphasis on the importance of observation).**	**Experience providing consultation services**
"It feels like [consultation] starts by really partnering and learning and listening to our consultees … bringing that curiosity to that space, so that they can then begin to be curious about both their own experience and the experiences of others. So that when I'm not there that curiosity, that interest in introspection, that interest in wondering, could remain, and still live in that system."-Consultant	"I see for myself like, I am an outsider who holds and sees"-Consultant "[It was important] having that outside person to be able to pick their brain, call for support for not just me as the director, but the teachers and the families and outside community members. [It] was really important." -Consultee	"I'm noticing the interns that [newer consultants and interns]], they're more clinical. [When the consultant is new], it's not the same. It's just a newer generation, a newer generation of clinicians."-Consultee "There's a very intentional reason why we don't have interns or folks that we know are only going to be a year doing consultation work. And it's not because we don't think that they would be great. It's that the relationships take so much time to build." -Consultant
Categorized by 18 statements	Categorized by 17 statements	Categorized by 9 statements

Conversely, focus group participants identified the following **consultee** dispositions were important in supporting a successful consultative relationship.

Themes: Effective CONSULTEE Dispositions/Strategies		
Being open to engaging in consultation; low stigma about children's mental health or developmental delays	**Having a baseline understanding about what ECMHC is and how it can be utilized.**	**The ability to pro-actively co-construct meaningful consultation experiences (e.g., bringing issues to the MHC, creating a utilization plan, finding a better match)**
'Once I built that relationship with [the consultant] things went smoother… I started talking and being more open. Then I had to buy in the rest of the staff. The rest of the staff didn't want to talk to her. It's like oh my god, here she comes again. But we were able to build that…and we saw a lot of growth in the children's social and emotional development that we worked with. "- Consultee "[Consultation] doesn't have to be a shameful thing… how do we destigmatize so that it's like, wow, you attune to the child, you see this family! -Consultant	"So, like being really clear about what it is and was, what it isn't, and those expectations…I had like a sheet of what consultation was and I understood it, but I think a tool to understand like even a video tool or something to articulate in multiple languages and help people understand what it is and what it isn't, is so helpful." -Consultee	"[Consultees] begin to get curious how they can utilize our consultation in a more systemic approach…For example, one site, they've been trying to do these reflective collaboration meetings, and they're like, here's our idea, but it's not landing. And they'll try it on their own. And they're like, oh, but you kind of talk about reflection, this is kind of consultation. Help us think about this, what do you see? That's huge because it takes a lot for a system to trust, to want to hear our opinions and lenses in their larger policymaking and all of that. Once the relationship is built, then leadership can trust a little more." -Consultant
Categorized by 35 statements	Categorized by 16 statements	Categorized by 12 statements

What is the impact of ECMHC?

Consultants and consultees discussed the impact of San Francisco's ECMHCI by sharing personal success stories, their perceptions of the objectives of ECMHC, and highlighting changes overtime (e.g., teacher, child, system changes). Eight distinct impacts emerged from these discussions and are summarized in the table below by frequency of occurrence, accompanied by exemplar quotes. For example, 'fostering relationship development' emerged as the most frequently discussed impact of ECMHC. This concept was present in 70 statements, followed by 2) 'providing knowledge about children's development, culture and wellbeing,' 3) 'providing behavioral intervention/prevention,' 4) 'building capacities,' 5) 'managing external stressors,' 6) 'providing resources,' 7) 'fostering organizational/structural changes,' and 8) 'fostering empathy'.

Themes: Perceived Impact		
Fostering relationship development. (Child-teacher relationships, parent-teacher relationships, teacher-teacher relationships, staff-staff relationships) "How do we, [as consultants], strengthen the quality of relationships between care providers and children, care providers and care providers, and between children and children? It's really centering the healing that happens through relationships. Our outcomes need to consider and think about the complexity of those relationships and hold them holistically". -Consultant "It helps us, [the ECE site], build rapport with the consultant and the teachers feel safe to let them know what is going on. Then [the consultant] builds rapport with the families and they backup what the staff is saying. Then we learn how we can all work together to support the child." -Consultee Categorized by 70 statements	**Providing knowledge about children's development, culture, and well-being.** "I think about our program over the years and there is a shift in how [the staff] think about how to respond to children, they understand children's behavior". -Consultant "When we started [consultation], our community of children were African American, and we had African American boys. Our teachers were just not able to deal with the behavior of those children. When the MHC were there, we had meetings to help the teachers to get a better understanding of what some of the issues that those children were dealing with. [The teachers] couldn't deal with the behaviors because they didn't understand anything about what was going on in their lives." -Consultee Categorized by 45 statements	**Providing information on and modeling techniques around behavioral intervention and prevention for children and families.** "[The consultant] joined parent orientation and now when there is a challenging behavior [the parents] will ask me, 'can I talk to your MHC?' they know there is someone there for them." -Consultee "Parents with concerns about their children's behaviors or learning problems… for example bilingual, should the child use their primary language? How can they teach children their primarily language while using English? So, the MHC will share with them, when kids throw temper tantrums or have questions on language development" -Consultee Categorized by 44 statements

Building capacities in consultees.	**Managing external stressors (Educator's own family stress, personal trauma, self-care, bereavement, etc.)**	**Providing and facilitating the use of resources**
"Just building that capacity for those caring adults, those caregivers to really be able to meet the needs of children and families. Thinking about recognizing the impact of trauma and mental health concerns and learning and development." -Consultant "Little by little with our own relationship building, [consultees] can learn these skills that will help them when we are not there, because we're not the saviors; So, they can do it by themselves and pray the sense of mastery"-Consultant	"In the past two years like anti-Asian hate crimes have been happening frequently. I think we are grateful our consultants would come over and talk about the current events and issues, and there were tense moments when they would step up and provide support."-Consultee "Because our teachers just don't have the ability to before you come into the classroom, empty of your personal problems, because you have to pour all of that into the children. But we have teachers coming now that have nothing to pour into. They have nothing to give, very little to give. And so, we it's a greater need to support the whole classroom." -Consultee	"I see that it is a partnership. And if your partner, which is the consultants, have more experience and who can bring a lot of resources and offer to you, either to your teaching staff, or your parents, or directly to the children, that is a successful partnership." -Consultee "A mom was experiencing domestic violence…The mental health consultant did connect her to all different community resources, even in such a helpless situation, she did find some financial help on how to apply for welfare services, housing service, our mental health consultant did cover this kind of situation." -Consultee
Categorized by 32 statements	Categorized by 28 statements	Categorized by 25 statements

Fostering organizational and structural changes

" [ECE educators and administrators] start to think about how systems affect families, and how systems affect families from various cultural backgrounds. For example, calling Child Protective Services and what that would mean and how that would affect families. And what's the cultural background of that family and the immigration status? So those are some longer-term internal changes." -Consultant

"I've noticed that when I offer feedback or offer an insight, and then later on I will see that the director has implemented that insight to the rest of the rest of the crew. It's like, what makes the work so awesome is to see something that you suggested to help the organization or to help the staff there. And then it's being implemented later on." -Consultant

Categorized by 22 statements

Fostering empathy

"I really appreciate the support of the mental health consultant to make me mentally very strong, so that I can be strong with the family to support them, understand them more and have more empathy with their problem." -Consultee

"I think making directors aware of trauma, as well and what the effect that trauma has on kids and on families in general, it helps them be a little bit more empathetic as well; to understand that families and children a little bit better." -Consultant

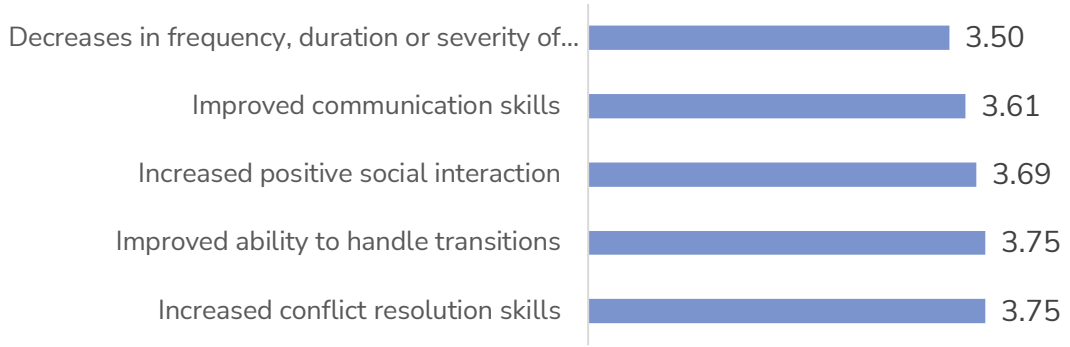
Categorized by 13 statements

These eight key impacts were often discussed in combination with one another. That is, an exemplar quote about fostering relationship development among teachers and parents may also contain evidence of fostering empathy, structural changes, and knowledge development. Though we were able to split these impacts into distinct categories, when we examine code co-occurrence, we find that these eight impacts are very much related and highlight the nuanced and complex nature of providing consultation. Thus, it is likely that there is no one main impact or objective of consultation. Instead, the data suggest that the primary impact or objective is that the consultant is deeply integrated at the site and prepared to support any situation that may arise, as they are in relationship with the consultee and with the site. To bring this idea to life we share a quote from a consultant who aptly articulates this idea:

> ***"In order for ECMH Consultation relationships to be most effective/supportive, it is important to have room/flexibility to account for potential consultees' varying needs and levels of willingness/readiness to engage and make use of the service. And when a program's needs change/increase, it would be best if ECMH Consultants/agencies had the flexibility to increase/adapt services. In situations where multiple outside consultants/supports are involved with a program (like inclusion coaches and instructional coaches, etc.), it is important to be able to build a clear, shared understanding among all parties involved of each person's role and how they will work together in service of children, families, and consultees. …[T]he ability for consultants to track these factors as they navigate their relationships at sites and then have intention around building on or focusing on any one of the issues as they assess needs lends itself to a strong consultative alliance."***

Survey data also gauged impacts associated with the ECMHC initiative, as educators were asked, "What changes did you notice in children as a result of mental health consultation through direct intervention with the child, parent, teacher, director or site?" This question was adapted from the San Francisco ECMHC Initiative's previous parent feedback survey. Participants could respond on a five-point Likert scale: 1 = No change, 2 = A little change, 3 = Some change, 4 = Much change, 5 = A great deal of change. On average, teachers responded that they experienced "***some"*** to "***much"*** change in all the domains.

Educators notice moderate levels of change across domains as a result of mental health consultation



Note. Responses were from 32 participants (5 = 'a great deal of change')

Directors were also asked to reflect on the changes they noticed as a result of consultation. Overall, average ratings suggest that directors notice less change overall, as compared with educators' average ratings. Directors noticed the greatest change in identifying outside resources and meeting the social and emotional needs of children. Directors reported seeing the least change in exclusionary practices: 1) changes in disciplinary practices and policies; and 2) changes in the center's ability to think collaboratively about whether exclusion for a child is best.

Directors also responded to a set of feedback items that probed suspension and expulsion patterns. Questions are from a larger feedback survey that was developed by Indigo Cultural Center and the Athena group (The Athena Group, 2021). Directors were also asked if they considered excluding (suspending or disenrolling) children from their site in the last six months. Five sites reported that they had considered excluding children. A total of eight children were reported at risk for exclusion, five children were at risk of suspension and five children were at risk of disenrollment. However, directors reported that **none** of the children were ultimately excluded. Directors were asked if working with a consultant was helpful in retaining children in the program who were at risk of expulsion. On a 6-point scale from 1 = 'strongly disagree' to 6 = 'strongly agree', directors ***agreed*** that the consultant was helpful in retaining children in the program (M=4.5).

What changes over time? Consultants' perspectives

Given the uniqueness of San Francisco's long-term ECMHC relationships, we sought to explore the arc of outcomes that unfold over a longer period. Traditionally, research has been conducted on only short-term relationships and has measured a consistent, yet limited set of outcomes (e.g., expulsion risk, child regulation, student-teacher closeness, consultative alliance, teacher self-efficacy, social-emotional climate in the classroom). The current research shows that a significant change is detected from consultees in the beginning six months of intervention, which is sustained over the next six-month period. Implementation science literature describes this process as a successful component of the "initial implementation stage" (Fixsen et al., 2005). However, it is quite possible that other types of measurable changes occur within the first six months of consultation, or that changes occur between one to two years of consultation, or that might occur after five years of consultation. We asked both consultants and consultees to report on the changes and improvements they notice or expect across specific time segments.

First, each of the four ECMHC grantee-agencies were asked to complete a timeline that outlined the types of changes they expect to occur across time given their experiences. Their combined responses are available in Appendix E and a summary of their integrated timelines are provided below.

What changes over time? Perspectives from SF's ECMHC Workforce

Changes in the first year:	• Building relational trust at the site with educators, staff, children, and families. • Focus on capacity building of the adults and families at the site. • Developing and building on reflective practice and curious stance with staff through individual and/or group consultation. • Identifying site needs and developing plans. • Working with and developing strategies with other helpers at the site (e.g., inclusion coaches, instructional coaches, family support specialists, etc.).
Changes in years 2-3:	• Increased capacity is built at the site and more complex issues and challenging conversations begin around site dynamics and relationships, implicit bias, cultural competence, and restorative justice practices. • Increased collaboration and coordination with other helpers at the site. • Relationships with the site have deepened and personal issues, issues around educators' own mental health, and trauma begin to emerge and are addressed. • Families increasingly turn to the mental health consultant for support and parents begin implementing strategies learned from their site's consultant. • Educators have internalized several strategies to support children's social-emotional wellbeing and development.
Changes at 3+ years:	• Mental health consultant begins to hold historical knowledge at the site. • Systemic gaps in service and systemic inequities are discussed within a collaborative system of stakeholders. • Sites have gained institutional knowledge, such that if a consultant leaves or changes, they have the capacity to support themselves as they transition to a new consultant. • Site has gained capacity to identify their mental health needs and develop strategies to facilitate conversations about mental health and are able to work effectively and strategically to enhance support. • Teachers have gained internal efficacy and mastery of their own skills. • Patterns related to relational dynamics, triggers, and trauma responses become more apparent and easier to name with long-term relationships. • Site has developed a strong mental health framework around how to support social emotional needs of children and has developed strong equitable practices to reduce disparities in communities of color. • ECE systems of care incorporate consultants into pre-service trainings and MHCs may consult on more system-wide issues regarding protocols, child support, teacher wellness, and family engagement

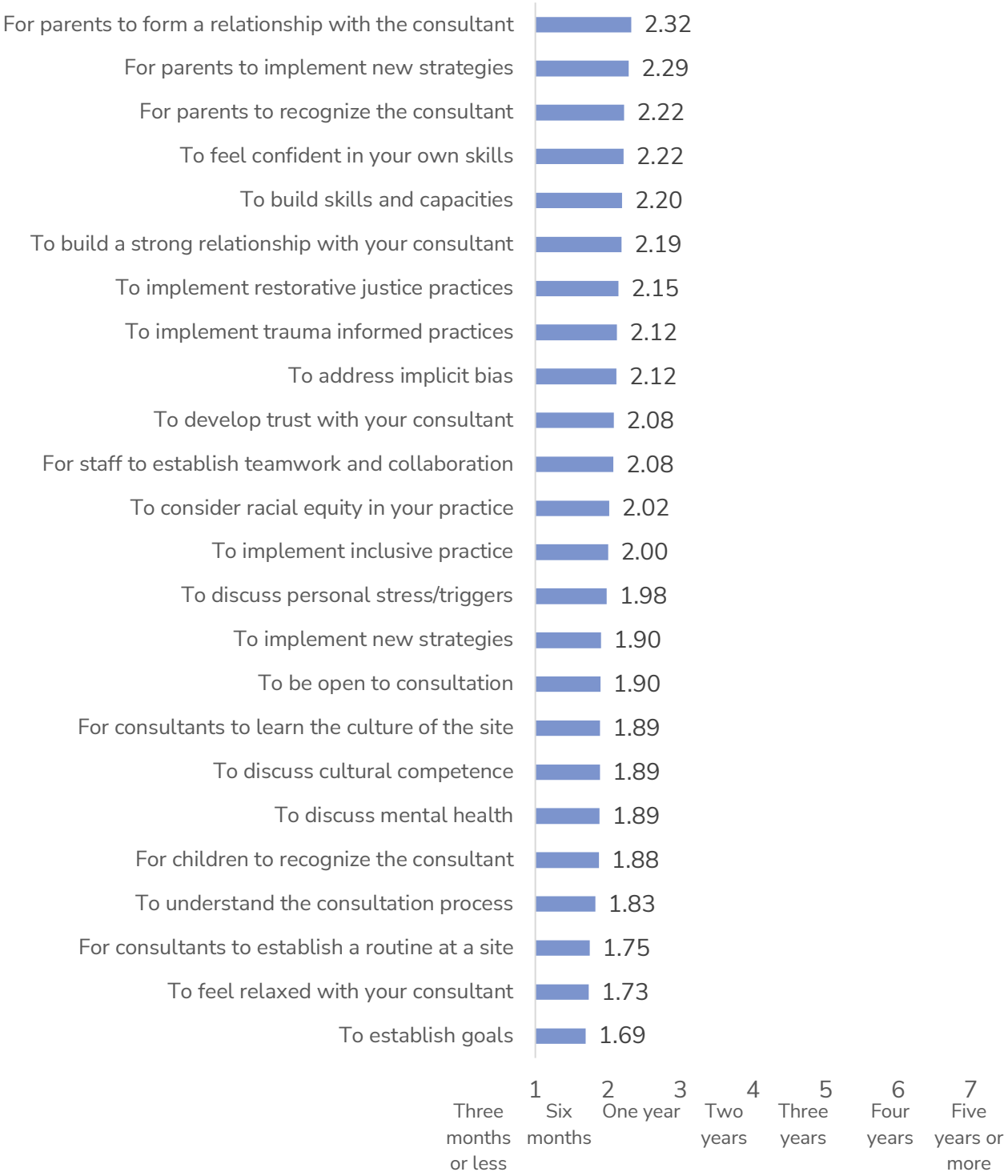
Photo courtesy of RAMS/ Fu Yau

What changes over time? Perspectives from consultees

Second, consultees were asked (via survey rankings) how much time working with their consultant is necessary before they or their site could engage in a series of activities and/or meet milestones that set the consultee/site up for successful outcomes. Though consultees' response options ranged from three months or less to five years or more, very little variability was found in responses, as consultees indicated that nearly all activities could be accomplished in about six months to 1 year. This finding is in stark contrast to consultants' and supervisors' strong beliefs (as indicated by the timeline above) that a longer relationship is required to achieve deeper, long-lasting change related to 1) long-term capacity building at the individual, team and organizational levels; 2) systemic changes; 3) team collaboration among other early childhood TA providers at the site (e.g., quality coaches; instructional coaches; etc.); and 4) addressing various manifestations of racial inequities – including implicit bias.

