A Quality Start in Louisiana

Early Childhood Mental Health Consultation as a Primary Support in a Statewide Quality Rating and Improvement System

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Young children develop in the context of their relationships with their primary caregivers. When these attachment relationships are strong and secure, the caregiver will be the most important factor in a child's ability to successfully navigate the demands of development, achieve positive outcomes, and recover from traumatic experiences (Zeanah & Zeanah, 2001). Children who do not have strong, secure, and ongoing attachment relationships are at risk for a variety of negative outcomes, including social and emotional difficulties, behavioral problems, and even learning delays (Dicker & Gordon, 2004; Melmed, 2011). The early childhood mental health consultation (ECMHC) model developed by the Tulane Institute of Infant and Early Childhood Mental Health (the Institute) is founded on the principle of supporting the establishment of healthy relationships between young children and their caregivers and teachers as well as parents.

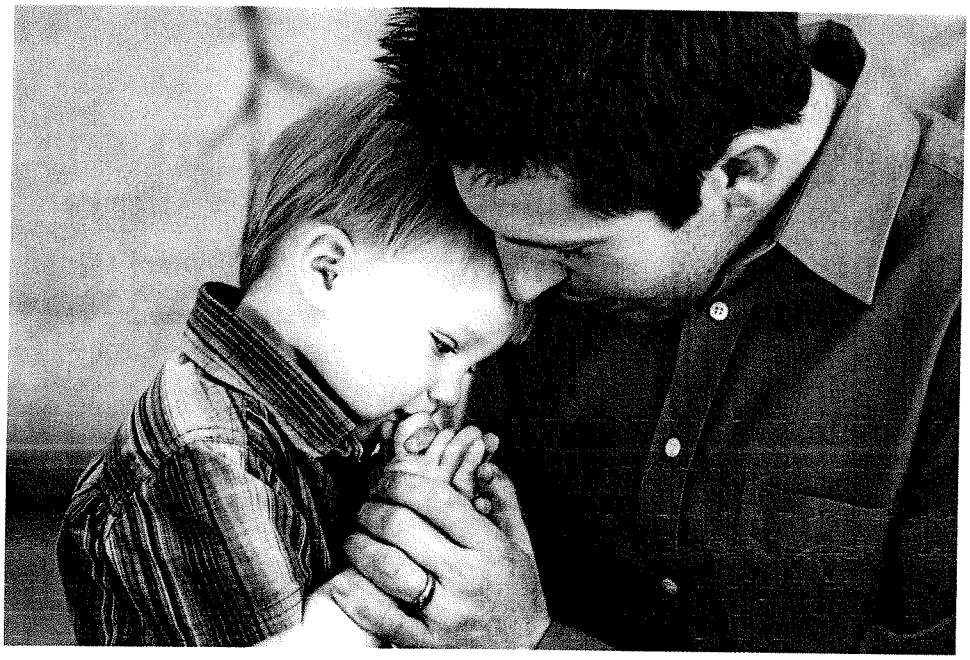
In Louisiana, during the years 2003 and 2004, the Institute worked to educate state government leaders about the critical needs of young children less than 5 years old, especially those in foster care, who spent a significant amount of time in child care settings. The goal was to have state leaders recognize that young foster children had great vulnerability because of the abuse and or neglect that they had experienced and were in need of higher quality child care (Connors-Burrow, Patrick, Steier, & Lloyd, this issue, p. 38).

However, many of Louisiana's children, including many children in foster care, were not in high-quality child care settings. With no quality rating system in the state, the only way to convey to government leaders the type of child care that children were experiencing was to observe the children in their child care settings. The Institute arranged a series of site visits for small groups of state leaders to observe foster children in their daily child care experiences. After each site visit, Institute faculty met with the state leaders to debrief them about what they had seen. These site visits proved invaluable as the lack of quality child care these children were experiencing was easily conveyed upon simple observation. The feedback the state leaders gave after the site visits included statements such as, "There was so much noise and chaos that I can't stop shaking," or "The children had nothing to do but watch television." Because of these visits, state leaders were becoming open to the idea that the quality of child care mattered.

