



Mental Health Consultation and Home-Based Child Care Providers

Expanding Participation

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Home-based child care (HBCC) is the most common form of child care in the United States, yet HBCC providers are often less connected than center-based providers to available public programs and services. Given the COVID-19 pandemic's impact on mental health and families' greater reliance on HBCC options during the pandemic,¹ we explored potential strategies for increasing HBCC providers' participation in infant and early childhood mental health consultation (IECMHC) services.

Children's social and emotional well-being is foundational to their learning and success in life. Core to social and emotional well-being is the experience of positive relationships. Nurturing and responsive relationships with adult caregivers, including child care providers, support children as they learn to express and manage a full range of positive and negative emotions, actively explore their environments, and build relationships with others (OCC 2021). To best support children, especially those experiencing emotional and behavioral challenges, child care providers can benefit from publicly available services such as IECMHC. In turn, improvements in children's social and emotional skills can alleviate provider stress and reduce burnout and turnover (Duran et al. 2009; Le et al. 2018).

This brief provides an overview of opportunities, challenges, and steps needed to expand IECMHC to support more HBCC providers. It is one of a series of briefs focusing on supporting HBCC provider participation in a number of federal programs or service systems.² Based on interviews with experts and a brief review of the literature, we first describe the HBCC context and how it is unique and then describe the basics of mental health consultation, how it is funded, and its benefits for child care providers and children. We discuss challenges and considerations for expanding IECMHC to support more HBCC providers, recommended action steps for states and advocates, and future directions for research to address gaps in knowledge. Box 1 summarizes key points.

BOX 1

Key Takeaways

IECMHC aims to build caregivers' (either parents or child care providers) capacity to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age 6. Evidence suggests IECMHC could be a beneficial resource for HBCC.

Challenges and Considerations for Expanding IECMHC Services

- **Availability of IECMHC services varies across states and communities.** Demand for mental health services is high, especially as the country recovers from the COVID-19 pandemic, but current service availability cannot keep up with this demand.
- **Capacity of the available workforce is limited.** Before the pandemic, but especially now, there are not enough trained mental health consultants to provide the level of services needed.
- **Mental health consultants work in various settings with different types of clients and often lack specific knowledge of HBCC.** Even consultants who are trained to provide services to child care providers may not be trained to understand the nuances of HBCC, which can affect the consultant's ability to appropriately deliver services.
- **The IECMHC field is still evolving and lacks a large body of evidence of effectiveness from experimental studies.** Only two randomized controlled trials of IECMHC have been conducted and both in center-based preschool programs. Less evidence exists on IECMHC models that work well with HBCC providers.
- **Knowledge of services may be a barrier to participation, especially among unlicensed providers, in communities where services do exist.** Services are often not advertised because they are not readily available. Providers in some communities may know about IECMHC services but also know the demand is high so they do not seek services.
- **Providers typically do not seek out IECMHC services until the situation escalates.** Experts mentioned how providers do not make the call to seek consultation when they first start noticing problems but often wait until the situation is so bad that they are out of options.

Recommended Action Steps

- Build the infrastructure and workforce needed to expand access to IECMHC.
- Develop a coherent strategy for building partnerships across early childhood systems.
- Establish communities of practice or networks to connect HBCC providers to services.
- Adapt the mental health consultation model and professional training to fit HBCC providers.
- Provide resources to support mental health professionals in becoming culturally competent.

Future Research Questions to Address

- How does IECMHC look different in the HBCC context versus center-based care?
- What specialized knowledge do mental health consultants need to work with HBCC providers?
- What are the impacts of IECMHC on HBCC providers? What is the optimal dosage?
- What metrics are most appropriate for measuring outcomes of IECMHC in HBCC?
- What lessons can be learned from states successfully providing IECMHC to HBCC providers?

Understanding the Home-Based Child Care Context

Prevalence and Characteristics of HBCC Providers

HBCC is the most prevalent form of nonparental child care in the United States, especially for children younger than age 3 and children from families with low incomes (box 2). In 2019, nearly 5.2 million home-based child care providers (including about 1.1 million paid and 4 million unpaid) served about 12.3 million children younger than age 13 across the US (NSECE Project Team 2021). HBCC arrangements are varied and include relatives caring for a single child or small group, licensed and unlicensed providers caring for small groups of unrelated children, and providers operating a home business with a larger group of children and support staff.