Consultees' responses indicated that establishing goals, feeling relaxed and establishing a routine took the least amount of time, while parent-related activities were rated as taking the longest amount of time (e.g., parents understanding the goals of ECMHC; implementing strategies; and forming a relationship with the consultant). Activities with the greatest variability in consultee's responses include the time it takes to be open to consultation (M=1.89, SD = 1.54); to discuss mental health (M=1.88, SD= 1.40); and to address implicit bias (M=2.12, SD = 1.40). Survey response options ranged from 1 to 7 (1= 3 months or less; 7= 5 years or more). See table below.

Consultees estimate 6-12 months for most skills to be developed in mental health consultation



Note. Responses were from 55 to 64 participants.

Consultants and consultees appear to be in agreement with timelines needed for establishing routines, building trust, and establishing collaboration and teamwork. However, the long-established ECMHC workforce in San Francisco identifies achievement of site-, director- and teacher-level capacity gains and emphasizes system-level and deeper anti-bias work occurring beyond the one-year window.

What role does race, language, and cultural responsivity play in the initiative?

Notably, consultees and mental health consultants alike discussed the importance of several key themes related to race, culture, and language in relation to forming a strong consultative alliance: 1) Cultural and linguistic match between consultant and consultees; 2) Establishing the trust and rapport needed to lean in to difficult conversations and address various forms of systemic inequities and racial injustice including bias (implicit and explicit), experiences of trauma, and other child and family outcomes.

The early childhood field is only beginning to explore hypotheses as to why IECMHC is emerging as an effective strategy for reducing disparities in suspensions, expulsions, and other discipline practices (Davis et al., 2020; Davis et al., 2018; Gilliam et al., 2016; Shivers et al., 2021). Davis et al. (2018) have theorized that IECMHC reforms adults and programs rather than children or families, leading to teachers' changing their interpretations of children's behavior. MHCs also enhance effective communication with families and increase educators' capacities to reflect on biased expectations of children in general and of individual children.

The ECMHC approach in San Francisco is celebrated for the consistent and focused use of the Consultative Stance (Johnston & Brinamen, 2006). This framework is helpful in exploring the mechanisms through which taking the time to establish trust, rapport and a strong consultative alliance can lead to enhanced racial equity outcomes and a stronger sense of cultural responsiveness. The Consultative Stance is highly compatible with the healing justice movement for racial equity which calls for individuals to attend to the “inner-work” of social justice. These inner qualities include self-awareness, presence in the here and now, perspective-taking, emotional regulation, and empathy which supports compassionate action.

These are all skills and ways of being that are the cornerstone of how mental health consultants approach their work with early educators (Magee, 2016; Shivers, 2016). Based on our understanding of the Consultative Stance (Johnson & Brinamen, 2006), reflective practice, and social justice liberatory strategies such as embodied somatics (e.g., ColorInsight, Magee, 2016), we posit that it requires this combination of strategies, stance, and disposition often embodied by mental health consultants to ameliorate stereotypes, micro-aggressions, and biases especially toward Black and Indigenous children and all children of color (Davis et al., 2020; Davis et al., 2018; Shivers et al., 2021). These ways of approaching the work and striving towards change takes time. The benefits of long-lasting relationships with ECMHC (including not just individual dyadic relationships with one specific consultant – but also the institutional knowledge of working with a mental health consultant over a long time) was emphatically raised in the context of race, culture and language during focus groups with mental health consultants as well as with long-time ECMHC partners (e.g., more than 5 years receiving mental health consultation).

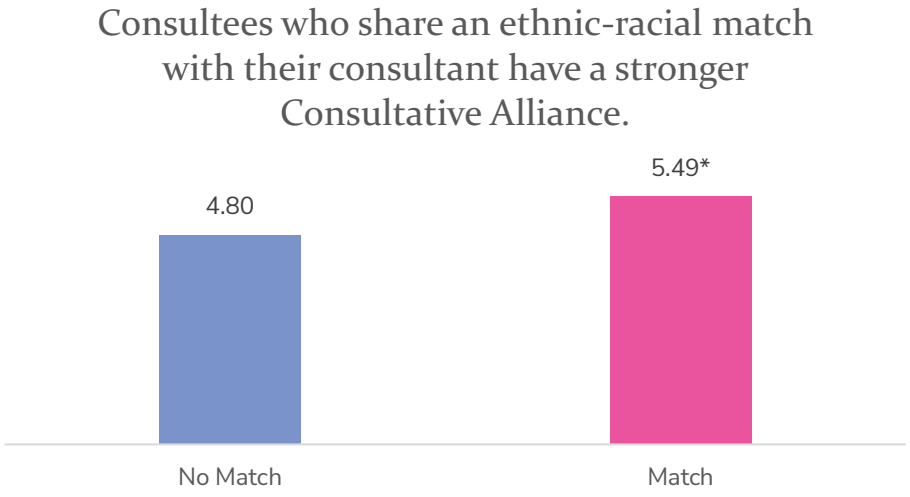
Participant-Consultant Linguistic Match

We explored if statistical differences would emerge pending if the consultant shared a linguistic match with the predominant languages of the site. Data was available to calculate linguistic match for 57% of participants who participated in the feedback survey (N=56). However, when calculating linguistic match, we found that all sites had a consultant with a linguistic match to the predominant languages used for instruction. Given there was no variability, we did not conduct t-tests to explore this question further. It must be noted that this finding of 100% linguistic match between sites and consultants is rare when compared to the majority of the ECMHC workforce in the US which is overwhelmingly white, female and English-speaking / monolingual.

Participant-Consultant Racial Match

We also explore if statistical differences would emerge pending if the consultant and the consultee shared a race-ethnicity match. Data was available to calculate ethnic-racial match for 57% of feedback survey respondents (N=56). Approximately 70% of these consultees had an ethnic-racial match with their consultant (N=38) whereas 32% did not share an ethnic-racial match with their consultant (N=18).

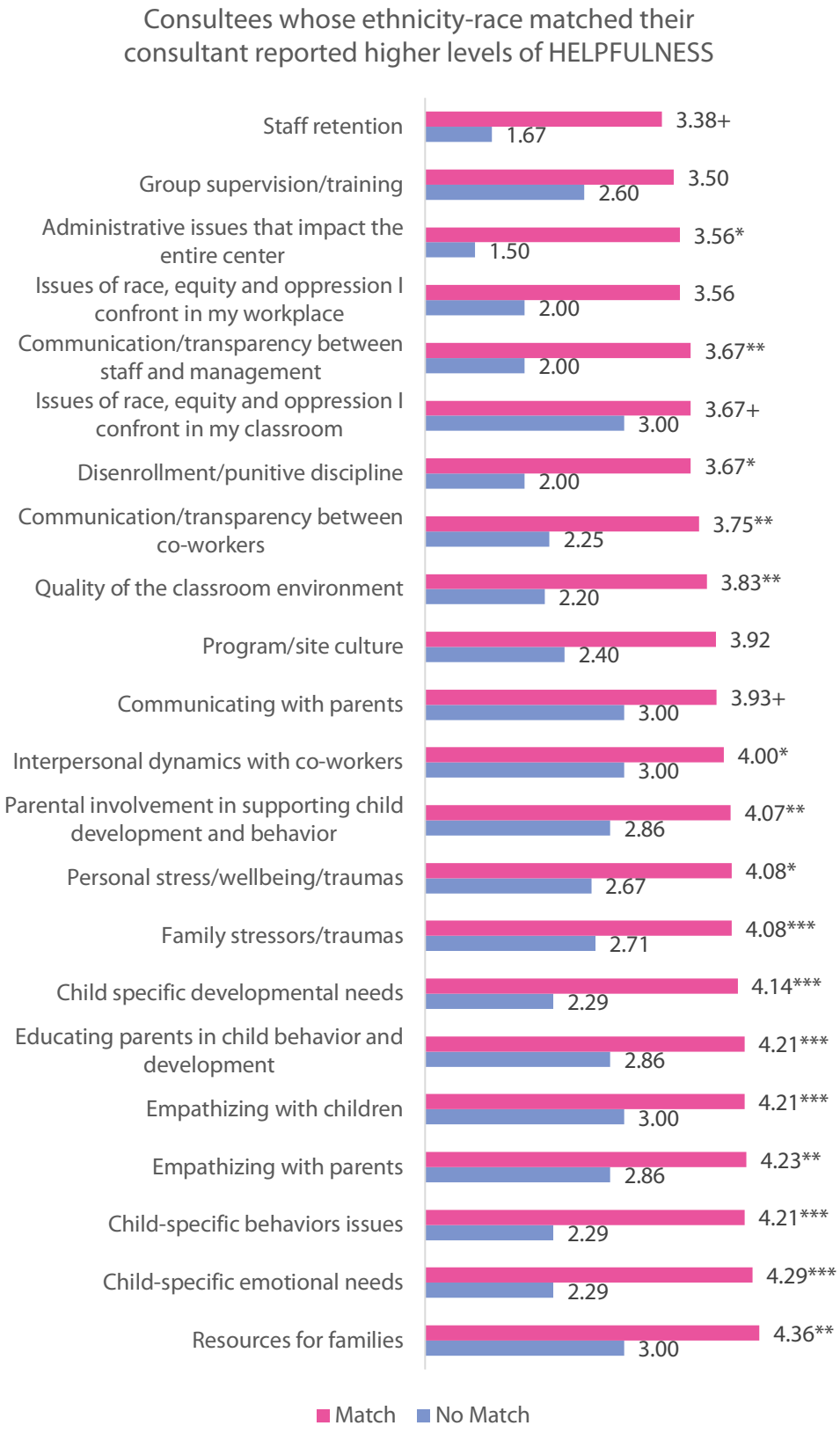
Does sharing an ethnic-racial match enhance the Consultative Alliance? Based on findings from Davis, Shivers, and Perry (2018), we tested our hypothesis that sharing an ethnic-racial match would enhance the quality of the relationship between consultees and their consultants. Consultees completed the Consultative Alliance scale (Davis, 2018) which asks 17 questions to probe their perceived closeness, comfort, and transparency with their consultants. We conducted a t-test to determine if mean scores on the consultative alliance might differ if a consultee shared an ethnic-racial match with their consultant. The results revealed that consultees who had a ethnic-racial match with their consultant reported a **STRONGER** alliance with their consultant (M=5.50) when compared with participants who did not share a racial match (M=4.80) and this difference was statistically significant [Equal variances assumed; T(23)= -2.59, p=0.02]. Differences between the mean scores can be viewed in the figure below.



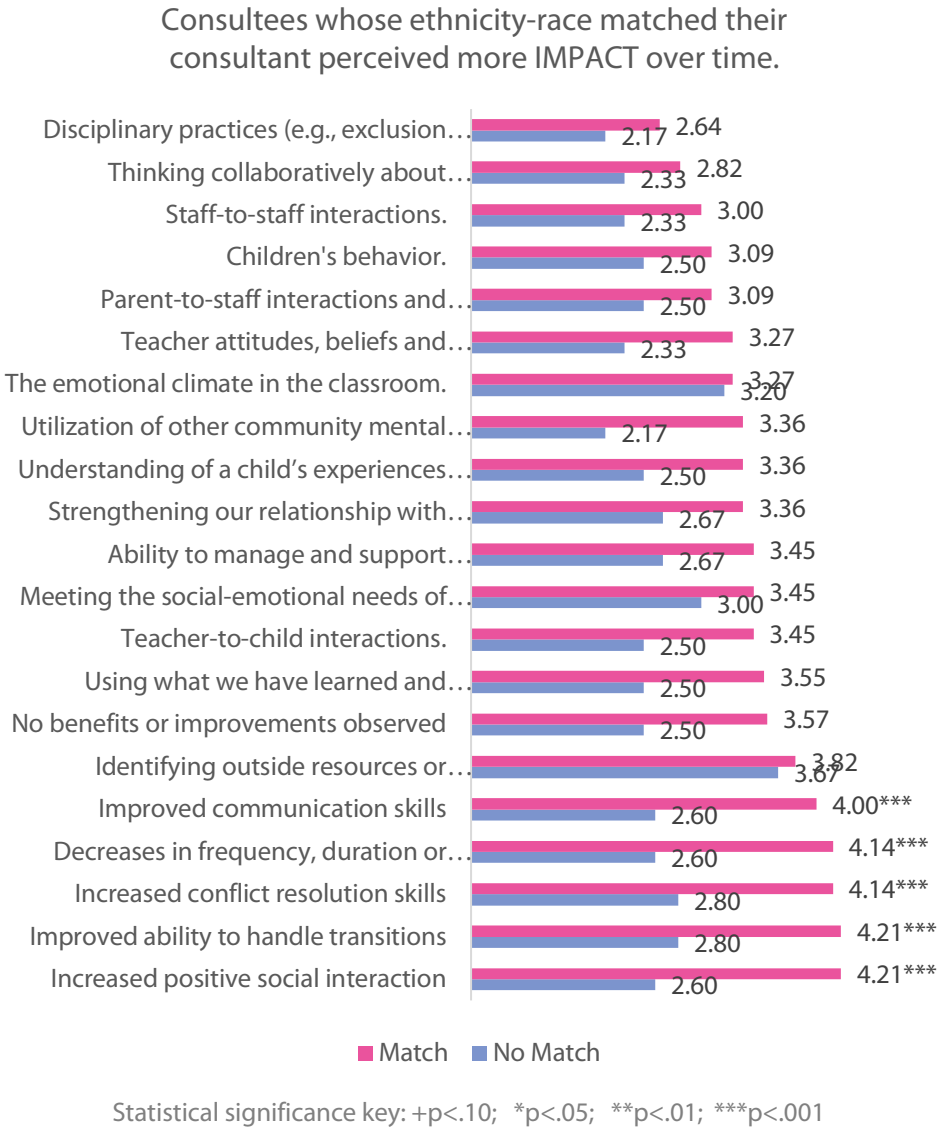
Note. Sample sizes across the variables in this chart are No Match (N=7) and Match (N=18)
Statistical significance key: +p<.10; * p<.05; **p<.01

Did consultees who shared a racial and ethnic match with consultants perceive ECMHC as more HELPFUL? We examined if sharing an ethnic-racial match would create differences in the perceived helpfulness of the consultant. Consultee's rated how helpful their consultant was on 22 domains. This question and the domains were developed based on focus groups with consultants and consultees. In addition, some domains were informed by the San Francisco ECMH Initiative's previous care provider and parent feedback surveys. At the statistically rigorous p<.05, p<.01, and p<.001 thresholds, we found 16 domains as demonstrating significant differences in perceived consultant helpfulness given the consultant and consultee shared an ethnic-racial match. That is, when they shared an ethnic-racial match with their consultant, consultees rated their consultant as MORE helpful in the listed categories. Out a total of 22 items, there were only three (3) categories where a shared racial and ethnic match did NOT show statistical differences in perceptions of helpfulness categories.

Statistical significance key:
+p<.10; * p<.05; **p<.01; ***p<.0



Did sharing a racial and ethnic match with consultants result in higher ratings of IMPACT over time? We examined if sharing an ethnic-racial match would create differences in the changes that arose in the center as a result of consultation. Consultees rated how much change they noticed in 20 domains. This question and the domains were developed based on focus groups with consultants and consultees. In addition, some domains were informed by the San Francisco ECMH Initiative's previous care provider and parent feedback surveys. In contrast to the previous table, for this question of perceived impact, there were fewer domains that were differently rated based on racial and ethnic match between consultant and consultee. At the statistically rigorous p<.05, p<.01, and p<.001 thresholds, we found only six domains as demonstrating significant differences in center change given the consultant and consultee shared an ethnic-racial match. That is, when they shared an ethnic-racial match with their consultant, consultees reported more significant changes in the domains listed in the table. There were an additional two domains with group differences that approached statistical significance.



Statistical significance key: +p<.10; *p<.05; **p<.01; ***p<.001

How could ECMHC in San Francisco be Improved?

Generally, consultees were very satisfied with their ECMHC consultant and services, with 74% of survey participants responding that they were ***satisfied*** or ***very satisfied*** with the consultation they received. Further, 64 statements in the focus groups were categorized as success stories where consultation led to meaningful, positive change for children, educators, and the consultants themselves. When focus group participants were asked to think critically about the initiative, participants were slow to identify barriers and challenges in their experiences with ECMHC, though two central challenges emerged from focus groups and survey responses.

More hours with their ECMH Consultant

The number one challenge reported by consultee-participants was that sites want more hours of consultation. This finding is consistent with virtually every IECMHC evaluation conducted across the country (Center of Excellence for IECMHC, 2022; Shivers, 2016). A total of 44 open-ended responses in this study's feedback survey referenced this desire. Consultants and consultee focus groups also identified this as a challenge and a desire. Consultees discussed the need to work with their consultation agencies to find ways for consultants to be on-site more frequently and for longer hours. Survey respondents highlighted staff turnover at ECE sites as a challenge that requires more time with consultants.

Importantly, consultees approached the desire for more time with their consultant with empathy, recognizing the high number of sites each consultant held, acknowledging the consultant's willingness to work hours beyond their scope, and noting the emotional labor that accompanies consultants' large caseloads. Consultees' ask for more hours was accompanied by an ask for more funding to alleviate consultants' caseloads and potential burnout.

"They actually go to too many sites; they are very busy…they should extend the hours on specific sites. It would be great if the agency can reduce the number of sites each consultant attends to. This can save them more time to each site upon request. This can make a better quality of services to the specific sites."- Consultee

"Sometimes because [the consultants] are busy as they have to take care of multiple sites and different agencies, so everyone has to accept the circumstance. Being flexible, compromise is very important, but I cannot be that demanding and ask them to be here as soon as we requested." - Consultee

Consultant turnover is a challenge

Given that this evaluation was primarily conducted during the COVID-19 pandemic, another formidable barrier involved turnover, and includes teacher, child, administration, and consultant turnover. Approximately 11 open-ended survey responses mentioned consultant turnover. Additional focus group mentions of other types of turnover were widespread, occurring in every focus group and across 47 statements. All participant groups in this evaluation discussed the challenge of how quickly ECE staff and children can transition out of the organization, which can have such a disruptive impact as to seemingly ***restart*** consultation. One consultant explained:

> "***When I've been at a site a long time it is because there's changes in leadership and management, you might be getting to work with a site moving in a certain direction, then there's a change in leadership. Then things can become quite different. Policies are different and staffing becomes different. You as the consultant have to like almost recalibrate with the site in a way. So you can feel like you are having success at times, then something can happen at the site and it feels like we are having to move back to a different position or found our way again"*** ~Consultant

Consultant turnover or transition out of an ECE site was primarily mentioned by consultees who reflected on the negative emotions that accompany a long-time consultant leaving the site. Consultees also expressed what felt like a revolving door of consultants across a short period of time.

> ***" If there are too many turnovers, in fact, it's all about the Domino effect. You spend a lot of time on a consultant and work out well, and then the consultant leaves the agency, and you need to work around again. If the agency can lower the turnover rate, this could lower the frequency of changing new consultants." - Consultee***

> ***"I say to [our consultant], I hope you don't move from here, because we get so used to people and we don't want them to leave, right? Because we already have that bond with her." -Consultee***

In contrast, some focus group participants also discussed how turnover can sometimes be helpful. One consultant mentioned that if they notice a plateau in progress, it may signal that it's time for a new consultant to join the site and bring a fresh perspective. One consultee suggested that depending on the site's shifting racial or cultural composition, a new consultant who is more closely aligned with the site's new configuration might be needed.