A parallel effort by the Institute in 2004 and 2005 was to advocate for a statewide quality

Abstract

Recognizing the economic impact of the child care industry and based on the needs of at-risk young children, Louisiana policymakers and stakeholders reorganized the child care industry after Hurricanes Katrina and Rita and developed a quality rating system using early childhood mental health consultation (ECMHC) as a primary support. Child care programs have embraced the ECMHC model, reporting positive subjective changes, and objective changes on the Classroom Assessment Scoring System have been observed. The ECMHC model developers are working to adapt to the ongoing changes in early education in Louisiana so that all young children are ready for school.



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Young children develop in the context of their relationships with their primary caregivers.

rating system for child care centers. Child care rating systems were new at the time, and only a handful of states had fully implemented them. North Carolina, building from its Smart Start efforts, had a rating system in place that became the model that the Institute pursued. The Institute presented the concept of the rating system at various community meetings of child advocates and child care providers. The concept was met with lukewarm reaction from the child care community. The advocates questioned the funding that would be available to pay for the quality demanded by such a system, and the provider community voiced a deep distrust of state regulations and intentions.

Economic Impact of the Child Care Industry in Louisiana

In February 2005, the Institute and the Louisiana State University Division for Economic Development and Forecasting completed a report that documented the economic impact of the child care industry in Louisiana. The study computed the short-run economic impact of the child care sector by applying standard input–output analysis to federal funds for child care injected into the Louisiana economy. Using methodology developed at Cornell University (Liu, Ribeiro, & Warner, 2004), the report documented conservative estimates of the size of the Louisiana child care sector as 12,701 businesses employing 22,644 workers, serving more than 149,000 children and 136,000 working parents and generating approximately $658 million in gross receipts. In addition, for every dollar that was spent in the Louisiana child care sector, $1.72 was returned into the economy. Similarly, for each new child care job that was created, 1.27 jobs were created in the larger economy. At the time, the state contributed $40 million dollars into child care (including prekindergarten), which helped leverage $251.7 million federal dollars into the child care system. In turn, this $251.7 million had a total impact of $433 million to the Louisiana economy. One of the concluding recommendations of the economic impact study was that quality ratings could guide consumer demand when choosing programs and thereby pressure the child care market to improve quality. The Louisiana Advisory Council on the Child Care and Development Block Grant joined in echoing this recommendation and used the findings of the economic impact study to call for additional supports for the child care sector (Advisory Council on Child Care & Development Block Grant, 2005).

Hurricanes: The Ultimate "Game-Changers"

In August 2005, Louisiana was struck by Hurricane Katrina and, 1 month later, by Hurricane Rita. These two storms completely disrupted the status quo. By January 2006, attention had shifted to rebuilding, and the Institute's prehurricane focus on quality child care and a child care rating system had assisted in paving the way for a new course of action. With this new focus came a unique willingness and receptiveness, inside and outside of state government, to start the process of designing and implementing a quality rating system. In effect, active planning for the rating system became part of the rebuilding effort, as there was an opportunity to infuse greater quality in the child care sector as it was re-established across much of the state.

In February 2006, the Louisiana Department of Social Services (now the Department of Child and Family Services) convened a statewide meeting with early education providers (e.g., prekindergarten, Head Start/Early Head Start, child care) and experts from three states that had implemented quality rating systems. The goal of the meeting, attended by approximately 200 people, was to decide whether to move forward with the development of a rating system. The meeting was positive and productive, and—on the basis of the presentations from Tennessee, Pennsylvania, and North Carolina—Louisiana made the decision to move forward. What had begun in 2003 as an effort to improve the quality of child care for children in the foster care system had, in combination with many other factors, led to the formal planning of a quality rating system to support high-quality child care for all children.

Quality Rating System Planning

Led by the state child care administrator in the Louisiana Department of Social Services, a Quality Rating System Steering Committee was convened with 39 members. Over the next several months, the committee developed the Louisiana rating system, subsequently named Quality Start. All of the details of the system are beyond the scope of this article, but a general ethos was embraced early on that the system should be focused on the social and emotional needs of children. The rationale for this approach was the belief that the literacy and numeracy needs of young children are already widely accepted and often emphasized; conversely, the social and emotional needs of children are seldom recognized as critical components of child development in these formal systems. This focus on social and emotional development was embraced and influenced how ratings would be earned and what supports that the state would provide to child care centers.

The Louisiana Quality Start assessment rates child care centers on a scale ranging from one to five stars.