"Maybe they need a new perspective, maybe they need someone more fresh because I'm the way I am, I have my own style, but maybe my coworker has a better way of helping the site. So, you ask for a change, or their manager feels like change is needed… after a while, it does get a little plateau, like the site's not gaining anything because you've taught them everything or you've done all you can. So, let's get in a new person and teach them something new." -Consultant

"Early on, there was an African American community. But since then, … I would say the community has changed totally where now our classroom is probably 50/40 Asian and Spanish. And we have maybe one African American child in the classroom. So, our mental health services have changed, the needs have changed." - Consultee

An important piece of the consultant turnover dynamic was the notion that collaboration between the old consultant and the new one can buffer some of a consultee's uncertainty and fear that sometimes accompanies a transition. In addition, some sites discussed that a collaborative transition often also includes the agency director: if they endorsed the new consultant, ECE sites felt confident a new relationship would be fostered. These ***warm handoffs*** were made even more warmer when the ECE site has 'institutional knowledge' of working with a mental health consultant – as is often the case in San Francisco.

"I've had a couple of [sites] where my fellow coworkers resign or go somewhere else. So we do have that transition meeting and it goes really smoothly. [The consultee] will trust you just because maybe it is word of mouth or maybe because of the previous consultant? Oh, yeah, he's really good. Those transitions are really smooth. And I'll have that relationship, maybe in week one."-Consultant

"It has helped us a lot that [the agency director] is always communicating with us, and told us that we were going to have a new consultant for this year, they gave us all her information… [The new consultant came with our old consultant]. 'Oh, look, they are going to be the consultant because I've been transferred to other centers.' Then I show them the center and I tell them look what they are, I introduce them to the teachers, and I tell them you are welcome."-Consultee

Recommendations for Improvements

Finally, we provide recommendations for improvements that were highlighted in survey and focus group discussions. Each area for improvement summarizes the number of statements that highlight the improvement area, accompanied by exemplar quotes for each recommendation.

Themes: Area for Improvement		
Increase consultant availability and decrease their caseloads	**Increase funding and expand ECMHCI into other early childhood settings where children spend time (e.g., after-school programs, in home care, summer school programs, family child care, FFN care,)**	**Renew focus on cultural competence. Hire more Spanish and Chinese speaking consultants; Hire more consultants of color; Increase all consultant's understanding of culture and race.**
"I would love to advocate lessening caseloads and having two or three maximum sites for each consultant to really address the needs of each site." -Consultee	"I think if they can have more funding. I think if it is possible, it will be great to lower the turnovers rates."	"I would like to have a magic wand that we have more culturally appropriate Spanish speaking folks available. Because we just have, a lot of times we refer families, and there's just not a practitioner that can work with them in their language."-Consultee
"In the beginning of the school year, allocate each center a full day of service for a period of time (2-4 weeks). After MHC has assessed and identified the needs of the site and discuss with the team/directors of the program, reallocate the hours as the team sees fit (and the team can re-evaluate at midterms or something)". -Consultee	"There's a huge need for mental health consultation and after school programs." -Consultee	"The mental health consultant learns from parents about Chinese culture. For example, when we say jokes, they need to have good Chinese background to understand them, but mental health consultant may not understand, so they learn from parents…When Asians were under attack, we held a support group to bring this up as a topic to understand other races' cultural backgrounds." -Consultee
Categorized by 17 statements	Categorized by 14 statements	Categorized by 14 statements

A unique request came from survey open-ended responses. Eleven open-ended responses discussed the need for more solutions and strategies to be provided by the consultant. As discussed above, mental health consultation is not designed to be a specific solutions-based intervention. These comments could indicate early educators' curiosities about new ways to approach their work. However, this could also indicate a misunderstanding of what consultation is:

> ***"[Consultants] giving more solutions for us teachers to practice on and [for the consultant to] be more informative about a child's behavior, like why they are doing it***
> ***More strategies in the moment or more modeling in the moment for teachers.***
> ***I feel the role of the consultant is too hands off in a PK classroom."***

> ***"Perhaps [the consultant] could push a little more for changes in behavior or share examples with staff of things they should change in how they communicate with each other and with children."***

> ***"[Consultants need to] support staff with tangible solutions.***
> ***We need the consultant to be able to work directly with the kids that have the highest need. It sometimes feels like they are just observing but not participating."***

Summary of Key Findings from Phase 2: Feedback for the Traditional Model and Approach

Strong consultative relationships are the secret sauce! The most prominent themes that emerged from the feedback focus groups centered on the importance of the consultative relationship: the ***secret sauce,*** if you will. The longer-term relationships that San Francisco mental health consultants maintain with their consultees over time foster consistency in practice and expectations. Cultural/linguistic match between consultant and site further strengthens the relationship through shared lived experiences, shared language, a deep understanding of cultural background, and the ability to counter unique, yet shared stigmas. Connections between a site director, staff, teacher, and parent involvement with consultation also deepen over time, as all ***actors*** collaborate and work towards common goals that support children. Finally, an unexpected relationship emerged from our findings between the consultant and the ECE site itself. Given high educator turnover, consultants are often with an ECE site longer than the staff employed by the site, thereby becoming institutional knowledge holders of sites.

Fostering relationships is among the greatest impacts of consultation. The most frequently discussed impact of ECMHC was the fostering of relationships among and between educators, administrators, and parents in ECE contexts. Relationship- building is critical to the consultation model. Other impacts identified include:

- Providing knowledge about children's development, culture, and wellbeing
- Providing behavioral intervention/prevention
- Building capacities
- Managing external stressors
- Providing resources
- Fostering organizational/structural changes, and
- Fostering empathy.

There is a long timeline of shifts that occur with consultation. By consultant and consultee accounts, within six to twelve months of engaging with consultation, the adults associated with a site begin to build capacities for reflection, gain greater understanding of child development, know how to access additional resources, and are starting to implement learned strategies on their own. Beyond that initial year, a consultant begins addressing more systems-level issues and works with the site and its stakeholders to strategically support and sustain their mental health capacity building.

Addressing racial equity Issues takes trust and time. The approach used by mental health consultants in San Francisco (i.e., implementing the Threads of Consultation and embodying the Consultative Stance) can lead to a disruption of racialized bias in the early education classroom (Davis et al., 2018; Shivers et al., 2021). Consultants and long-time consultees both discussed the shifts that can happen related to culture and race when there is a strong consultative alliance, trust, and time. In addition, intentionally matching consultants with consultees by culture, race and language is also seen as a key mechanism to establishing and maintaining a strong consultative alliance. Consultees called for a renewed focus on cultural competence. The racial and linguistic diversity of consultants is a strength in San Francisco,

however consultees expressed needs for more Chinese- and Spanish-speaking consultants, more consultants of color, and enhancement of all consultants' literacy around culture and race, particularly given the societal rhetoric against Black, Latino/a and Asian American Pacific Islander communities.

Consultees are satisfied and request more time with their consultant. Generally, consultees were very satisfied with their ECMHC consultant and services, with 74% of survey participants responding that they were ***satisfied*** or ***very satisfied*** with the consultation they received. Dozens of statements in the focus groups were categorized as success stories where consultation led to meaningful, positive change for children, educators, and the consultants themselves. Consultees' request for more hours was often accompanied by a request for more funding to alleviate consultants' caseloads and potential burnout.

Discussion and Recommendations

Discussion

This evaluation revealed important information about the On-Call services, the traditional model, and opportunities for the initiative's improvements and innovations at the intersection of these two approaches. A summary of the findings for the evaluation phases described in this report can be found on pages 54 and 79 respectfully.

The main take-away from this study

Though we were able to split this report by reporting findings from two distinct evaluation phases (i.e., Phase 1: On-Call evaluation; Phase 2: Feedback and experiences from the traditional model of ECMHC), we find that the impacts, perceptions and reflections on On-Call services as well as the traditional model of ECMHC are very much intertwined and highlight the nuanced and complex nature of providing consultation. The data demonstrate that the primary modality for bringing about meaningful change for ECMHC is that the consultant is deeply integrated at the site and prepared to support any situation that may arise, as they are in relationship with the consultee and with the site. We also learned from our data that this goal is very challenging in the On-Call context when consultants do not have enough time to develop a strong consultative alliance and to integrate all the approaches and strategies that are commonly reported and cited by the majority of the IECMHC literature. To illuminate the essence of what this study revealed we present a quote from a consultant who aptly articulates this idea:

> ***"In order for ECMH Consultation relationships to be most effective/supportive, it is important to have room/flexibility to account for potential consultees' varying needs and levels of willingness/readiness to engage and make use of the service. And when a program's needs change/increase, it would be best if ECMH Consultants/agencies had the flexibility to increase/adapt services.***
>
> ***…In situations where multiple outside consultants/supports are involved with a program (e.g., inclusion coaches, instructional coaches, etc.), it is important to be able to build a clear, shared understanding among all parties involved of each person's role and how they will work together in service of children, families, and consultees.***
>
> ***…[T]he ability for consultants to track these factors as they navigate their relationships at sites and then have intention around building on or focusing on any one of the issues as they assess needs lends itself to a strong consultative alliance".***

Although On-Call wasn't successful as a consultation approach, there was positive feedback from those who were able to use the service as triage or crisis intervention. Additionally, our findings demonstrated that there were some specific conditions that could make On-Call services more effective. Those conditions include previous experience with the traditional model of consultation and having access to additional resources that enable sites to make the best use of their limited time with consultants.

Key findings in Phase 2 of this evaluation that focused on exploring consultees' experiences with the traditional model include the recognition that deeper capacity building, which is also aligned with the original theory of change for ECMHC, happens with the traditional model over the longer arc of time. The historical theory of change for ECMHC in San Francisco also illuminates the importance of developing and supporting a consultant workforce that has cultural, racial, and linguistic alignment with the sites they serve. Indeed, our data shows that an ethnic and racial match between consultants and consultees is linked to a stronger consultative alliance and increased consultee perception that consultation is useful and helpful.

Key recommendations are listed here and expanded upon in the Summary sections that appear on pages 55 and 80 in the Implications section below.

Key Recommendations:

Reimagine On-Call Services

- Expand collaboration in determining sites' Tier assignments.
- Create, implement, and maintain a 'preparedness plan' for sites new to consultation.
- Generate more awareness about the ECMHC Initiative in general and about On-Call services in particular – this includes transparency about the Tier designation rationale and process.

Enhance the Traditional ECMHC Approach and Model

- Procure more funding for ECMHC.
- Support and center consultant wellbeing to prevent burnout and turnover.
- Re-center San Francisco's initiative's history of community and consultant trust.
- Cultural alignment and responsivity are key. Work to deepen consultants' capacity to bring the strong lenses of anti-racism and decolonization to their everyday work. Continue to strengthen the workforce pipeline to increase the rates of cultural, racial and linguistic match with sites.

Practice Implications

- Consultees expressed a desire for more **concrete strategies**, **hands-on solutions**, and **modeling with explanations** to help them gain confidence and competence in translating support received from their consultants into their own **mastery** and **self-efficacy**.

- Given the population of the San Francisco ECE educator community, and the findings that a racial and ethnic match for consultants and consultees is related to stronger a consultative alliance, consultees expressed a desire for greater **BIPOC representation** among mental health consultants AND that all consultants might receive more training and skills to enhance their work at sites with true **cultural awareness** and alignment, and with an **active anti-racist stance**.

- **Preparation** for receiving mental health consultation can set a consultative relationship up for success. Taking time to **onboard** a new site and its staff can help pave the way for a consultant to find or create **ports of entry** to begin the process of consultation.

- Build in **standard initiative-wide procedures** for **site assessments** on a regular, recurring basis to consider adjusting service dosage and/or to consider changing the consultant staffed at the site. And importantly, include **consultants' and consultees' voices** in assessing what a site needs.

Research Implications

- **Explore methods for measuring and understanding what changes over the longer arc of ECMHC**. San Francisco's ECMHCI has enjoyed a long history of very long-term relationships with ECE sites that have been beneficial to those who have had them. We know that some mental health consultants have been affiliated with ECE sites longer than any staff at that site. What is the added value of the history and institutional knowledge a long-term consultant might hold? How might this enhance a consultant's ability to support that site, whose staff, children, and families come and go?

- **Understand how a triage service can be effectively integrated into traditional ECMHC models**. The On-Call approach had its limitations but also demonstrated that there is a place for a triage-type of service that might be one part of a continuum of mental health care. It may be worth considering pilot testing an approach where triaged services are integrated into an ECMHC continuum of care to better support the ECE community.

- **Continue to explore the role that culture, race, language, world view, and shared lived experience play in maximizing outcomes for teachers, children and families.** We found in this study that a racial match between consultant and consultee is associated with more positive feedback about the service. Does racial concordance foster a level of comfort that is more quickly achieved as compared to consultative relationships that are developed between individuals whose racial identities differ? What might the role of shared lived experience and/or world view

play above and beyond the role that race matching plays in that consultative relationship? There is much to be learned here that carries practice and policy implications.

- In this study we only focused on center-based early care and education settings. There is a great need to **understand how ECMHC is received and its effectiveness in Family Child Care settings and in informal care settings** such as Family, Friend and Neighbor child care. From inception of ECMHC in the 1970's and 1980's San Francisco has a strong history of serving homebased child care providers. And given the centrality of racial equity movements in the IECMH and ECE fields, it is imperative that we expand access to ECMHC for our most marginalized providers and the children and families that utilize this type of child care.

Policy Implications

- **Increase funding for ECMHC – include funding for preventing consultant turnover.** Not surprisingly, consultees expressed great interest in having more time with their consultants. This finding is one of the most common findings in ECMHC evaluations throughout the country – including previous evaluations in San Francisco (Knitzer, 2000; Johns & Rassen, 2003; San Francisco Department of Public Health, 2005; Huang, 2018). It is also important to note that data collection in both phases of this evaluation revealed that consultants' well-being is at risk, and as a result, the stability and quality of the initiative are also at risk. We recommend that the initiative consider consultant well-being and support as primary. Consultants are the initiative's greatest resource and asset.

Increased funding for this initiative is one obvious recommendation that stems from these findings, but as more ECE sites enter the City's Quality Connections community, more resources will be needed to continue providing this critical service. As such, funders are indeed encouraged to consider expanding funding to allocate more service time, to provide service in more ECE settings (e.g., FCCs, after school care) and to consider other ways to build out a system of care to support the mental health needs of the ECE community. These might include formalizing agreements with other mental health providers to braid funding as well as services and creating a broader mental health system of care. In this context of growing needs for a service whose funding is not growing to keep pace, it becomes all the more important to consider creative ways to leverage other aligned providers and services to provide a network of support to meet that growing need.

- **Policymakers, funders, and other stakeholders must continue to evolve their awareness and understanding of how ECMHC works.** Although the aim of consultation is to improve the quality of relationships between children and early care and education teachers, the foundation for this improvement is attending to relationships between adults, particularly those between teachers, teachers and parents, and the consultant and consultee. Consequently, from the moment a consultant enters a child care center, they must attempt to understand the center's unique culture. Through inquiry and observation, the consultant must learn about the program's guiding philosophy, daily routines, bureaucratic structure, and inter-staff and staff-parent relationships, while at the same time learning about the relational styles of individual child care teachers the background contributors to these styles, and each teacher's expectations, emotional

capacities and beliefs about child development (Johns, 2003). This work takes time and revisiting the history of ECMHC in San Francisco is an important part of this deep awareness of what ECMHC is and what it isn't. The 'institutional history' that many sites have with ECMHC is an incredible strength that leads to deeper capacity at all levels within the early education community.

- **Consider coordinating with other mental health support services in designing a cohesive, comprehensive continuum of mental health care in the city.** Mental health consultation is primarily a capacity-building intervention for adults. Along with the addition of a triage-like service, consultation might fit within a broader network of mental health providers that together, comprise a continuum of care that might provide for additional mental health services that consultation does not address. While current contracts allocate small amounts of funding for direct services, a more robust, coordinated network of clearly delineated services - of which mental health consultation would be just one - would have the potential to provide specific services to address specific needs. This would also avoid the role challenges noted by consultation agency directors that some consultants struggle with when they try to provide both consultation and direct therapy services.

- **Coordinate more intentionally with the state's CIBC network.** Recently renamed the California Infant and Early Childhood Mental Health Consultation (IECMHC) Network, consultation services are now being offered to all early learning programs and providers in the state. Designed as a time-limited intervention, this service could potentially be leveraged by the City as a stop gap when City-funded services have reached capacity. The CA IECMHC service also operates an IECMHC Network Helpline offering one-on-one non-emergency support with questions or concerns about children's social, emotional, and behavioral health. This service too, might be meaningfully incorporated into San Francisco's continuum of mental health care.

- **Continue efforts to transform systems through an equity lens.** The On-Call approach was developed with equitable access at the heart of the intention. However, its implementation revealed some unintended outcomes that can inform future efforts. Continuing to interrogate systems transformation efforts to ensure that equity is centered requires:
  - meaningful involvement from those most impacted,
  - addressing the root causes of inequity – not just its manifestation,
  - disrupting the status quo,
  - recognizing power dynamics,
  - transparency, and
  - moving away from a one-size-fits all paradigm.

  ~ Center for Social Policy Inclusion

Next Steps

The next phase of this evaluation is currently in the planning stages and will include exploration of pre/post changes among teachers and sites new to consultation, so we can explore what outcomes change at the site/director level, teacher, consultant, classroom, and child levels.

"It feels like [consultation] starts by really partnering and learning and listening to our consultees … bringing that curiosity to that space, so that they can then begin to be curious about both their own experience and the experiences of others. So that when I'm not there, that curiosity, that interest in introspection, that interest in wondering, could remain, and still live in that system, whether a consultant is there or not."

~San Francisco Mental Health Consultant

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Appendix A
On-Call Approach Codebook

The On-Call codebook contained three layers. Layer one included codes that were used to describe the creation, implementation, and experience of the On-Call approach. Layer two consisted of codes that described the presence of the consultative stance and the threads of consultation. Finally, Layer three consisted of codes that described culture and equity Issues. The three layers of the codebook include primary codes, secondary codes and tertiary codes and are formatted as follows:

Primary Code

- Secondary Code
    - Tertiary Code

Layer One - Coding to describe On Call

"The What": This primary code is used when there is mention of what On Call is. This thematic group includes the definition of On Call and how On Call is described.

- "Reduced model": This secondary code is used when there is mention of On call being the traditional consultation model but shrunken or more limited.
- "Not consultation": This secondary code is used when there is mention of On Call being different from consultation; that On Call is not IECMHC.
- "Triage": This secondary code is used when there is mention of On call being about putting out fires or addressing crises.
- "Leveraging": This secondary code is used when there is mention of On call helping to leverage other services and resources (e.g., social workers)

"The How": This primary code is used when there is mention how On Call is implemented. This thematic group includes the strategies, time commitment, method of delivery, etc.

- "Problems addressed with On Call":Mention of any issues/problems that consultants worked to address with On Call
    - "Teacher Focused Problem":Consultation was focused on a teacher or teachers
    - "Administrative Focused Problem": Consultation was focused on administrators, case managers, directors, or other leadership staff.
    - "Family Focused Problem": Consultation was focused on parents, guardians, grandparents, siblings, or other family members
    - "Child Focused Problem": Consultation was focused on the child
    - Systemic Problem: Consultation was focused on a systemic issue/problem like teacher and director interactions, overall climate of the system; Consultation at all levels of the system is described.

- "Problems beyond the scope of On Call": Mention of any issues/problems that consultants could not address with On Call
    - "Teacher Unmet Need": Consultation could not address an issue/problem/need for a teacher or teachers.
    - "Administrative Unmet Need": Consultation could not address an issue/problem/need for an administration, director, site managers, etc.
    - "Family Unmet Need": Consultation could not address an issue/problem/need for the parents, grandparents, or other family dynamics.
    - "Child Unmet Need":Consultation could not address an issue/problem/need for the child.
    - Systemic Unmet Need: Consultation could not address a systemic issue/problem like teacher and director interactions, overall climate of the system; Consultation at all levels of the system was not possible.
- "Strategies":
    - "Group sessions with teachers"
    - "Group sessions with parents"
    - "Individual sessions with teachers"
    - "Individual sessions with parents"
    - "Individual sessions with administration"
    - "Providing solutions"
- Readiness for Consultation: Mention of the site's or consultee's readiness to receive and participate in mental health consultation.
    - Solutions Oriented: Consultee highly motivation to seek a solution, solve a problem
    - Previous Exposure: Consultee had a prior relationship with consultation.
        - Open to On Call: Open to continue working within the limits of on call
        - Strained: Consultee is hurt by the hour reduction and confused why the consultant isn't more available.
    - Not Ready: Consultee is confused about consultation, has no idea what consultation is or how to use consultation
    - Not open: Consultee is closed to consultation, they do not want the service, they do not respond, they may have other services that they use and do not want more.
- "Time implementing":The mention of how many hours the consultant actually spends providing On Call to a center/site/or generally

- "2 hours": There is mention that consultation is delivered within the two hour allotment
- "Over 2 hours": There is mention that the consultant(s) provide more than the 2 hours to their consultee.
- "0 Hours": Consultation is not provided to a site or consultee

- "Method of delivery": The method in which On Call is delivered
  - "In person": Consultant visits the site in-person, hosting services on-site.
  - "Phone":Consultant provides services via phone calls
  - "Virtual":Consultant provides services via zoom or other virtual platforms.
  - -"Text": Consultant provides support via text messages.

"The Why": This primary code is used when there is mention of why On Call was created.

- Funder decision": This secondary code is used when there is mention that On-Call was a funder-created idea.
- No child/site left behind": This secondary code is used when there is mention that on call was created to provide consultation at increased quantity to SF children/programs
- "Decision communication": This secondary code is used when there is mention of how the hour reduction, or On Call model was communicated to partners.
  - "Consultant Communicated": The consultant explained to their site they had been designated 2 hours a week.
  - "System Communicated": An agency or organization in the system explained to their site they had been designated 2 hours a week.
  - "No one Communicated": There is mention that this transition was never communicated to the site/center.
  - "Funder Communicated": The funders explained to the site they had been designated 2 hours a week.

"Does it work?": This primary code is used when there is mention of the effectiveness or ineffectiveness of On Call. How it could be modified to work. Factors that are necessary.

- Factors impacting effectiveness: The mention of factors necessary for On Call to be effective. An example includes previous exposure to consultation (and understanding of what the service is and how to use it) or previous relationship, etc.
- Effective On Call: The mention of situations or example of On Call being successful for the consultee
- Ineffective On Call: The mention of situations or example of On Call being unsuccessful for the consultee
- Opportunities for Change: The mention of how On Call can be improved, modified, or changed to be more successful/effective.

Infrastructure: The mention of structural factors associated with On Call

Funder: Funder related factors or other structural related factors that are outside of the agency.

- Feedback: Mention of how funder or other guiding organizations responded to feedback from consultants, agencies, and consultees
- Funder Support: Mention of the supports provided by the funders and other guiding organizations during the implementation of On Call (e.g., meeting, calling sites, etc.)

Agency: Agency related factors

- Adjusting the On Call Model: Agency creates their own rules, guidelines for On Call
    - More hours: Providing more than 2 hours of support for a site.
    - Bank of hours:Creating a bank of hours from non-responsive cases.
    - Other creative solutions: Other solutions that allow them to adjust the on call model.
- Agency Support: Mention of the supports provided by the agency during the implementation of On Call (e.g., meeting, calling sites, etc.)
    - On Call Training: Mention of receiving or the need for On Call training

Layer Two - Threads of Consultation (coded if the element is mentioned in a positive way or a negative way)

Elements of the Consultative Stance

"Mutuality of endeavor": This primary code is used when there is mention of the consultee's ability to contribute to and participate in the process.

- "Positive Mention Mutuality": Consultant/Consultee WAS able to embody/do Mutuality of endeavor
- "Negative Mention Mutuality": Consultant/Consultee WAS NOT able to embody/do Mutuality of endeavor

"Avoiding the position of sole expert": This primary code is used when there is mention of On Call consultation being/not being a collective effort between consultant, providers, and parent; in On Call consultation valuing/not valuing the expertise of others equal to the consultant.

- "Positive Mention Sole Expert": Consultant/Consultee WAS able to avoid the position of sole expert.
- "Negative Mention Sole Expert": Consultant/Consultee WAS NOT able to avoid the position of sole expert.

"Wondering instead of knowing": This primary code is used when there is mention of On Call consultation eliciting/not eliciting the involvement of the consultee in the process and properly preserving the sense of the consultee as the holder of the essential information and knowledge as the agent of change.

- "Positive Mention Wondering": Consultant/Consultee WAS able to embody wondering instead of knowing.
- "Negative Mention Wondering": Consultant/Consultee WAS NOT able to embody wondering instead of knowing.

"Understanding another's subjective experience": This primary code is used when there is mention of On Call consultation allowing/not allowing the consultant to introduce the importance of "not knowing" by demonstrating curiosity about internal experience of the other.

- "Positive Mention Subjective": Consultant/Consultee WAS able to embody understanding another's subjective experience.
- "Negative Mention Subjective": Consultant/Consultee WAS NOT able to embody understanding another's subjective experience.

"Considering all levels of influence": This primary code is used when there is mention of On Call consultation being influenced/not influenced by: the personal histories of caregivers and the other numerous influences on their views of a child and on their ability to respond effectively.

- "Positive Mention Influence": Consultant/Consultee WAS able to embody considering all levels of influence.
- "Negative Mention Influence": Consultant/Consultee WAS NOT able to embody considering all levels of influence.

"Hearing and representing all voices": This primary code is used when there is mention of On Call consultation eliciting/not eliciting the voices of everyone involved, the consultant is dedicated to hearing about and from each individual.

- "Positive Mention Voices": Consultant/Consultee WAS able to embody hearing/representing all voices.
- "Negative Mention Voices": Consultant/Consultee WAS NOT able to embody hearing/representing all voices.

"The centrality of relationships": This primary code is used when there is mention of On Call consultation being promoted/not promoted through interactions between child and caregivers, the centrality of relationships underlies all beliefs about ECMHC.

- "Positive Mention Centrality": Consultant/Consultee WAS able to embody the centrality of relationships
- "Negative Mention Centrality": Consultant/Consultee WAS NOT able to embody the centrality of relationships

"Parallel process": This primary code is used when there is mention of On Call consultation centering/not centering the consultant's way of being emanates from their conviction that the ways in which people are treated affect how they will feel about themselves and treat other people.

- "Positive Mention Parallel": Consultant/Consultee WAS able to embody parallel process.
- "Negative Mention Parallel": Consultant/Consultee WAS NOT able to embody parallel process.

"Patience": This primary code is used when there is mention of On Call consultation fostering/not fostering patience in caregivers' relationships with children and consultants with the caregivers and family.

- "Positive Mention Patience": Consultant/Consultee WAS able to embody patience.
- "Negative Mention Patience": Consultant/Consultee WAS NOT able to embody patience.

"Holding hope": This primary code is used when there is mention of On Call consultation being hopeful/not hopeful despite daily crises and persistent challenges; Maintaining a belief in change in a slowly shifting system.

- "Positive Mention Hope": Consultant/Consultee WAS able to embody holding hope.
- "Negative Mention Hope": Consultant/Consultee WAS NOT able to embody holding hope.

Threads of Consultation

Capacity Building: The mention of IECMHC delivering indirect supports or supports that work to build internal capacity.

- "Positive Mention Capacity Building": Consultation supported capacity building
- "Negative Mention Capacity Building": Consultation DID NOT support capacity building.

Collaborative: The mention of IECMHC as a collaborative process between the consultee and the consultant.

- "Positive Mention Collaborative": Consultation supported a collaborative process.
- "Negative Mention Collaborative": Consultation WAS NOT a collaborative process.

Relationship-Based: The mention of IECMHC being relationship-based.

- "Positive Mention Relationship-Based": Consultation was relation-ship based.
- "Negative Mention Relationship-Based": Consultation WAS NOT relation-ship based.

Individualized: The mention that IECMHC is individualized to each consultee.

- "Positive Mention Individualized": Consultation was individualized.
- "Positive Mention Individualized": Consultation WAS NOT individualized.

Family-Centered: The mention that IECMHC is family-centered.

- "Positive Mention Family-Centered": Consultation was family-centered.
- "Positive Mention Family-Centered": Consultation WAS NOT family-centered.

Culturally/Linguistically: The mention that IECMHC is delivered with cultural and linguistic competence.

- "Positive Mention Cultural/Linguistic": Consultation WAS culturally/linguistically competent.
- "Positive Mention Cultural/Linguistic": Consultation WAS NOT culturally/linguistically competent.

Strength-based: The mention that IECMHC is strength-based.

- "Positive Mention Strengths-Based": Consultation WAS strengths-based.
- "Positive Mention Strengths-Based": Consultation WAS NOT strengths-based.

Reflective: The mention that IECMHC is reflective.

- "Positive Mention Reflective": Consultation WAS reflective.
- "Positive Mention Reflective": Consultation WAS NOT reflective.

Promotion-Intervention: The mention that IECMHC spans the continuum from promotion through intervention.

- "Positive Mention Promotion-Intervention": Consultation DID span from promotion through intervention.
- "Positive Mention Promotion-Intervention": Consultation DID NOT span from promotion through intervention.

Integrated: The mention that IECMHC is integrated with community services and supports.

- "Positive Mention Integrated": Consultation WAS Integrated.
- "Positive Mention Integrated": Consultation WAS NOT Integrated.

Layer Three - Coding for Culture and Equity Issues

Educator equity practices: Anytime there is mention about practices from teachers and educators about culture/racism/bias toward children. How is culture/racism/bias playing out in centers? What are children experiencing?

Culture/Equity conversations among adults: At what level are these conversations happening? Among:

- Family & Consultee (teacher and/or director)
- Consultant & Consultee(teacher and/or director)
- Co-workers: Teacher & Teacher
- Organizational: Teacher & Director

Equity: On Call being an equitable solution to the shortage of MHC/funding

Bias: Any mention of bias

Systemic Racism: Any mention of systemic racism

Oppression: Any mention of oppression

Appendix B
Feedback Codebook

The feedback codebook was created using an inductive approach, meaning the codes were created based on themes that existed in the data.

Challenge: The mention of a challenge of consultation

Cohesion: The mention of cohesion between MHC Agencies/Staff

Consultant Characteristic/ Thread of consultation

- Balancing Expert (Avoiding the position of expert but helping)
- Maintaining curiosity
- Extensive experience providing consultation services
- Language/culture match to center/consultee and knowledge of their culture
- Meet consultee without judgment
- Objective in-person presence at the center

Consultee Characteristics

- Being open/ready for consultation/knowing what it is
- Knowing what consultation is
- Leading/directing consultation

Negative Attitude about SF Mental Health Consultation

Perceived objective of consultation

- Capacity building/empowerment
- Empathy
- knowledge development
- Manage external stressors
- Org/structure changes

- Other
- Prevention/behavioral intervention
- Relationship development
- Resources

Positive Attitude about SF Mental Health Consultation

Recommendations for improvement

- Expand ECMHCI
- More consultants, lower caseloads
- More in-person at the centers
- Renew focus on cultural competence

Secret Sauce: The mention of the secret sauce of consultation

Success: The mention of a success story of consultation (when consultation worked)

Integrated: The mention of integrated Consultation (consultation happening at multiple levels of the center)

Timeline: The mention of the timeline of consultation(the long arc)

Turnover: The mention of turnover at the teacher, director, consultant level

Unique: The mention of the uniqueness of SF model

- Cultural/Community Based
- Longevity of relationships

Appendix C

Supplementary Quotes

This appendix provides additional quotes that we found relevant to our findings. This appendix is organized utilizing the outline of the main document.

Findings

Phase 1: What is the On-Call approach of mental health consultation?

Who provides On-Call services?

Why was the On-Call approach needed?

> ***"The funder didn't have enough money and that is why they created On-Call. I mean, to be completely honest, there is only so much budget and there are so many sites that need to be served. But, you know, the hours/pay is being raised and they still having the same budget. They don't really know how to satisfy everyone, but they couldn't also get more budget. So they just put some sites to be On-Call sites to seems like something working but it isn't working."***

How was On-Call perceived by San Francisco's ECHMC community?

> ***"[On-Call was] presented as like a crisis-based intervention that had a limited amount of time a week. We were only there for like crises or even just for backup"***

> ***"Some of them had a crisis and called us, some of them never had crises, some of them we checked-in constantly and some of them didn't ever respond."***

How is On-Call implemented?

On-Call Designation

> ***"From the preschool perspective it was almost like if you got a high score on the QRIS then you are On-Call. I guess it is just to have someone there just in case? These sites seem like they are doing well. They have the capacities to a certain extent but you can still have this person, I mean I don't know."***

> ***"My perception was that there was a structural or funding change. The "need" or "neediness" of the site, I can't remember the parameters, but the site I was at used me intensely for 12 hours a week or more and then they became On-Call. This means that I had to restrict my access to them for 1 or 2 hours. Luckily Covid happened and I was available much more. My perception was that these programs are high-functioning and doing well on metrics and they don't need the continued presence of a consultant in the same way."***

Rollout

> ***"So, we were notified of the redesign in January 2019. Then, we got the list of the sites and literally they only gave us the names of the sites. No contact information or anything. So I have to look it up on Yelp to see the address and phone number. To look at the reviews to look and see what the parents are and the community says about that site. Then we made a list of the contacts for the sites and then I called all of them. I think I started calling around like March or April of 2020 and then most of them went to voicemail. There were 5 of them that picked up the call. Then I mentioned to them that our agency was assigned to them and they would be like, "What? I don't know what you are talking about." So, I told the supervisor at that time to let***

them know that no one knows that they were even assigned. They don't even know that they have the service of ECMHC."

Implementation

"...I'm going to redistribute [the total On-Call hours] to those four where we used to be. We used to be with those sites 8 or more hours [per week]. They were really high needs sites with immigrant families. So we really pushed back and they were in agreement with us….I had been around long enough that I leaned into my history to do that."

Burnout & Guilt

"Like when she starts talking about the students, and I feel sometimes it is not enough time to actually circle back to how could we support this family and a lot of the times the children in the classroom have older siblings that are in the elementary school, so sometimes I can check in with the family because I'm already working with their other child in the elementary school. So that is how I've been creative in how I can circle back to the parents. The follow up between the parent and the pre-k teacher is what is hard. That is really hard to do."

"The site says if we only have two hours that they will just figure it out themselves. It is hard because I can't do anything about the hours. Again, it's the relationship, right? This consultant did this for me before, can you do that? I can't."

Covid Complications

"Well essentially we had two transitions. First our hours were kind of cut down because we shifted tiers, and it felt like our consultant was coming less into the classrooms. It was more on a case by case basis. It felt a little different because she wasn't really seeing what was happening in the classrooms anymore, which you know, I mean it placed a great problem in terms of being able to provide consultation to begin with. So that part was a little challenging. Then the next transition was when we changed consultants and that happened in April 2020, the beginning, the middle, the onset of the pandemic."

How is On-Call different from the traditional ECMHC model?

"We are trained how to harness the relationship and sit upon it and stepping in without knowing the culture or having a relationship and the expectation of having an hour and a half to work and provide this service AND assessment at the same time, right? So along the lines of building relationships, it being new and for us having the most amount of On-Call sites, to be responsible for reaching out and connecting with those sites at the same time, who may or may not know what ECMHC is."

"We feel strongly that On-Call is a different service. I have worked with systems that have had On-Call model so I just myself differentiate in my brain in what we have done at this agency is build off the relationships and community connections and our reputation to scaffold enough to hold enough you know? We say, things are good enough but they are not sufficient."

Quantitative Exploration of On-Call as Distinct from Consultation

Time for On-Call versus the Traditional Approach

Effectiveness of On-Call versus the Traditional Model

How effective is the On-Call approach to ECMHC?

"We have a very good consultant. She actually extended her consultation with our families that we referred to her. So. I couldn't ask anything more from the services that she has given my classroom. So we're pretty much happy with it, with the services that we received from her."

Limitations of On-Call Consultation

"There were a few parents that wanted specific or direct services from our mental consultant but unfortunately she was not able to provide them. She was only able to provide the surface of resources to these parents and that's where the conflict is. We need more help but we can't have it because of the limited hours." -Director group

How can the On-Call approach be more effectively employed?

"I think it is important for the sites to offer their own ideas for what their need is. That their experience is included in the process of determining their need. And that the designation could shift. There is such a dynamic, so many things can happen. The way it is set up there is a presumption that once a program has arrived at self-sufficiency then they stay that way. This is not reality. There is a lot of turnover and Covid. No one knows how to do this. I think it is so important for the programs to have a say in how they are categorized and speak to their level of need and that there is flexibility with their categorization. That it can change, there is interest in knowing how much turnover and stressors are presenting at this program, what kinds of structures are and aren't in place, what resources have shifted, I hope all that can be incorporated and consultants can get that flexibility."

Summary of Findings from Phase 1 Evaluation: On-Call Approach

Phase II: How Does the SF Community Experience ECMHC? Reflections on Relationships, Impacts and Barriers

What is the "secret sauce" of mental health consultation?

Developing Long-Term Relationships

What is the impact of IECMHC?