- One star – The one-star rating indicates that the center has a license in good standing and no outstanding deficiencies.
- Two stars – The two-star rating indicates that the center staff has received more specialized training and the center has completed a self-assessment plan.
- Three to five stars – The three- to five-star rating indicates that the center

provides quality child care based on staff qualifications and the Environment Rating Scales (ERS; Harms, Clifford, & Cryer, 2005).)

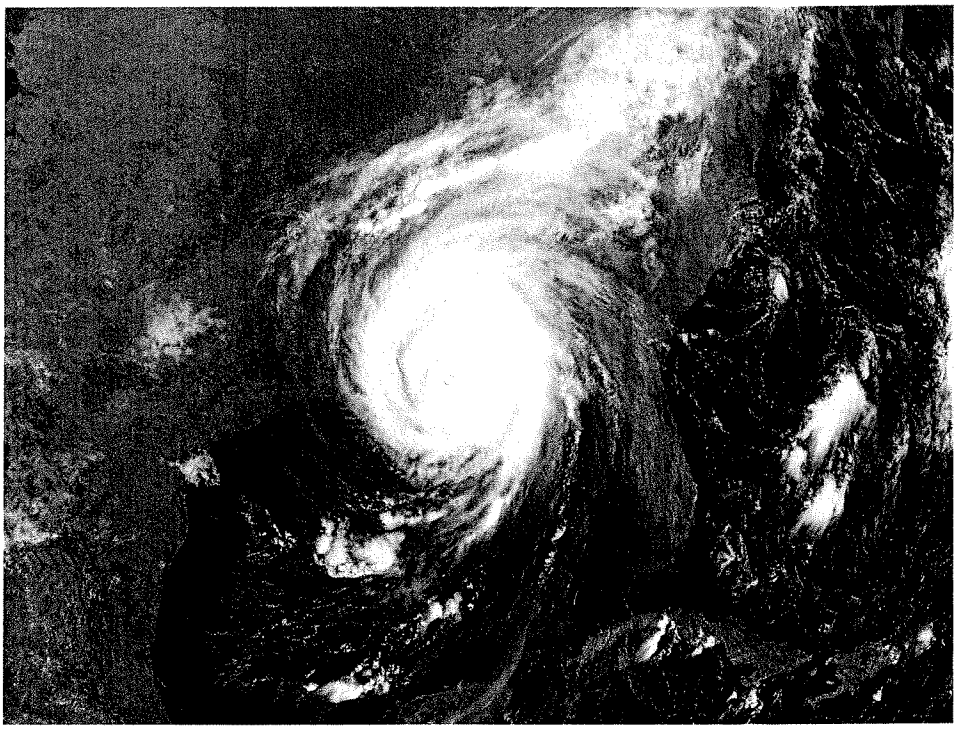
Louisiana's Quality Start system uses the ERS (Harms et al., 2005) as the observational assessment tool. After the observations, centers receive their scores, which consist of an overall score and six subscale scores. In addition, Louisiana implemented a unique social–emotional (SE) subscale after we consulted with the ERS authors. The SE subscale is defined as a composite of the following subscales: Listening and Talking, Interaction and Program Structure on the Infant/Toddler Environment Rating Scale—Revised (Harms, Cryer, & Clifford, 2006); Language and Reasoning, and Interaction and Program Structure on the Early Childhood Environment Rating Scale—Revised (Harms et al., 2005).

The SE subscale score was given more weight in the determination of star level than the overall ERS score; therefore, providers needed to focus on social–emotional aspects of caring for young children. The SE subscale score became the most critical component of earning points for stars for the majority of centers that achieved three to five stars on Louisiana's five-star scale.

With all of the changes to the child care sector that the new Quality Start system presented, it was expected that there would be confusion, concern, and resistance to the system. The state put in place several technical assistance (TA) mechanisms to assist with many of these issues, but no support has been larger or more sustained than the implementation of a statewide ECMHC program.

The Institute's ECMHC Model

To support centers in increasing the quality of care they provide, with a focus on the social–emotional health of young children, all centers participating in Quality Start are able to access ECMHC services. These services are provided by the state through a contract with the Tulane University Institute of Infant and Early Childhood Mental Health, which subcontracts with six regional nonprofit agencies throughout the state. Quality Start mental health consultation services provided through the Institute are designed to assist all children in center-based care, not only those who are exhibiting behavior problems. The goal is to achieve healthy behavioral, social, and emotional development. This consultation program has three main objectives: (a) to promote the social and emotional health of young children; (b) to support caregivers' promotion of healthy child development within the classroom setting; and (c) to refer young children exhibiting behavioral problems for treatment or design interventions.