Fostering Relationship Development - The magic [of consultation] happens when we can pull a group of teachers within a classroom, to come together, to learn from one another and reflect on what we think is happening and create this sense of belonging and we are in this fight together."-Consultant

Providing knowledge about children's development, culture and wellbeing. "When I started [working at my site as a teacher] it was all typically children… then to a full inclusion program. There were children with challenging behaviors that I didn't understand… I had to learn how to work through this, with these children, find ways to give them hands on experiences that could alleviate whatever they were trying to communicate… before [the consultants] came on board, i noticed a lot of teacher burnt out…Teachers weren't prepared, there weren't any experts on board… In the years I've been with the MHCs, I find it is really, really crucial."-Consultee

"[The consultants] have been good partners, [they share] their perspective and what they observe. We compare and share and then really work on it."-Consultee

Providing information on and modeling techniques around behavioral intervention and prevention for children and families.***"The beautiful thing about the consultants is they offer trainings to families. We have exercise work in the park with all the parents and it was divine… we felt like we were free. It was so nice to see how the parents connected with the children, connected to other parents and felt like a normal environment."-Consultee***

Managing external stressors. ***"[The consultant] would come consult me to come calm down to go through the difficult times. So I really like enjoy and love to have the mental health consultant to work together." -Consultee***

"About a year ago, one of our colleagues Ashley was sick and passed away. Our work dynamic was down, I was very sad, at that time, in fact, I did contact Mental Health Consultant to help us to debrief, distress , or just a discussion on this passing coworker."-Consultee

Providing/ facilitating resources:

"I followed [the consultant's] direction for the resources and the solution came out bigger picture and was a better change to the family."-Consultee

"So if I had doubts on how I was leading, or the resources that I had, I would speak with [the consultant] so I really felt like she was up here for me and they were actually filling a gap that we didn't have capacity to."-Consultee

Fostering organizational and structural changes. *"[Structural changes] it's also the change paperwork, taking into account so many other situations that are really important for the family, cultural background, history of trauma….And I think that [through the] partnership, things change or start to shift, for example, now they call it child support plans instead of, you know, other things that we had before, and also incorporating the wellness activities in their pre services. And ask us to one time, we did a workshop on implicit bias. So we we gave a lot of examples and even dramatize, you know, they were really engaged with that. So I think in that level, the administration needs to really be aware of what consultation is and what it can provide. And that is a phenomenon that is created collectively, right?"-Consultant*

"[The consultant] will do a check in with me each time, then will ask me about the classroom or school situation, about children and parents and also teachers. [The consultant] will give out a lot of advice, check in individually, then they would engage conversations. If they could disclose, they would share with me, and I would also try to adapt teachers and families need in order to change my program"-Consultee

Fostering empathy. *"The empathy that the consultants have with the family; Because you have to remember that all families are different and each has its own difficulties. So I think that's a very important part of empathy. And being able to help the family in different ways, different strategies, giving suggestions."-Consultee*

"To be candid, I've always been challenged with the workforce. And I know my mental health consultant has been phenomenal and helping me show my love through"-Consultee

Impacts of ECMHC Across Time

What changes over time? Perspectives from consultees

What role does race, language, and cultural responsivity play in the initiative?

How could ECMHC in San Francisco be Improved?

"[The consultant] left because something on the top changed, so they had to [leave]. I was just like [mimes crying], you know!? - Consultee

"We had a lot of consultants… One, two, like four. [names the consultants]..So around 5 or 6, around there. They have all been great." - Consultee

More hours with their ECMH Consultant

Turnover is tough!

Recommendations for Improvements

Summary of Findings from Phase 2: Feedback for the Traditional Approach

Appendix D

On-Call Focus Groups: Positive and Negative mentions of the 10 Elements of the Consultative Stance and the 11 Threads of Consultation

Consultative Stance	62	Threads of Consultation	79
Avoiding the position of sole expert	10	Collaborative	43
Negative Avoiding the Position of the sole expert	7	Negative Collaborative	23
Positive Avoiding the Position of the Sole Expert	0	Positive Collaborative	20
Capacity Building	**17**	Culturally/Linguistically Competent	2
Negative	11	Negative Cultural/Linguistic	1
Positive	6	Positive Cultural/Linguistic	1
Considering all levels of influence	2	Family-Centered	12
Negative Considering All levels of influence	2	Negative Family-Centered	5
Positive Considering All levels of influence	0	Positive Family Centered	7
Hearing and representing all voices	1	Individualized	7
Negative hearing all voices	1	Negative Individualized	0
Positive hearing all voices	0	Positive Individualized	7
Holding hope	0	Integrated	2
Negative Holding Hope	0	Negative Integrated	2
Positive Holding Hope	0	Positive Integrated	0
Mutuality of Endeavor	35	Promotion-Intervention	2

Negative Mutuality of Endeavor	26
Positive Mutuality of Endeavor	9
Parallel process	0
Negative parallel process	0
Positive Parallel process	0
Patience	1
Negative patience	1
Positive patience	0
The centrality of relationships	11
Negative centrality of relationship	8
Positive centrality of relationship	1
Understanding another's subjective experience	4
Negative Understanding another's experience	3
Positive Understanding another's experience	0
Wondering instead of knowing	1
Negative wondering instead of knowing	0
Positive wondering instead of knowing	0
Negative Mention Promotion-Intervention	2
Positive Mention Promotion-Intervention	0
Reflective	5
Negative reflective	4
Positive reflective	1
Relationship-Based	48
Negative Relationship-based	30
Positive Relationship-based	13
Strength-based	3
Negative Strengths Based	1
Positive Strengths Based	1

Appendix E

Consultant's Timeline of Consultation

This appendix provides the full timeline of consultation created by each agency (note: IPP did not submit a timeline for inclusion). Together with their consultees, agency directors indicated the types of activities, strategies, and changes that are present in the first six months of consultation, between six months and one year of consultation, between one year and two years of consultation, and after 3 years of consultation.

0 to 6 months of consultation

- ***Building relational trust at Teacher, Classroom, Child, Family levels. Consultant's role is to primarily listen, learn, and observe relationships within the consultation environment.***
- ***Clarify role at the site to staff, families, and children and maintain consistent schedule and routine for predictability.***
- ***Consultant gains understanding of processes & procedures at the site (i.e. referrals); Working relationships between MHCs and site staff begin to develop and the role of MHCs in relationship to the site's care team onsite develops.***
- ***Site agreements are reviewed with leadership to reflect on initial assessment of site strengths, needs, culture. Co-create partnership plan and establish goals for consultation services.***
- ***Relationships are slowly developed with teachers. As relationships deepen, teachers are more open to learning about consultation services, and become more open about their challenges. Working with the consultant, teacher slowly develops confidence to approach more sensitive subjects.***
- ***Consultee begins understanding MHC role at the Teacher, Classroom, Site, Child, and Family levels.***
- ***Consultant introduces self and interacts with families such as at site meetings or briefly during pickup/drop-off and provides notice of services through parent letter.***
- ***Consultation themes begin to take shape, related to understanding the meaning of child behaviors in classroom, teacher wellbeing/work-related stressors, & family case management needs.***
- ***Consultation regarding focal children emerges, with strategies that are implemented collaboratively with teachers and families.***
- ***MHCs initiate and facilitate conversations about mental health/wellness.***
- ***Children begin to open up and allow MHC to play with them, become familiar with them.***
- ***Teachers initiate contact with MHC with any updates, needs, and/or concerns.***
- ***Some parents recognize MHC when they see them on site and recognize the MHC as a part of the site.***

6 to 12 months of consultation

- ***Continuous collaboration on assessing site needs and understanding of what consultation services are/are not (prioritizing systems and prevention, rather than direct intervention)***

- ***Building relational trust and understanding of MHC role at the site level. Increased consultation to site lead and other helpers to align efforts and understanding (i.e., working with other Mental Health providers, coaches, Help Me Grow, etc.).***
- ***Site needs identified. Focus on capacity building and apply consultation services strategically.***
- ***Building reflective practice and curious stance with staff either through individual or group consultation.***
- ***Teachers/staff may begin disclosing personal stressors and/or may be more open about challenges impacting their work.***
- ***MHC learns the dynamics and culture of each classroom through collaboration with teacher.***
- ***MHC models intentional interventions in classroom setting.***
- ***Teachers begin implementing strategies learned from consultation***
- ***Trusting working relationships with families are deepening, as well as understanding of community and cultural needs (It is also ideal to be able to see some changes within a year as their children will be staying in the school for 1-2years only).***
- ***Parents start to approach MHC for direct services or referrals.***
- ***Parent workshop topics and goals established in collaboration with site; Parents come to the workshops and ask questions.***
- ***MHC holds more historical context for teachers, classroom and family level. MHC can track progress or difficulties a focal child/family is having and provide perspective for the site. (helps to instill hope and recognize developmental progress)***
- ***Consultation themes emerge related to understanding the family experience, holding cultural, trauma, relational lens to supporting family mental health integrated to consultation.***

1 to 2 years of consultation

- ***A routine has been established for delivering MHC services, with an increase in comfort, trust, and confidence in the relationship between consultant and site; Greater integration of consultant role into the larger program level.***
- ***While increased site capacity is building, sites reach out more readily consult when there is a crisis or concern surfacing.***
- ***Supporting and holding Mental Health and Wellbeing across ALL Levels including deepening relationships and connections to consultees' personal lives.***
- ***Staff begin to internalize MHC reflections and begin to ask deeper questions about the meaning of behavior and family context.***
- ***Teachers' motivation to learn, confidence, and awareness as professionals starts to increase.***
- ***Teachers have a number of strategies to support children's emotional learning.***
- ***A relationship based on trust is evident as more teachers are bringing issues and needing support.***
- ***As trust is established with teachers, deeper and more challenging conversations can start happening within the safety of the relationship. It is possible for consultation to include***

conversations about teacher wellness, mental health, implicit bias, personal triggers, cultural competence, site dynamics, and not just focus on children's individual needs.

- ***Center staff and families increasingly more receptive to consultant leading trauma-informed, equity-focused, restorative justice practices and thought processes; Themes related to staff transitions, grief/loss & healing become more common.***
- ***Consultant develops relationships with other staff including Family Support Specialist, Social-Emotional Specialist, etc.***
- ***Increased coordination & alignment of efforts across all helpers.***
- ***Widening focus from the individual child to include families as relationships with them develop and deepen.***
- ***Parents begin to implement strategies they learned from consultation***
- ***Preschool-aged children can name their emotions and can utilize a few strategies to self-regulate.***
- ***Increase in direct work with children and families.***

3 years of consultation and beyond

- ***Sites gain deep understanding of consultation: the first step is capacity building of adults before requesting individual services for the child or before requesting referral for external therapy***
- ***Holding historical context for Site Directors and System Level***
- ***Increasing collaborative work with systems (eg school district, local agencies, etc).***
- ***Increased participation in holding a system-wide mental health goal, plan, vision, etc. with the leadership team.***
- ***Naming systemic gaps and areas of growth to further strengthen relationships – new and old.***
- ***Issues regarding implicit bias and racial inequities are easier to address with the institutional trust and deeper level of partnership.***
- ***The institutional transference is more established – therefore, if there is a change in a MHC, sites can adjust and embrace a new consultant and the work can continue where the last MHC left off. (If the fit with a former MHC wasn't good – then a repair needs to happen and be addressed)***
- ***ECE Systems of care incorporate MHCs into pre-service trainings and may consult on more system-wide issues regarding protocols, child support, teacher wellness, and family engagement.***
- ***Achieved goal of capacity building for mental health service. Site is able to articulate mental health needs and come up with strategies, facilitate conservations about mental health/wellness, and use MHCs strategically to enhance and support.***
- ***Site has developed a strong mental health framework around how to support social emotional needs of children and has developed strong equitable practices to reduce disparities in communities of color.***
- ***Teachers may occasionally have questions but generally comfortable with their own skills.***

- ***Continue increase teachers' awareness as a professional, recognizing where the personal is bleeding into the professional.***
- ***Increasing the knowledge of developmental disabilities and challenging behaviors and how teachers can support the child (eg, what they can do in the classroom and with parents and when to reach out to MHC or make referral, SST, EI).***
- ***Patterns related to relational dynamics, triggers, and trauma responses become more apparent and easier to name with long-term relationships across all relationships across all levels.***
- ***Parents can begin to look at behavioral issues through the lens of mental health needs.***
- ***Strong parallel process of positive outcomes on the child and family level.***
- ***MHCs focus mental health services at the individual level-staff/families/children***

Appendix F

ECMHI Dashboard 2021-2022

(Early Childhood Mental Health Consultation Initiative)

San Francisco Department of Early Childhood

EXECUTIVE SUMMARY

In FY 2021-22,

- 12,332 care providers, children, and parents/caregivers were served at 227 sites through the ECMHCI by 46 consultants.
- 41,638 total hours of services were delievered.
- 91% of early intervention charts and 83% of mental health charts were closed with goals met or partially met.
- 21 developmental screenings were directly administered and 82 screenings were supported.
- 180 referrals/linkages were made to services.
- 145 parent/caregiver support groups, 198 parent/caregiver workshops and training, and 138 care provider workshops and training were provided.

Agencies
Homeless Children's Network (HCN)
Instituto Familiar de la Raza (IFR)
RAMS/Fu Yau Project (RAMS)
UCSF Infant-Parent Program (IPP)

Number of Sites Served

Family Resource Centers	FCCQN Licensed Family Child Care Home	Homeless and Domestic Violence Shelters	Licensed Early Care and Education Centers	SFUSD	SUD Treatment Programs	Grand Total
25	61	9	115	10	7	227

Number of Participants

	Licensed Early Care and Education Centers	Family Resource Centers	Homeless and Domestic Violence Shelters	FCCQN Licensed Family Child Care Home	SUD Treatment Programs	SFUSD	Grand Total
Care Providers	1,096	187	93	126	39	75	1,616
Children	3,535	2,235	268	79	34	160	6,311
Parents/Caregivers	1,344	2,835	110	44	42	30	4,405
Grand Total	5,975	5,257	471	249	115	265	12,332

Hours of Services Delievered

Mental Health Consultation	Early Intervention Services	Mental Health Treatment Services	Systems Work	Grand Total
31,711	474	62	9,390	41,638

Early Intervention & Mental Health Treatment Charts

	Charts Opened	Charts Goals Met	Charts Goals Partially Met	Charts Goals Not Met
Early Intervention Services	57	15	36	5
Mental Health Treatment Services	6	3	2	1
Grand Total	63	18	38	6

Other Service Details

# of Referrals and Linkages to Services	# of Developmental Screenings Directly Administered	# of Developmental Screenings Supported	# of Parent/Caregiver Support Groups	# of Parent/Caregiver Workshops and Training	# of Care Provider Workshops and Training
180	21	82	145	198	138

ECMHI Dashboard 2021-2022

(Early Childhood Mental Health Consultation Initiative)

San Francisco Department of Early Childhood

SUMMARY STATISTICS BY AGENCY

Number of Sites Served, by Agency

Agency	Family Resource Centers	FCCQN Licensed Family Child Care Home	Homeless and Domestic Violence Shelters	Licensed Early Care and Education Centers	SUD Treatment Programs	SFUSD	Grand Total
HCN	4	20	3	6	4	10	47
IFR	4	26	0	30	0	0	60
RAMS	9	10	0	55	0	0	74
IPP	8	5	6	24	3	0	46
Grand Total	25	61	9	115	7	10	227

Number of Participants, by Agency

	Licensed Early Care and Education Centers	Family Resource Centers	Homeless and Domestic Violence Shelters	FCCQN Licensed Family Child Care Home	SUD Treatment Programs	SFUSD	Grand Total
HCN	218	41	136	28	76	265	764
IFR	1,393	134	0	72	0	0	1,599
RAMS	2,817	201	0	99	0	0	3,117
IPP	1,547	4,881	335	50	39	0	6,852
Grand Total	5,975	5,257	471	249	115	265	12,332

Hours of Services Delievered, by Agency

Agency	Mental Health Consultation	Early Intervention Services	Mental Health Treatment Services	Systems Work	Grand Total
HCN	7,610.5	13	0	2,280	9,903.5
IFR	7,867.3	158.4	9	2,299	10,333.7
RAMS	10,364	267.8	0	1,534.2	12,166
IPP	5,869.5	35	53	3,277	9,234.5
Grand Total	31,711.3	474.2	62	9,390.2	41,637.7

Early Intervention & Mental Health Treatment Charts

	Early Intervention Services			Mental Health Treatment Services		
	Charts Opened	Charts Goals Met	Charts Goals Partially Met	Charts Opened	Charts Goals Met	Charts Goals Partially Met
HCN	3	1	1	0	0	0
IFR	25	1	24	4	3	1
RAMS	23	13	8	0	0	0
IPP	6	0	3	2	0	1
Grand Total	57	15	36	6	3	2

Other Service Details, by Agency

	# of Referrals and Linkages to Services	# of Developmental Screenings Directly Administered	# of Developmental Screenings Supported	# of Parent/Caregiver Support Groups	# of Parent/Caregiver Workshops and Training	# of Care Provider Workshops and Training
HCN	16	2	0	34	12	86
IFR	125	6	8	41	55	34
RAMS	18	2	3	66	34	17
IPP	21	11	71	4	97	1
Grand Total	180	21	82	145	198	138

ECMHI Dashboard 2021-2022

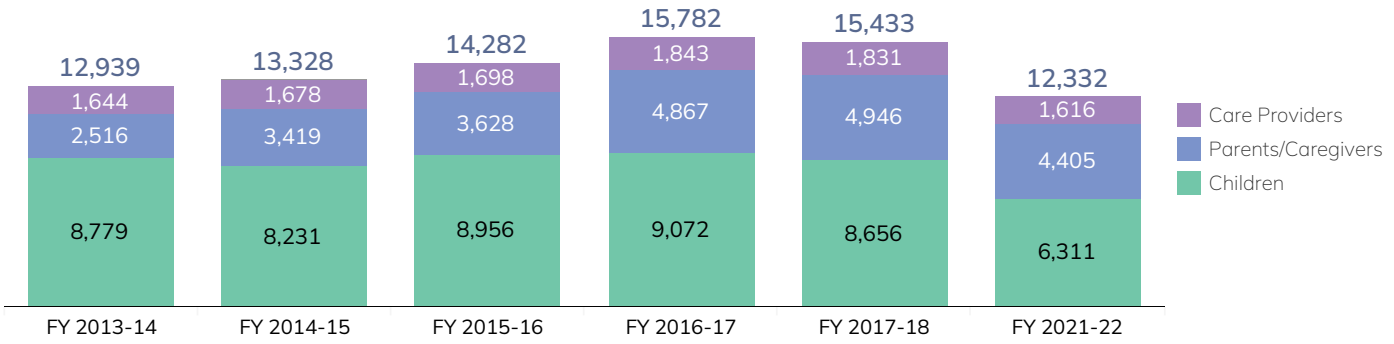
(Early Childhood Mental Health Consultation Initiative)

San Francisco Department of Early Childhood

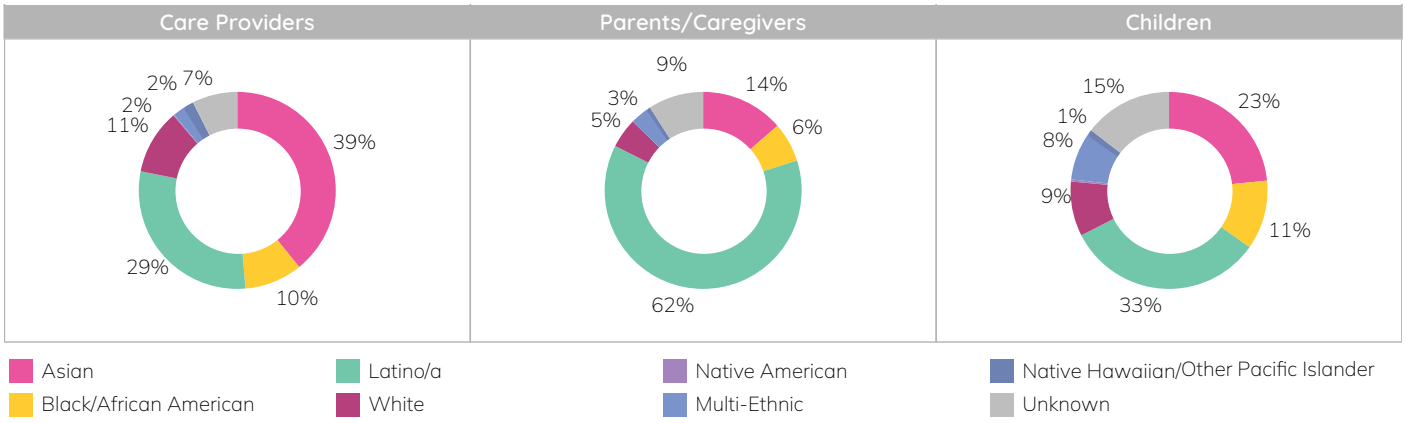
Who We Served

- Out of 12,332 total participants in FY 2021-22, 6,311 (51%) were young children, aged 5 and under; 4,405 (36%) were parents/caregivers; and 1,616 (13%) were care providers.
- The greatest proportion of care providers served were Asian (39%), followed by Latino/a (29%). White (11%), and Black/African American (10%).
- The majority of parents/caregivers served were Latino/a (62%), as were one-third (33%) of the children served.
- English was the primary language for 42% of care providers served, while most (60%) of the parents/caregivers spoke Spanish.
- Among children served, 35% spoke English and 29% spoke Spanish as their primary language.

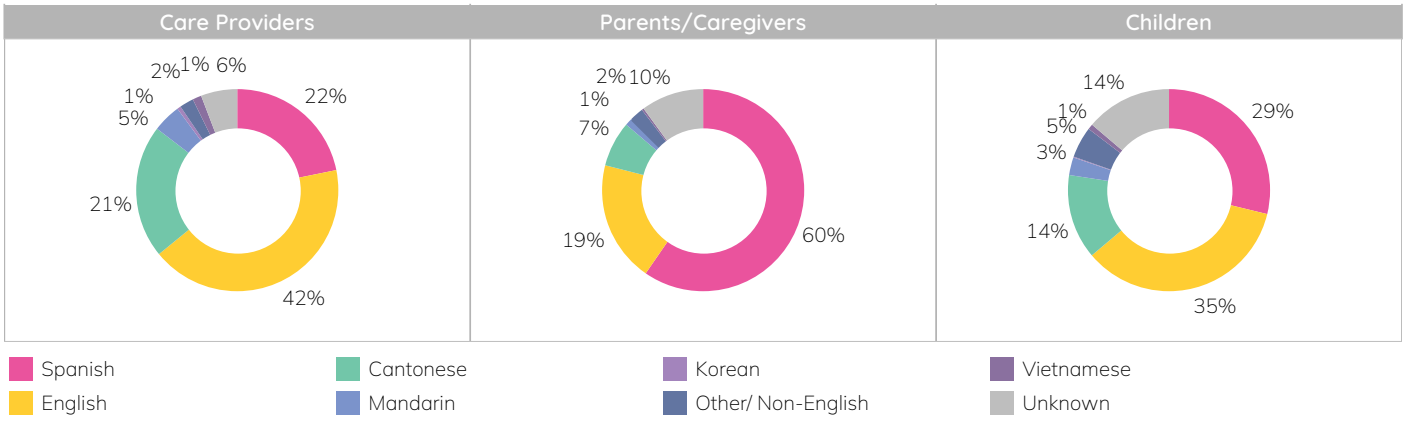
Total Number of Care Providers, Parents/Caregivers, and Children, Served by ECMHCI, FY 2013-14 through FY 2021-22



Participant Race/Ethnicity



Participant Primary Language



ECMHI Dashboard 2021-2022

(Early Childhood Mental Health Consultation Initiative)

San Francisco Department of Early Childhood

Who We Served, by Agency

- Each agency served different types of sites. For example, out of 47 sites that HCN served, 20 were FCCQN and 10 were SFUSD sites. Out of 74 sites that RAMS served, 55 were ECE centers. IFR served mostly ECE and FCCQN sites.
- Both HCN and IPP served participants through Homeless and Domestic Violence Shelters and SUD Treatment Programs.
- IPP served 6,852 participants, consisting of 55% of the total ECMHCI participants, primarily through FRCs (71%). RAMS served 3,117 participants (25% of the total ECMHCI participants). IFR served 1,599 participants (13%) and HCN served 764 participants (6%).
- Children comprised 45% to 61% of the participants across agencies.

Number of Sites Served by Agency

	Homeless Children's Network	Instituto Familiar de la Raza	RAMS/Fu Yau Project	UCSF Infant-Parent Program
Licensed Early Care and Education Centers	6	30	55	24
Family Resource Centers	4	4	9	8
FCCQN Licensed Family Child Care Home	20	26	10	5
Homeless and Domestic Violence Shelters	3	0	0	6
SUD Treatment Programs	4	0	0	3
SFUSD	10	0	0	0
Grand Total	47	60	74	46

Number of Participants by Site Type, Agency, and Participant

		Care Providers	Parents/Caregivers	Children	Grand Total
Homeless Children's Network	Licensed Early Care and Education Centers	40	18	160	218
	Family Resource Centers	37	4	0	41
	FCCQN Licensed Family Child Care Home	20	6	2	28
	Homeless and Domestic Violence Shelters	46	70	20	136
	SFUSD	75	30	160	265
	SUD Treatment Programs	31	40	5	76
	Total	249	168	347	764
Instituto Familiar de la Raza	Licensed Early Care and Education Centers	362	301	730	1,393
	Family Resource Centers	36	68	30	134
	FCCQN Licensed Family Child Care Home	30	15	27	72
	Homeless and Domestic Violence Shelters	0	0	0	0
	SFUSD	0	0	0	0
	SUD Treatment Programs	0	0	0	0
	Total	428	384	787	1,599
RAMS/Fu Yau Project	Licensed Early Care and Education Centers	451	559	1,807	2,817
	Family Resource Centers	25	94	82	201
	FCCQN Licensed Family Child Care Home	67	12	20	99
	Homeless and Domestic Violence Shelters	0	0	0	0
	SFUSD	0	0	0	0
	SUD Treatment Programs	0	0	0	0
	Total	543	665	1,909	3,117
UCSF Infant-Parent Program	Licensed Early Care and Education Centers	243	466	838	1,547
	Family Resource Centers	89	2,669	2,123	4,881
	FCCQN Licensed Family Child Care Home	9	11	30	50
	Homeless and Domestic Violence Shelters	47	40	248	335
	SFUSD	0	0	0	0
	SUD Treatment Programs	8	2	29	39
	Total	396	3,188	3,268	6,852

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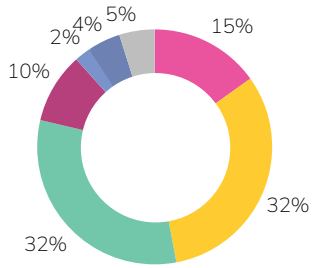
Who We Served (Demographics by Agency)

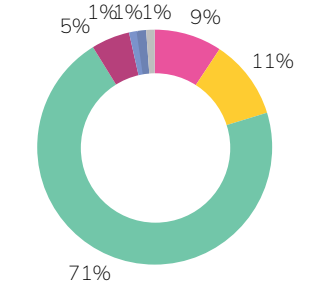
- Race/ethnicity and primary language among participants (care providers, children, and parents/caregivers) varied by agency.
- Among those served by HCN, 32% were Black/African American and 32% were Latino/a and most (61%) spoke English.
- Among those served by IFR, most (71%) were Latino/a and 55% spoke Spanish and 43% spoke English.
- The majority (54%) of those served by RAMS were Asian and Cantonese was the primary language of 40% of the participants.
- Among those served by IPP, 54% were Latino/a and 53% spoke Spanish.

Participant Race/Ethnicity by CBO

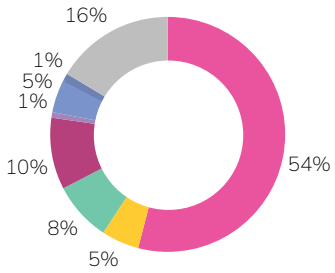
Homeless Children's Network



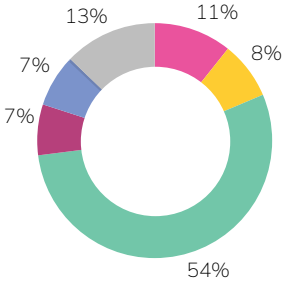
Instituto Familiar de la Raza



RAMS/Fu Yau Project

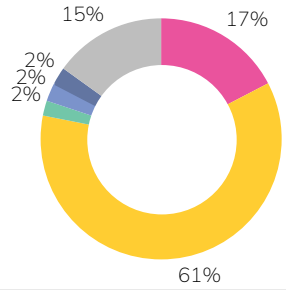


UCSF Infant-Parent Program

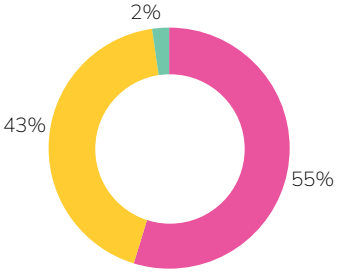


Participant Primary Language by CBO

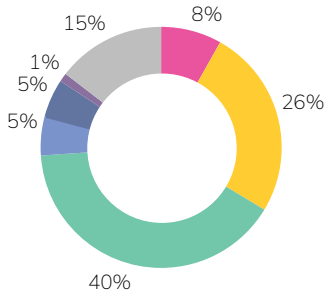
Homeless Children's Network



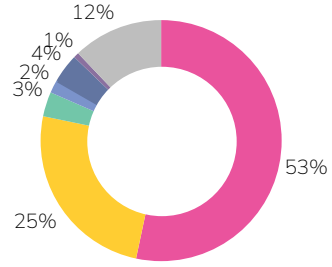
Instituto Familiar de la Raza



RAMS/Fu Yau Project



UCSF Infant-Parent Program



Asian
Black/African American
Latino/a
White
Native American
Multi-Ethnic
Native Hawaiian/Other Pacific Islander
Unknown

Spanish
English
Cantonese
Mandarin
Korean
Other/ Non-English
Vietnamese
Unknown

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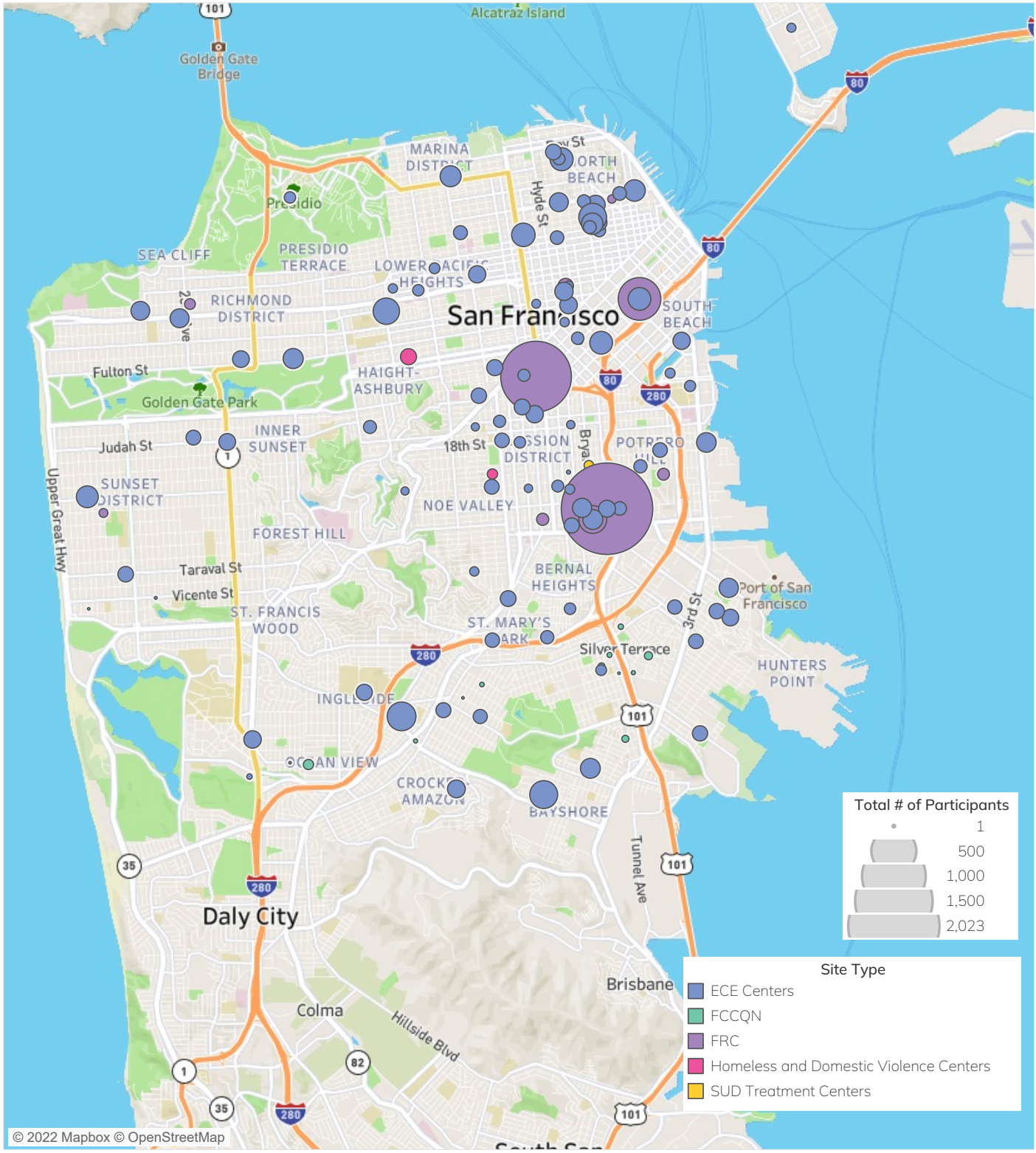
Where We Served



*HCN did not provide the number of participants by site and IFR did not provide addresses of FCCQN sites. Hence, these participants are not represented in the map.

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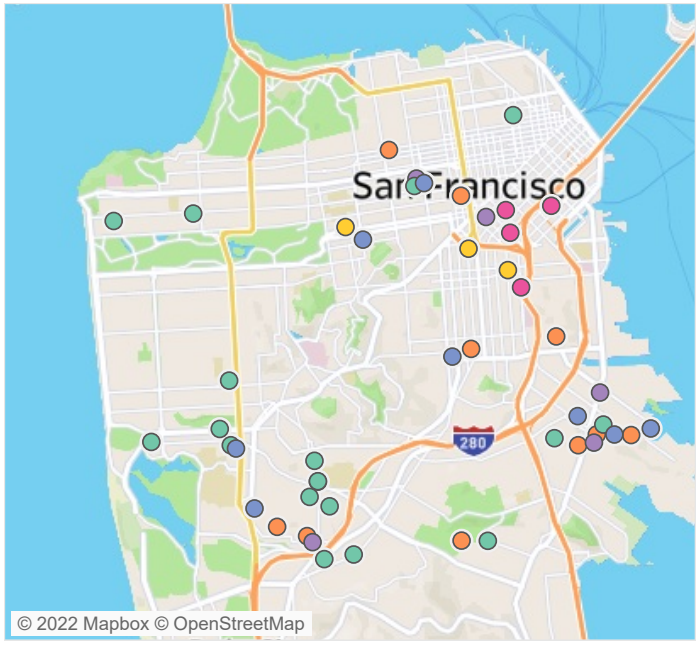
Where We Served, by Agency

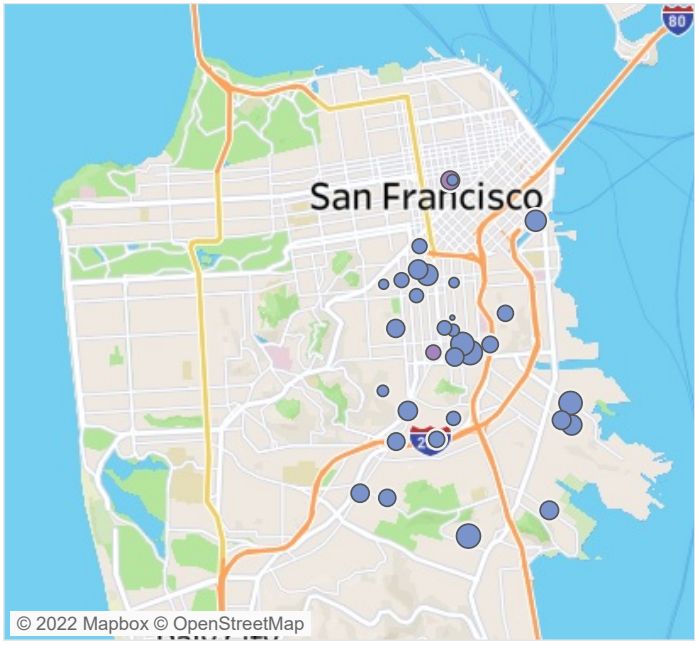
- ECE Centers
- FCCQN
- FRC
- Homeless and Domestic Violence Centers
- SUD Treatment Centers
- SFUSD

Homeless Children's Network



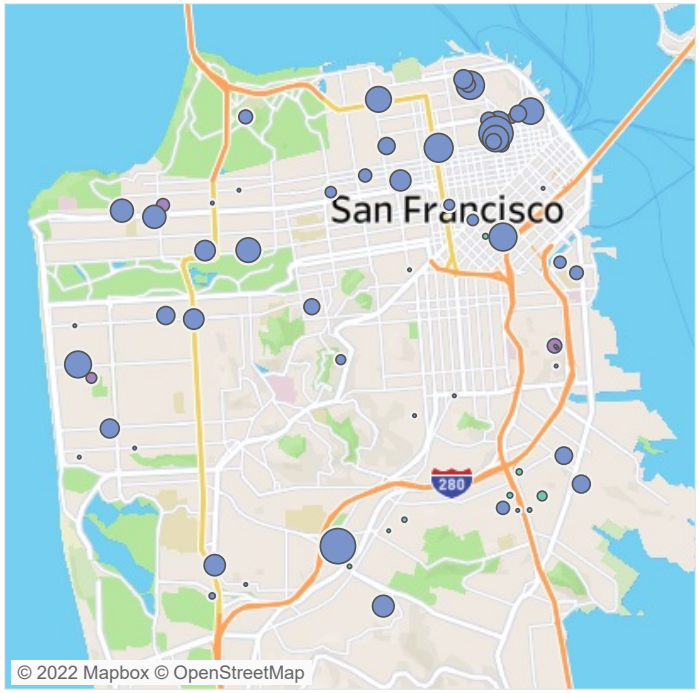
*The size of the circles is not proportional to the number of participants as the number of participants by site was not provided.