PUBLIC DOMAIN PHOTO FROM NOAA

In August 2005, Louisiana was struck by Hurricane Katrina.

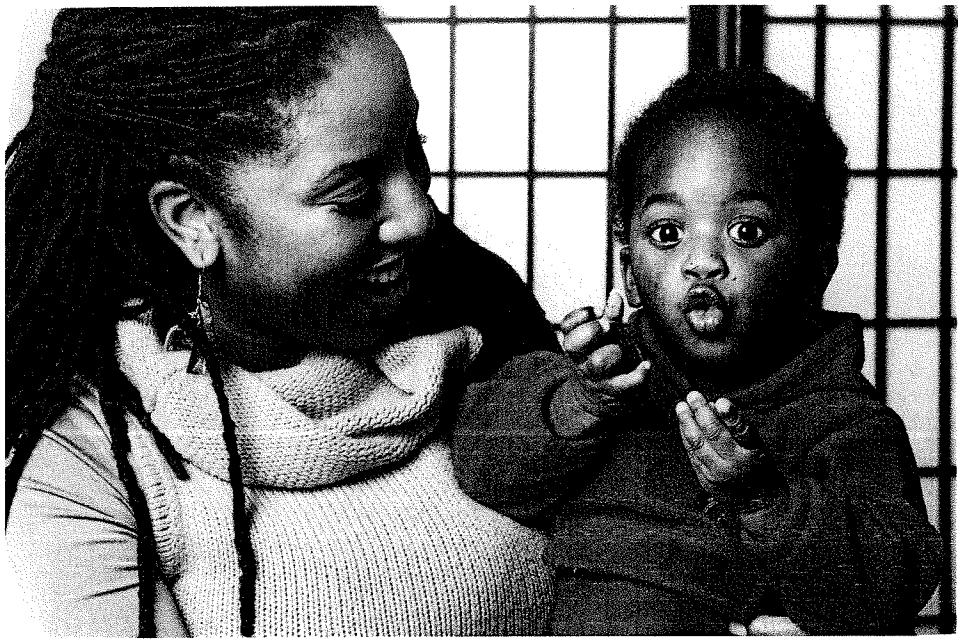
The model merges two types of consultation: child-centered and program-centered (Johnston & Brinamen, 2006). Child-centered consultation focuses on the needs of a specific child: how to intervene to better support that child's development (e.g., classroom behavior management strategies, referral to an external specialist such as speech or mental health; parent support) and how to diminish the negative effect of that child's behavior within the classroom. Programmatic consultation focuses on the child care program as a whole and how factors specific to that child care program affect the social–emotional development of the children enrolled there.

The mental health consultants are on site working with center staff for 1 day every other week or per week (depending on center size) for 6 months. Child care programs with eight or more classrooms are eligible to receive weekly visits. (For more information about the Institute's ECMHC model, please see Heller et al., 2011.)

The model has as its primary underpinning a "curiosity and respect for differences" (Johnston & Brinamen, 2006, p. 7). As consultation work is focused on understanding another's subjective experience, it is necessary to take into account how culture, race, and other individual factors may affect perception. Consultants must consider how culture, race, ethnicity, or other factors influence the approach of both child care center staff and parents with reference to child rearing, parenting, communication styles, and developmental expectations (Johnston & Brinamen, 2006).

On the basis of input from other ECMHC programs around the country (e.g., Day Care Consultants, a program of the Infant-Parent Program of the University of California, San Francisco), the Institute designed a model tailored to the particular needs of Louisiana. As ECMHC was to be a primary support for early education providers participating in Quality Start, it was important to establish a model that allowed consultants to work with a program long enough to form relationships and support change while also permitting them to work with multiple programs over the course of a contract period (e.g., 18 months). Building relationships with center staff and supporting relationship building between staff, children, and the children's families is a foundation of the Institute's ECMHC model. Moreover, relationships between consultants and center staff have been shown to be a key factor in a successful ECMHC experience (Green, Everhart, Gordon, & Gettman, 2006). A visit schedule of every other week was established, with visits occurring over a 6-month period for a total of 12 visits. We theorized that such a schedule would allow participants time to process, develop, and practice skills between consultation visits while the 6-month time period would allow time for successful relationship development between consultants and staff.