Instituto Familiar de la Raza

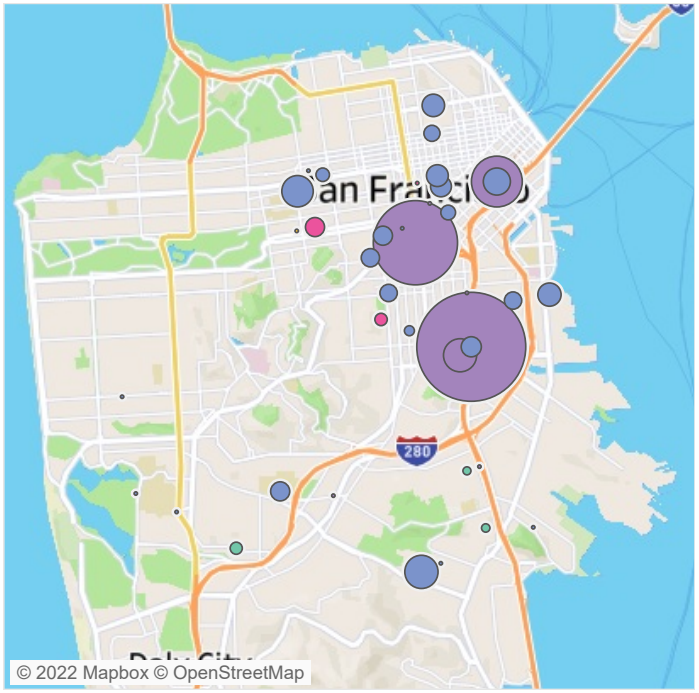


*FCCQN sites are not presented in the map.

RAMS/Fu Yau Project



UCSF Infant-Parent Program



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What We Provided

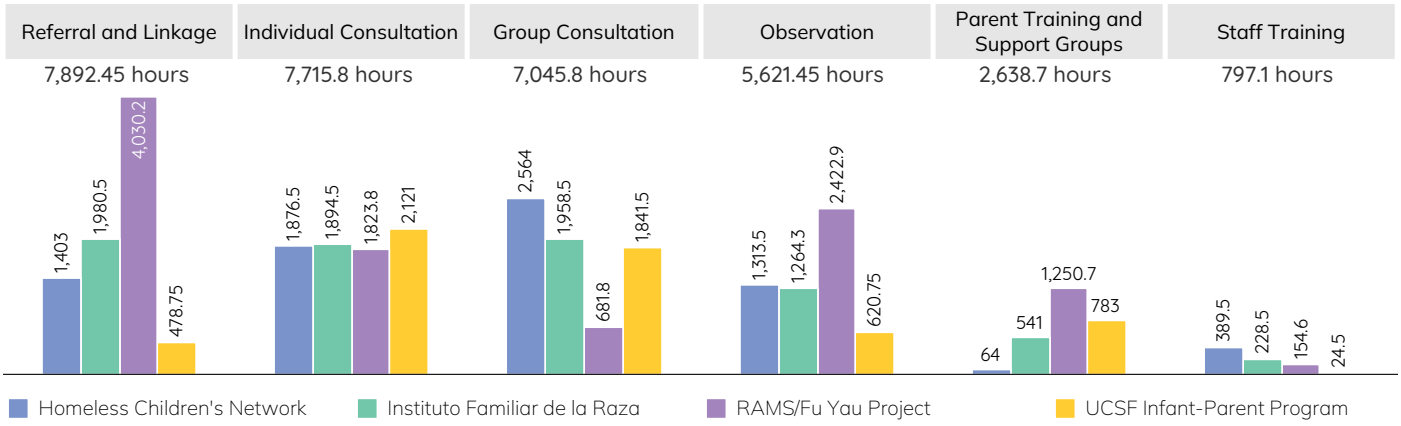
Service Model

The ECMHCI service model provides onsite behavioral health interventions and support services designed to improve child outcomes by enhancing the capacity of care providers, parents, and caregivers to support the social and emotional development of young children. At the core of the service model are trusting, collaborative relationships between mental health consultants and care providers, as well as mental health consultants and parents and caregivers with young children. Consultation services are individualized and can take many forms including prevention-oriented consultation activities and sessions, observations of children and classroom environments, parent training and support, early intervention and mental health treatment, and service linkages for families in need of community services and resources. ECE workforce development services also are offered.

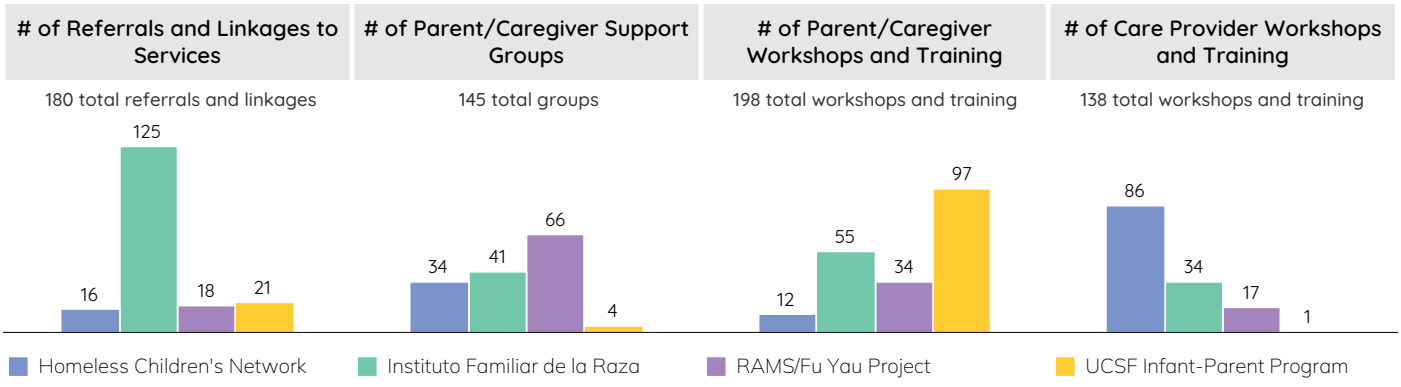
Mental Health Consultation

- Out of the total 31,711 hours of mental health consultation services, 7,892 hours were spent on referrals and linkages; 7,716 hours were spent on individual consultations; 7,046 hours were spent on group consultations; 5,621 hours were spent on observations; 2,639 hours were spent on parent traning and support groups; and 797 hours were spent on staff training.
- RAMS spent 4,030 hours on referrals and linkages and 2,423 hours on observations. HCN spent 2,564 hours on group consultations. All four agencies spent approximately 1,824~2,121 hours on individual consultations.
- Out of the total 180 referrals and linkages, 125 were made at IFR.
- Out of the total 145 parent/caregiver support groups, 66 groups were created at RAMS.
- Out of the total 198 parent/caregiver workshops and training, 97 were held at IPP.
- Out of the total 138 care provider workshops and training, 86 were held at HCN.

Mental Health Consultation Service Hours Delivered



Number of Services Delivered



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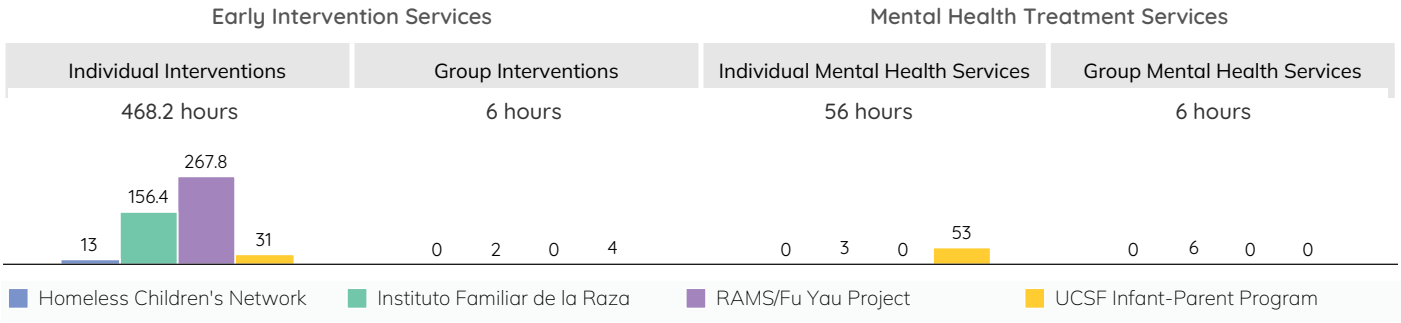
Early Intervention & Mental Health Treatment Services

Early Intervention Services
At times, a child may need direct "early interventions" to compliment the consultation work that is being provided, particularly if that child is at risk of expulsion or removal from his or her program. These early intervention services are not mental health treatment services, but represent targeted support for children with identified concerns based on observations, developmental screenings, and related data.

Mental Health Treatment Services
For young children identified in need of more intensive services, ECMHCI consultants provide planned mental health treatment services when there is no appropriate mental health treatment available offsite and where it is mutually agreed upon that onsite services would be more beneficial. All children provided with onsite treatment services are assessed using the Child and Adolescent Needs and Strengths (CANS) assessment tool. An individualized treatment plan is developed based on CANS findings.

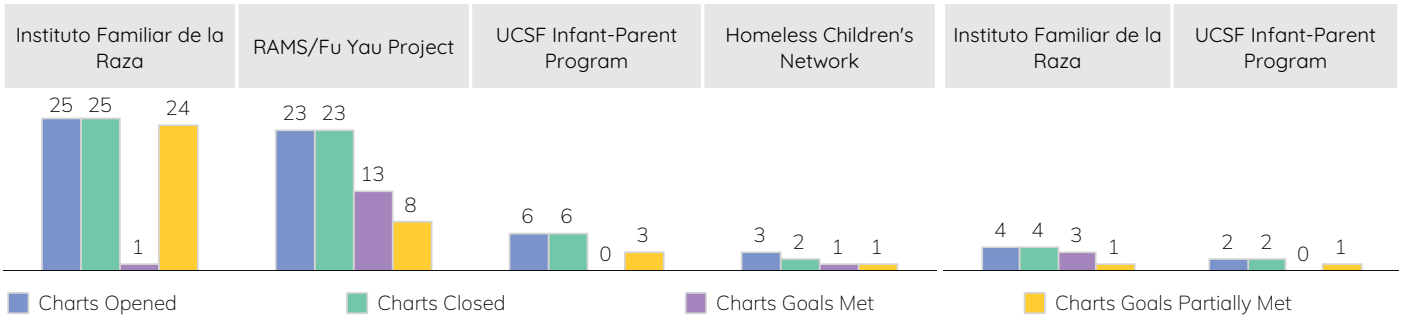
- 468 hours of individual and 6 hours of group early interventions were delivered for Early Intervention Services.
- 56 hours of individual and 6 hours of group mental health services were delivered for Mental Health Treatment Services.
- 57 Early Intervention charts and 6 Mental Health Treatment charts were opened. Among them. 91% of early intervention charts and 83% of mental health charts were closed with goals met or partially met.
- IPP directly administered 11 screenings and supported 71 screenings.

Service Hours Delivered

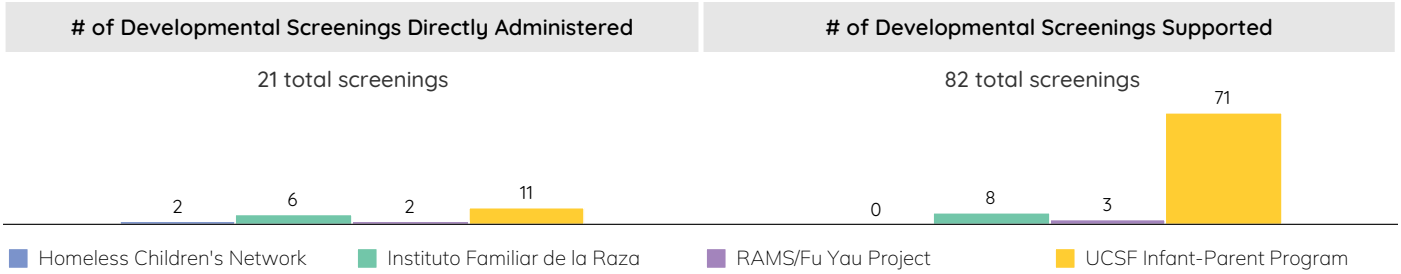


Early Intervention Charts

Mental Health Treatment Charts



Developmental Screenings



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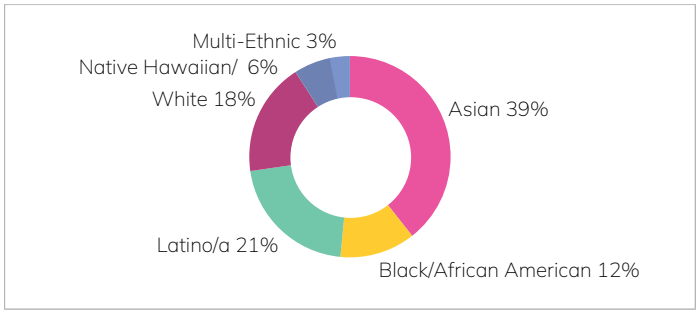
Who Provided the Service

- A total of 115 consultants provided services.
- About 39% were Asian; 21% were Latino/a; and, 12% were Black/African American.
- 44% primarily spoke English; 25% spoke Spanish; and, 23% spoke Chinese.
- 44 mental health consultants held advanced degrees including AMFT (14 consultants) and LMFT (12 consultants).

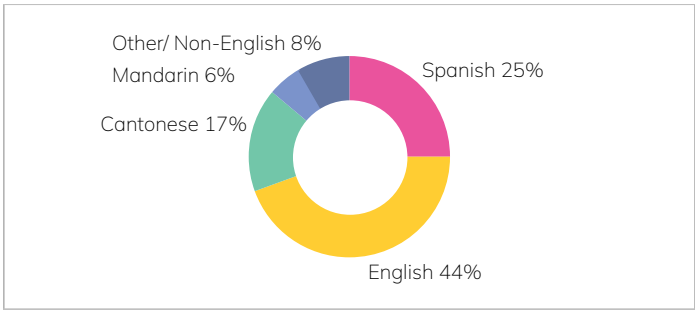
Number of Consultants

Homeless Children's Network	Instituto Familiar de la Raza	RAMS/Fu Yau Project	UCSF Infant-Parent Program	Total
39	13	30	33	115

Consultant Race/Ethnicity



Consultant Primary Language

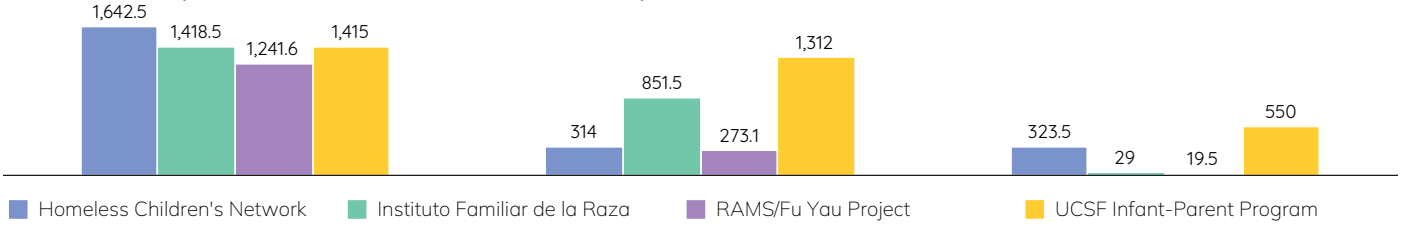


Mental Health Consultation Workforce Advanced Degrees

	Homeless Children's Network	Instituto Familiar de la Raza	RAMS/Fu Yau Project	UCSF Infant-Parent Program	Total
Associate Marriage and Family Therapists (AMFT)	9	2	3	0	14
Licensed Marriage and Family Therapists (LMFT)	1	4	2	5	12
Licensed Clinical Social Worker (LCSW)	0	3	0	4	7
Associate Clinical Social Worker (ASW)	1	4	1	0	6
Associate Professional Clinical Counselor (APCC)	1	0	2	0	3
PhD/doctoral level, licensed psychologists	0	0	0	1	1
Other Advanced Degrees	0	0	0	1	1

Other Service Hours Delivered

Training and Supervision	Systems Work	Evaluation
5,717.6 hours	2,750.6 hours	922 hours



Appendix

A. Number of Sites Served by Site Type and Agency

	HCN	IFR	RAMS	IPP	Total
Grand Total	**47**	**60**	**74**	**46**	**227**
Family Resource Centers	4	4	9	8	25
FCCQN Licensed Family Child Care Home	20	26	10	5	61
Homeless and Domestic Violence Shelters	3	0	0	6	9
Licensed Early Care and Education Centers	6	30	55	24	115
SFUSD	10	0	0	0	10
SUD Treatment Programs	4	0	0	3	7

B. Number of Service Participants by Site Type and Agency

		HCN	IFR	RAMS	IPP	Total
Grand Total		**764**	**1,599**	**3,117**	**6,852**	**12,332**
Family Resource Centers	Total	41	134	201	4,881	5,257
	Care Providers	37	36	25	89	187
	Children	0	30	82	2123	2235
	Parents/Caregivers	4	68	94	2669	2835
FCCQN Licensed Family Child Care Home	Total	28	72	99	50	249
	Care Providers	20	30	67	9	126
	Children	2	27	20	30	79
	Parents/Caregivers	6	15	12	11	44
Homeless and Domestic Violence Shelters	Total	136	0	0	335	471
	Care Providers	46		0	47	93
	Children	20		0	248	268
	Parents/Caregivers	70		0	40	110
Licensed Early Care and Education Centers	Total	218	1,393	2,817	1,547	5,975
	Care Providers	40	362	451	243	1,096
	Children	160	730	1807	838	3,535
	Parents/Caregivers	18	301	559	466	1,344
SFUSD	Total	265	0	0	0	265
	Care Providers	75				75
	Children	160				160
	Parents/Caregivers	30				30
SUD Treatment Programs	Total	76	0	0	39	115
	Care Providers	31		0	8	39
	Children	5		0	29	34
	Parents/Caregivers	40		0	2	42

C. Number of Participants by Language and Race/Ethnicity and Agency

			HCN	IFR	RAMS	IPP	Total
Care Provider	By Language	Cantonese	14	7	276	33	330
		English	168	242	94	151	655
		Korean	0	0	8	1	9
		Mandarin	7	0	35	28	70
		Other/ Non-English	13	0	21	1	35
		Spanish	37	149	14	138	338
		Unknown	4	0	85	1	90
		Vietnamese	2	0	14	6	22
	By Race/ Ethnicity	Asian	39	68	373	118	598
		Black/African American	51	31	23	40	145
		Latino/a	48	235	19	147	449
		Multi-Ethnic	2	5	21	4	32
		Native American	0	0	2	0	2
		Native Hawaiian/ Other Pacific Islanders	7	9	5	3	24
		Unknown	12	3	76	22	113
		White	32	47	28	56	163
Children	By Language	Cantonese	4	27	697	143	871
		English	314	342	547	1,048	2,251
		Korean	2		2	5	9
		Mandarin	15		97	71	183
		Other/ Non-English	6	7	120	186	319
		Spanish	79	406	165	1,200	1,850
		Unknown	38	1	259	587	885
		Vietnamese	1	4	22	28	55
	By Race/ Ethnicity	Asian	56	57	961	404	1,478
		Black/African American	115	112	94	396	717
		Latino/a	102	564	155	1,242	2,063
		Multi-Ethnic	12	14	102	366	494
		Native American	0	0	22	0	22
		Native Hawaiian/ Other Pacific Islanders	18	6	24	5	53
		Unknown	14	13	325	565	917
		White	30	21	226	290	567
Consultants	By Language	Cantonese	1	-	4	1	6
		English	11		2	3	16
		Korean	0		0		0
		Mandarin	0		2		2
		Other/ Non-English	0		1	2	3
		Spanish	3		1	5	9
		Unknown	0		0		0
		Vietnamese	0		0		0
	By Race/ Ethnicity	Asian	1	-	9	3	13
		Black/African American	3		0	1	4
		Latino/a	3		1	3	7
		Multi-Ethnic	1		0		1

		Native American			0		0
		Native Hawaiian/ Other Pacific Islanders	1		0	1	2
		Unknown	0		0		0
		White	3		0	3	6
Parents/ Caregivers	By Language	Cantonese	3	1	280	49	333
		English	151	85	153	497	886
		Korean	0	0	0	0	0
		Mandarin	4	0	31	20	55
		Other/ Non-English	5	0	18	78	101
		Spanish	65	297	74	2,294	2,730
		Unknown	115	0	109	235	459
		Vietnamese	0	0	0	15	15
	By Race/ Ethnicity	Asian	39	21	353	211	624
		Black/African American	117	29	45	106	297
		Latino/a	130	314	81	2,335	2,860
		Multi-Ethnic	7	0	22	113	142
		Native American	0	0	0	0	0
		Native Hawaiian/ Other Pacific Islanders	14	3	0	5	22
		Unknown	17	2	110	287	416
		White	24	15	54	131	224

D. Charts for EIS and MHTS

		HCN	IFR	RAMS	IPP	Total
Early Intervention Services	Charts Opened	3	25	23	6	57
	Charts Closed	2	25	23	6	56
	Charts Goals Met	1	1	13	0	15
	Charts Goals Not Met	0	0	2	3	5
	Charts Goals Partially Met	1	24	8	3	36
Mental Health Treatment Services	Charts Opened	0	4	0	2	6
	Charts Closed	0	4	0	2	6
	Charts Goals Met	0	3	0	0	3
	Charts Goals Not Met	0	0	0	1	1
	Charts Goals Partially Met	0	1	0	1	2

E. Consultant Degrees/Licenses/Certificates

	HCN	IFR	RAMS	IPP	Total
Grand Total	12	13	8	11	4
Associate Clinical Social Worker (ASW)	1	4	1	0	6
Associate Marriage and Family Therapists (AMFT)	9	2	3	0	14
Associate Professional Clinical Counselor (APCC)	1		2	0	3
Licensed Clinical Social Worker (LCSW)	0	3	0	4	7

Licensed Marriage and Family Therapists (LMFT)	1	4	2	5	12
Licensed Professional Clinical Counselor (LPCC)	0	0	0	0	0
Other Advanced Degrees	0	0	0	1	1
PhD/doctoral level, licensed psychologists	0	0	0	1	1

F. Hours of Services

		HCN	IFR	RAMS	IPP	Total
Grand Total		9903.5	10333.7	12166	9234.5	41637.7
Early Intervention Services	Group Interventions	0	2	0	4	6
	Individual Interventions	13	156.4	267.8	31	468.2
Mental Health Consultation	Referral and Linkage	1403	1980.5	4030.2	478.75	7892.45
	Individual Consultation	1876.5	1894.5	1823.8	2121	7715.8
	Group Consultation	2564	1958.5	681.8	1841.5	7045.8
	Observation	1313.5	1264.3	2422.9	620.75	5621.45
	Parent Training and Support Groups	64	541	1250.7	783	2638.7
	Staff Training	389.5	228.5	154.6	24.5	797.1
Mental Health Treatment Services	Group Mental Health Services	0	6	0	0	6
	Individual Mental Health Services	0	3	0	53	56
Systems Work	Evaluation	323.5	29	19.5	550	922
	Systems Work	314	851.5	273.1	1312	2750.6
	Training and Supervision	1642.5	1418.5	1241.6	1415	5717.6

G. Other Service Details

	HCN	IFR	RAMS	IPP	Total
# of Care Provider Workshops and Training	86	34	17	1	138
# of Developmental Screenings Directly Administered	2	6	2	11	21
# of Developmental Screenings Supported	0	8	3	71	82
# of Parent/Caregiver Support Groups	34	41	66	4	145
# of Parent/Caregiver Workshops and Training	12	55	34	97	198
# of Referrals and Linkages to Services	16	125	18	21	180

H. Parent and Caregiver Workshops and Trainings by ECMHCI Contractor, FY 2021-22

CBO	Parent and Caregiver Workshops and Training	
Homeless Children's Network	1	Infant Massage
	2	Parent Support group
	3	Self Care
	4	Tantrums vs. Meltdowns
	5	Developing Secure attachment with your infant
	6	Early childhood development
	7	Positive parenting skills
	8	Rewards and Consequences
Instituto Familiar de la Raza	1	Monthly parent meetings for MNC Head Start; Glide;
	2	Limit setting/Positive Parenting (multiple)
	3	Importance of self-care for care providers (multiple)
	4	Transition to Kinder 3 part workshop series
	5	Parent group support series: Managing difficult behaviors
	6	Parent support group series: Self-care Strategies during COVID
	7	Parent support group series: Books to Support Children's Social Emotional Literacy,
	8	Parent support group series: How to Cultivate Hope and Resilience in Children and Parents
	9	Parent support group series: What is co-regulation and self-regulation in children and adults
	10	Latinx Heritage month: gender roles and culture
	11	Children's Transitions & Behavior going back to in-person
	12	Gratitude
	13	Bittersweet and holiday memories
	14	Self-care, anxiety relievers (multiple)
	15	Love (self love, community love, caregiver love)
	16	Parent and Child Stress
	17	3 Part Grief Group (Grief in the pandemic, The stages of grief, and how to support someone grieving)
	18	Transitions and Changes (multiple)
	19	Summer - children and parents bonding
	20	Routines & stress reduction
	21	Cultivando Presencia y Comunidad
	22	Comunicación y Conexión
	23	Apego
	24	Promoviendo el bienestar emocional de nuestras familias
	25	Bimonthly Family Childcare provider Process Group
	26	Felton Parent Covid Support Group
	27	Parent Support Group for Newcomer Families
	28	Building positive relationships with your children
	29	How to talk to your child about COVID-19 (multiple)
	30	Distance Learning - what is it, how to support your child
	31	Mindfulness, importance of self-regulation and co-regulation
	32	Social Emotional Wellness & movement
	33	Toxic Stress in adults - what it is and how to navigate toxic stress
	34	Children's Mental Health
	35	ABCs of Mental Health - what is mental health?
	36	Supporting children in times of uncertainty
	37	Socio-Emotional Workshop for parents
	38	Healthy Relationships Series of Workshops (Topics: CERTS model, Communication, IPV & Keeping Children Safe)
	39	2021 Family Chat Series with TLC & IFR: "Communication, Resiliency, and Joy for All"

RAMS/FU Yau Project	1	Child development
	2	Social and emotional development
	3	Kindergarten readiness
	4	Positive Parenting Program (Triple P)
	5	Adult and Children Mental Health
	6	Love Languages for adults and kids
	7	Separation Anxiety
	8	Learning Style
	9	Growth Mindset
	10	Child Development/Ages and Stages of Development
	11	Summer Planning for children
	12	Teaching Methods based on children's personality
	13	Kindergarten Readiness,
	14	Preventing Child Abuse;
	15	Kindergarten transition
	16	Child Abuse and Protection
	17	Positive Descriptive Acknowledgement;
	18	Routines and Consistency
	19	Emotion Regulation
	20	Foster Children's Independence
	21	Self Care;
	22	Anxiety for toddlers
	23	sleeping disorders
	24	adjustment and grief for early childhood
	25	Growth Mindset
	26	What is Grit,
	27	Prevention of Fraud and Scams,
	28	Why does Mass Shooting Happen
	29	How to have good sleep
	30	Learned Helplessness
	31	Sibling Rivalry
	32	Positive Parenting
	33	Candle-making and Setting Wellness Intentions for Spring
	34	Self-Care for Teachers
	35	Developing Relationships with Families
	36	Physical Movement for Healthy Childhood Development
	37	Teaching Children About Big Feelings and Self-Regulation
	38	Taking Care of Ourselves During Omicron
	39	Developmental Milestones in Early Childhood, Part 1
	40	Developmental Milestones in Early Childhood, Part 2
	41	Staying Health During Covid-19
	42	Transition & School Readiness
	43	Move It, Move It - Staying Active through the Summer
	44	Positive Parenting for Acting Out Behavior
	45	Nutrition for Little Learners
	46	Stop Asian Hate Safety Workshop
UCSF Infant-Parent Program	1	Buen Dia Monthly Reflective Parent Meeting
	2	JBC Parent Meeting
	3	City College Ocean Ave Lab School: Monthly Parent Meeting
	4	City College Mission Campus Lab School: Social-Emotional/Kinder Readiness
	5	City College Mission Campus Lab School Parent Meeting
	6	Wu Yee Cadillac: Managing Children's Anxiety and Challenging Behaviors
	7	Wu Yee Home Base: Managing Parent Stress Workshop
	8	Wu Yee Home Base: Managing Children's Anxiety/Starting School

	9	Wu Yee Home Base: Monthly Socialization Groups
	10	Guidry's: Parent Cafe
	11	Friends of St. Francis: Joint Parent-Staff Meetings

I. Care Provider Workshops and Trainings by ECMHCI Contractor, FY 2021-22

CBO		Care Provider Workshops and Training
Homeless Children's Network	1	Importance of boundaries
	2	Self Care
	3	Vicarious Trauma and Compassion Fatigue
	4	Substance Abuse Disorder & Pregnancy
	5	Antepartum Depression
	6	Prioritizing Wellness over Productivity
	7	Gender In Multiple Forms- Exploring Gender, Gender Identity & Expression
	8	Ongoing self care group
	9	Emotion regulation
	10	Safe Bodies (boundaries)
	11	Conflict resolution,
	12	Peer to Peer communication
Instituto Familiar de la Raza	1	Trauma Informed Care - MNC Pre-service
	2	Enhancing Communication
	3	Vicarious Trauma and the ripple effect
	4	Wellness Wednesday Series for Felton (monthly all year)
	5	Aromotherapy Workshop (multiple workshops)
	6	Mindfullness Workshop
	7	Wellness/Self-care Workshop (Multiple workshops)
	8	Mindfulness movement activities (Multiple workshops)
	9	Trauma Responses in the Workplace
	10	Stress responses in children and anger ice berg
	11	Self care strategies (multiple workshops)
	12	Managing Difficult behaviors
	13	Implicit Bias/anti-blackness (multiple workshops)
	14	Gender Bias
	15	Bullying-Ideas to Support Families
	16	Anger Management Strategies
	17	Co-regulation and importance of fostering safety
	18	Cafecito con las maestras: COVID safe space for teachers to reflect on impact classroom closures and covid on them (multiple sessions)
RAMS/FU Yau Project	1	Healing & Deepening Our Understanding of Trauma
	2	Reading and Mental Health
	3	Nature and Mental Health
	4	Physical Movement for Healthy Childhood Development
	5	How to Stay Grounded During COVID
	6	What is Trauma?
	7	How to navigate difficult conversations with parents
	8	Separation Anxiety and Transitions
	9	Introduction to Mental Health-Anxiety
	10	Introduction to Mental Health-Depression
	11	Behavior Management
	12	Self care with staff after covid diagnosis and mass shooting
UCSF Infant-	1	Trauma-informed care: Working with young children using a trauma sensitive approach
	2	ASQ:3 & ASQ: SE
	3	Ashbury House - Regulation and Dysregulation in Newborns and infants

Parent Program	4	Ashbury House - Racial Justice with pre and perinatal residential treatment participants
	5	Ashbury House -Stress in newborns and infants
	6	Ashbury House Parent- infant bonding and the impact on recovery in residential treatment
	7	Hamilton Family Services - regulation and dysregulation in Infants and Toddlers
	8	Hamilton Family Services - trauma informed care for parents & babies in shelters
	9	Wu Yee Home Base Providers: Community Violence
	10	Young Family Resource Center: PD on Child Welfare System
	11	Friends of St. Francis: Toilet Learning (2/28/2022)
	12	Friends of St. Francis: The Whole-Brain Child/Supporting Brain Integration (6/13/2022)
	13	Friends of St. Francis: Joint Parent-Staff Meeting (3/8/2022)

J. Mental Health Consultant Training Attended, FY 2021-22

CBO	Mental Health Consultant Training	
Homeless Children's Network	1	Immigration Trauma
	2	Early Child Consultation training
	3	DC-0-5
	4	Suicide Assessment training
	5	Assessing Family Issues
	6	Child Parent Psychotherapy Training
	7	Emotionally Focused Family Therapy (EFFT)
	8	Play therapy
	9	Trauma informed CBT
	10	Art Therapy,
	11	Narrative Therapy
	12	Linguistically Responsive Trauma Informed Care Principles and Interventions for Spanish Speaking Clients and Families-
	13	Telehealth practice, guide, and interventions
	14	Working with Translation Services
	15	Reclaiming Identity & Healing Through Decolonization
Instituto Familiar de la Raza	1	ECMHI Training Institute 2021-2022
	2	Harm Reduction
	3	Healing and Deepening Our Understanding of Trauma in Early Childhood
	4	MWE - Daniel Siegel
	5	Racial Bias - and ECE
	6	Sensory Integration and Preschoolers
	7	Grief and Bereavement: Lessons Learned in the COVID-19 Pandemic
	8	Module 100: Trauma Informed Practices and Resiliency Building for Early Childhood Educators.
	9	QPR Suicide Prevention Training
	10	La empatía en la infancia temprana (edad 0-5)/Empathy in early childhood (age 0-5)
	11	Harm-Reduction Training
	12	Trauma from the Pandemic: Healing as we Return In-Person
	13	Protective Factors & ACEs: Meeting Families with Hope and Healing
	14	Narrative Therapy by the Latinx Center of Excellence in Behavioral Health, UC Berkeley
	15	Ending Child Poverty in CA: Collective Impact of Cradle to Career Communities
	16	Zero to Three: Racial Equity Webinar
	17	Law and Ethics for Mental Health Professionals:
	18	It's Too Late to Agree With Me...I've Changed My Mind
	19	Race-based Traumatic Stress & Mental Health Stigma
	20	What's in a Name: BIPOC and African American Cultural Identity
	21	Self Care and Resilience

	22	Changing the Narrative: Eliminating Negative Stereotypes About Black People
	23	Trauma Training
	24	Former Unaccompanied Minors and Their Stories of Resilience
	25	Talking Trauma with Young Children
RAMS/FU Yau Project	1	Trauma informed practice for early childhood educator
	2	DC0-5 Training
	3	Polyvagal Theory training
	4	Eating Disorders in Children
	5	Youth, and Families
	6	Trauma-Responsive and Resilience Building for Early Childhood Providers
	7	Understanding Self-Regulation
	8	Principles and Practice Webinar
	9	Child Centered Play Therapy
	10	Principles and Practice for Groups and Organizations
	11	the Grief Summit 2022
	12	Counseling and Treatment Tools for the Changing Face of Grief and Loss
	13	The Neurobiology of Me and We (MWe)
	14	Integrating Both for Belonging and Thriving Relationships After COVID
	15	DC 0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood
	16	Law and Ethics,
	17	Language and Cultural Considerations when working with Latino Families,
	18	Trauma's Impact on Youth Behaviors,
	19	Cognition, & How it affects Diagnoses
	20	Youth & Families; ECMHCI Training Institute
UCSF Infant-Parent Program	1	Child-Parent Psychotherapy
	2	Zero to Three Conference
	3	The Ripple Effect
	4	Sensory Integration
	5	Equity Chat on Unpacking the Revised IECMH Consultant Competencies
	6	Supporting Tribal Populations through IECMHC
	7	Equity Chat on Unpacking the Revised IECMH Consultant Competencies
	8	2022 Center of Excellence for IECMHC Conference: Infant & Early Childhood Mental Health Consultation: Equity from the Start
	9	Monthly Consultation Community of Practice
	10	Harris Professional Development Network Tribal Nations, Child Welfare System, Democratizing Mental Health
	11	Harris BIPOC Connecting to Your Leadership
	12	Supporting transgender clients part 1 Dr. Cadyn Cather's
	13	Understanding and Addressing Racial Trauma - Ken Hardy
	14	Understanding Foster Care and Therapuetic Interventions
	15	Infant Toddler Mental Health Consultation Conference Fall 2021
	16	The Impact of George Floyd and Breonna Taylor on DEI work
	17	Indigenous Wisdom for Listening to Children and Families
	18	The Role of Code-Switching in Diversity, Equity, Inclusion and Belonging
	19	The Psychology of Pregnancy and Early Parenthood
	20	Infant Toddler Development Series, Part 1
	21	Infant Toddler Development Series, Part 2
	22	Indigenous Perspectives with Dr. Tyson Yunkaporta
	23	At the Crossroads- Body Centered Transformation with Resmaa Menakem
	24	Compassion in Therapy Summit
	25	Liberation Psychology- Trauma Informed Integrated Behavioral Health
	26	Reclaiming Identity and healing through Decolonization
	27	Talking Trauma with Young Children

	28	Linking Sensory Integration and Mental Health in Nurturing Self-Regulation in Infants and Young Children
	29	Understanding Sensory Processing Differences in Children
	30	Barnard Center Lecture: Reproductive Justice (4/12/2022)
	31	Zero To Three Webinar - Neurorelational Development (4/13/2022)
	32	Barnard Center Lecture - Racial Equity in ECMH Consultation (5/18/2022)
	33	StarVista (Community of Practice) ECMHC seminar
	34	Attachment Vitamins

K. Consultant Specializations

In addition to advanced degrees, the ECMHCI workforce collectively bring a high level of specialization and practice-based experience to their work:

- Infant Mental Health
- Community Mental Health
- Trauma Informed Approached
- Cultural humility and cultural competence
- Child Parent Psychotherapy
- Traditional Healing Practices
- Trauma informed practices
- Culturally Responsive family engagement Strategies
- Community Mental Health
- Anti-racist consultation framework
- Child-Parent Psychotherapy Rostered
- Perinatal-Child-Parent Psychotherapy Trained
- Perinatal Mental Health and Reproductive Justice Specialization
- Substance Use Recovery, Caregiving and Infant-Child Experience
- Newborn Behavioral Observations (NBO) System - Certified
- NCAST/Parent-Child Interaction (PCI) Feeding Scale - Certificate of Reliability
- Napa Infant-Parent Mental Health Fellowship Program - Graduate
- Neuro-sequential Model of Therapeutics - Phase 1 Certification Forthcoming (9/2022)
- EMDR Therapy trained
- Expressive Arts Therapy (Registered)
- Endorsement as IFECMH Specialist and Reflective Practice Facilitator with CA Center for Infant-Family and Early Childhood Mental Health
- Community Mental health
- Infant mental health
- Trauma Training Julie Kurtz
- Triple P Level 4 Group
- Triple P Pathways
- DC 0-5
- Polyvagal theory