During the first 6 months of piloting the ECMHC model, we learned that, to support change in this relatively short period of time,



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the consultant needed a method of training through which she could offer and receive information in a somewhat formal way with several staff members. As several of the TA providers across the state had received training on the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) pyramid model for supporting social and emotional competence in infants and young children, we decided to build upon the CSEFEL language and ideas to which many child care staff may be exposed through TA providers. CSEFEL language and the basics of the pyramid model were incorporated and became the foundation for the ECMHC trainings (Heller et al., 2011).

Consultants use a combination of group process and didactic training techniques when providing these trainings. The sessions serve multiple purposes. Staff members are allowed to discuss their own feelings, concerns, challenges, and triumphs from their classes and can assist each other in solving challenges along with the consultant's support and guidance. The consultant is able to point out positive interactions that had occurred in the center and can support and promote the social–emotional development of young children through the interactions with staff. The trainings are flexible and can be tailored to the unique needs of each teacher, classroom, and center. All ECMHC trainings count toward the continuing education clock hours for child care staff that are required by child care licensing. This assisted consultants in recruiting centers and encouraged participation among staff members.

Beyond the more formal trainings, the bulk of the Institute ECMHC model is built on time spent in classrooms with the teachers and time spent meeting with the director. Activity forms completed daily by each consultant reveal that approximately 67% of a consultant's visit time is spent observing (e.g., watching teacher–child interaction or children's behavior) and modeling in the classroom (e.g., demonstrating developmentally appropriate interactions with children). Approximately 20% of the consultant's time is used to meet with or train teachers individually or within groups, and the final 13% is typically spent meeting with the center director, owner, or both (Boothe & Heller, 2012). The consultants were given the opportunity to provide anonymous feedback about how they made activity decisions. Answers reflected a series of choices. Consultants reported that, first, they typically met with the director to incorporate her thoughts for how the consultant should spend the day. Second, when the consultant entered a classroom, the consultant asked for the teacher's input; and finally, but possibly most important, the consultant worked to address the needs of the children (Boothe & Heller, 2012).

We have received positive feedback from both teachers and administrative staff about the combination of time spent in classrooms observing, modeling, and relationship building and the time spent in didactic trainings. The proverbial "carrot" of free continuing education hours for staff proved to be a selling point for the program while also giving the consultant and staff members time to work together as a group, which may not have occurred if the training time had not been included.

Statewide Launch of Quality Start and ECMHC

All centers across Louisiana were invited to participate in a Louisiana Department of Child and Family Services, Division of Childcare, training program titled "Foundations, Up," which aimed to provide a base from which programs could enter Quality Start when it began. "Foundations, Up" provided trainings on the ERS (Harms et al., 2005), training specific to Quality Start, and the ECMHC director provided social–emotional development training. This central position in the statewide in-person and televised trainings alerted child care providers that ECMHC was going to be a significant resource.

After approximately 6 months of piloting ECMHC, the Institute moved into a longer term contract with the state to design a method for serving new Quality Start centers once that program was up and running. We spent the next 6 months continuing to hone the ECMHC model further, securing regional subcontracting agencies through which consultants would be hired, and hiring consultants in cooperation with the subcontracting agencies. Appropriately assessing regional need was one of the most difficult aspects for the first 2 years of the program. We calculated the number of consultants to be hired by determining how many consultants were needed to serve 20% of centers in each region over an 18-month contract period. However, as Quality Start began, we also took into account regional participation in the rating system and openness to consultation. With these factors as part of the equation, we settled on a feasible number of full-time equivalent positions per region that allows for the consultants to maintain a small waiting list and consistently serve centers. There has continued to be a small ebb and flow of these numbers over the 5½ years of the program.

Program Challenges

A key challenge during the statewide launch of Quality Start and ECMHC was the difficulty that MHCs had in recruiting centers. Despite the offer of no-cost services, the consultants had to work at finding centers to serve. Several methods of recruitment were used including e-mail blasts from the State Department of Child and Family Services, telephone calls and visits from consultants to child care centers, flyers advertising services handed out at Quality Start trainings, and consultants networking with directors at regional meetings. Supporting quality child care for vulnerable children is a foundation

for our model; therefore, recruitment efforts focused on those centers identified as serving children in foster care. We found that word of successful consultations spread throughout each region, creating a positive climate for recruiting new centers. In addition, as a center completed its consultation cycle, the director was typically interested in receiving consultation again. However, in an effort to reach more centers, repeat centers were given lower priority. Since the beginning of our ECMHC program, consultants have consistently focused on recruiting centers serving children who are in foster care or whose families are receiving child care assistance payment so that those children more vulnerable to risk factors could receive quality care.

From the beginning, a challenge has been securing accessible and appropriate referral sources for young children and their caregivers. In choosing our partner subcontracting agencies, we looked for regional nonprofits that provided therapy services or other community services that support the mental health of young children and families. When administering a program across a wide geographical area, however, there can be gaps in services available. In more rural areas of the state, the consultants struggle to secure appropriate referral sources. In this time of severe cuts in funding, our referral sources continue to dwindle. Now the consultant is often the only mental health professional that children, families, or teachers see as they join long waiting lists to access the limited treatment options available. Directors and teachers have provided consistently positive feedback as to how their consultant was able to support children and families. One director stated that her consultant was most helpful to children and families "by offering our families resources for specific developmental needs, meeting with our parents, and helping these families with answers beyond anything a pediatrician could provide. The families were very open to [the consultant] and her suggestions."

PHOTO: MARILYN NOLT

Quality Start mental health consultation services provided through the Institute are designed to assist all children in center-based care, not only those who are exhibiting behavior problems.

Program Strengths

Key strengths of the program are the background and training of our consultants and the ongoing reflective supervision they receive. Each is a licensed mental health professional (e.g., licensed clinical social worker, licensed professional counselor) who received intensive training in infant and early childhood mental health during the first year as a consultant. With a graduate degree in a mental health field and experience working with children and families as a mental health professional, the consultants are prepared with a level of clinical acuity that is necessary to provide mental health consultation services to child care centers. In addition, each consultant receives individual reflective supervision by telephone twice a month and participates in a reflective supervision group through a conference telephone call once a month. Consultants have reported that reflective supervision assists them in maintaining connections to other consultants, as they are primarily working alone in the field. Reflective supervision also gives them opportunities to gain perspective and insight into their centers, which supports their work.

The reflective supervision for our program is provided by four licensed, doctoral-level senior clinicians. Each has extensive experience in infant and early childhood mental health, including clinical and research experience in working with young children and their caregivers. This leadership team also provides preservice and ongoing in-service training for the consultants. Another strength of the program is the subcontracting model. The ECMHC program is able to have a presence in every parish across the state through six regional nonprofit agencies across the state that employ the consultants. The consultants are local to their communities and understand their communities' unique needs. By working through regional agencies, the staff members of those agencies learn about the ECMHC program and its benefits for children, families, and child care staff in its community. In this way, the ECMHC model has gained champions throughout the state and has localized the provision of services. Consultants are able to capitalize on the unique strengths of their agencies to support early education providers. Child care community members are often more comfortable as they embark upon ECMHC when the provider is employed through a trusted community agency.

The decentralized model of ECMHC employment is balanced with the centralized nature of the ECMHC program administration. As discussed earlier, all supervision and training is provided by the four-member Institute leadership team. Centralized program administration and supervision allows for quality control and program adherence. Moreover, as consultants are typically working in the field, group supervision and in-service training that occur across regions and subcontracting agencies support consultants to operate as a part of the statewide team.

ECMHC Program Evaluation

Evaluation of the Tulane model of ECMHC for the Quality Start program has demonstrated an increase in teacher-reported self-efficacy, or the teacher's belief that he can make a difference in a child's life. This increase was maintained after 6 months (Heller et al., 2011). In addition, there was a significant increase in the teacher's report of his sense of influence (i.e., the teacher's sense that what he does will influence a student in comparison with other factors in the child's life). The

teacher's report of his sense of influence also continued to increase after 6 months (Heller et al., 2011).

More important, observational assessments of teachers who participated in the Quality Start ECMHC program demonstrated significant changes in all seven areas measured on the Classroom Assessment Scoring System: Pre-K (Pianta, La Paro, & Hamre, 2008). These areas were examined across two domains. The Emotional Support (relationship) domain included increases in positive climate, teacher sensitivity, regard for emotional perspective, and a decrease in negative climate. In the Classroom Organization domain, increased scores were observed in behavior management, productivity (i.e., productive use of classroom time), and instructional learning formats. The Instructional Support domain was not assessed in this evaluation, as we did not expect this ECMHC model to affect this more academic domain of the CLASS. The intervention was equally successful across racial groups (e.g., Caucasian and African American participants), socioeconomic groups, and geographic settings (i.e., urban, suburban, and rural settings; Heller et al., 2012).

The success of the model contributes to the evidence base of ECMHC as a primary method of supporting and increasing the quality of child care and supporting healthy relationships between caregivers and young children and their families in early care settings.

Learn More

Louisiana Quality Start
www.QRSLouisiana.org

The Tulane Institute of Infant and Early Childhood Mental Health
www.infantinstitute.com

Quality Rating and Improvement Systems
www.QRISnetwork.org

Early Childhood Mental Health Consultation and Supporting Early Childhood Caregivers
www.ecmhc.org

Center on the Social and Emotional Foundations for Early Learning (CSEFEL) Pyramid Model
www.csefel.vanderbilt.edu

Programmatic consultation focuses on the child care program as a whole and how factors specific to that child care program affect the social–emotional development of the children enrolled there.

Where We Are Now

We are currently in our 6th year of providing ECMHC services as part of Louisiana's evolving Tiered Quality Rating and Improvement System. Our team size has stabilized, with each consultant serving, on average, 16 centers per year for formal 6-month consultation periods and 11 centers that had previously received ECMHC services for follow-up visits. Most of the consultants maintain an ongoing waiting list with a combination of centers that have not yet received consultation and centers that have requested another round of consultation.

As the Child Care Resource and Referral agencies, which provide TA to child care centers, and the consultants are all working in support of Quality Start, in several regions consultants have informal partnerships with the technical assistants at the Referral agencies. The technical assistants in these regions have become champions of the ECMHC program and often suggest to centers that they request consultation. Likewise, the consultants often suggest that centers reach out to the regional technical assistant for support on those specific child care questions that are outside of the ECMHC domain.

Although it can be somewhat confusing for a child care center at first to have different individuals providing support, when a consultant and a technical assistant can meet with a director together to help work through a difficult aspect of the Tiered Quality Rating and Improvement System, the center and the system are strengthened. For example, in one area, the regional consultant and technical assistants are employed by the same agency and work in the same office. The consultant is often invited to participate in ERS feedback sessions that the technical assistant provides if the consultant has a relationship with the director. The consultant can use her clinical support skills to help ensure that the technical assistant is sensitive but clear in providing the feedback from the ERS assessment. Moreover, the consultant can support the director in the emotionally charged process of reviewing what she has learned about the strengths and challenges of her center.

Looking Ahead

There is new attention in Louisiana on early childhood and how it relates to school readiness. This resulted in legislation being passed in 2012 with the intention of improving school readiness through the creation of a common governance structure across early education programs. The belief on which this is based is that this new structure would use existing state and federal funds for early education programs more efficiently, as there is already enough money in the early education system. On the basis of this approach, Louisiana did not pursue the Race to the Top–Early Learning Challenge grant.

The legislation that passed put the overall responsibility of early education programs under the state board of elementary and secondary education and also requires a letter-grading system for early education providers that receive public funding. The present plan is to have the letter grades determined by child assessments, thereby creating a new high-stakes test for early education providers for children of all ages before kindergarten. Ultimately, these letter grades would affect the ability of a program to receive public dollars and, possibly, whether a provider would be allowed to operate.

With the pending implementation of a new quality system, letter grades, and this high-stakes test, there is great concern about the significance and weight of the test. The challenge is to ensure that such assessments of very young children are appropriately inclusive of social and emotional development and validly measure these domains. This is much easier said than done, especially in a high-stakes structure. Instead, the threat is that the test will push early education providers to emphasize the cognitive skills, such as knowledge of numbers and letters, thereby neglecting the social and emotional needs of children and the fact that competency in these areas is equally as critical to a child's ability to achieve school readiness. What this all means for the ECMHC program remains to be seen.

Public forums have been held throughout the state to gather input from community stakeholders, and numerous surveys have been collected to assist in guiding the implementation of the new law. Feedback from the child care community continues to support the work and focus of the Institute's ECMHC program. With the time the consultants spend in centers, they have become, in many ways, the "faces" of the Quality Start system.

As part of this program, we are examining ways in which we can continue to support early education providers across the state as the new law and system are implemented. As a seasoned participant in the development of a system of quality early care, the Institute will continue its efforts to highlight the importance of social and emotional development as the foundation for school readiness.

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