BOX 2

Understanding the Terminology Used to Describe HBCC

The HBCC field has many terms—often poorly defined—that are used to refer to HBCC caregivers, including “family child care,” “family, friend, and neighbor (FFN) care,” “informal care,” and “relative care.”^a Licensed home-based providers are those who meet their state or local licensing requirements, whereas license-exempt home-based child care settings are those legally exempt from state or local licensing, which can include care by individuals who are related or not related to the child. States vary widely in which HBCC providers they require to be licensed, with some states requiring HBCC to be licensed as soon as they care for even one unrelated child and others not requiring HBCC providers to be licensed until they are serving many children.

In this brief, we differentiate between licensed and license-exempt providers as well as “listed” and “unlisted” providers. Listed providers are connected to a public system within their state, appear on state or national lists of early care and education services, and are typically regulated.

^a Sarah Haight, “Family Prosperity: 10 Minutes with a Leading Early Childhood Researcher on Home-Based Care and Opportunities Ahead,” Aspen Institute, November 9, 2020, <https://ascend.aspeninstitute.org/family-prosperity-10-minutes-with-a-leading-early-childhood-researcher-on-home-based-care-and-opportunities-ahead/>.

Early childhood educators broadly, including HBCC providers, are predominantly female, racially, ethnically, and linguistically diverse, and often have children of their own (Whitebook et al. 2018). In 2019, nearly 40 percent of early childhood educators were people of color compared with 20 percent of K–12 educators (Whitebook et al. 2018). According to the 2019 National Survey of Early Care and Education (NSECE), 21 percent of HBCC providers identified as Black, 63 percent as white, 1 percent as Asian, and 7 percent as another race.³ Moreover, 16 percent identified as Hispanic or Latinx and more than 9 percent were born outside the US.⁴ Depending on their circumstances, some of these women are likely facing structural racism, unequal wealth and access to education and medical care, anti-immigrant discrimination, and disparities in mental and physical health outcomes (Bailey et al. 2017).

Stress, Trauma, and Child Behavior Challenges in HBCC

HBCC is unique from center-based care in ways that can contribute to higher stress levels and concerns about providers' well-being. The care environment is a home (typically the provider's home), which can offer convenience but also challenge the provider's work-family boundaries. HBCC providers often care for children of multiple age groups at the same time, including school-age children before and after school and during school breaks. A wide age range requires a certain skill set to manage behaviors and plan activities. HBCC providers often work long hours and nontraditional schedules (early mornings, late evenings, and weekends) to accommodate families' needs with few breaks to address their own personal needs. When working alone, providers often experience feelings of isolation (Gerstenblatt, Faulkner, and Ahyoung 2014).

HBCC providers often experience stressful work environments but have little access to supports in most communities. According to the 2019 NSECE, more than 28 percent of HBCC providers reported feeling like "everything was an effort" some, most, or all of the time in the past week; 38 percent reported having restless sleep some, most, or all of the time.⁵ Only 29 percent reported having access to a mental health consultant or a guidance counselor to help with issues parents raise.⁶

This stress may be partly connected to child behavior problems that become too difficult for providers to handle, especially on their own. Before the pandemic, an estimated one in ten children ages 2 through 5 experienced difficulties with mental health, including attention deficit and hyperactivity disorders, oppositional defiant and conduct disorders, anxiety disorders, and depressive disorders, with boys more likely to present externalizing behaviors that trouble caregivers (Egger and Angold 2006). The full impacts of the pandemic and racial injustice on young children remain unknown, and trauma in children can manifest as behavioral issues (Absher, Maze, and Brymer 2021). Providers need the tools to identify and understand how to manage these behaviors to promote positive child social-emotional outcomes. Studies show inequities around how early childhood educators deal with behavioral issues, with implicit bias against Black children, particularly Black boys (Gilliam et al. 2016).

Among listed HBCC providers, 13.3 percent reported in 2012 that they refused care to a child in the past year because of behavioral problems (Hooper and Sweiker 2020) compared with 9.4 percent of center-based providers that expelled a child in the past three months.⁷ (Though the duration is different across NSECE survey questions for HBCC and center-based providers—one year versus three months—HBCC providers care for much fewer children at any given time than a child care center, suggesting this rate is proportionately higher.) The frequency of refusing a child was lower for unlisted, paid providers (4.3 percent) and unlisted, unpaid providers (1.1 percent), who are more likely to care for children they are related to or with whom they had a prior relationship, such as a neighbor (Hooper and Sweiker 2020). Similar rates were found in 2019, when 11.7 percent of listed HBCC providers and 11.7 percent center-based providers reported refusing care to a child because of behavioral problems within the past year or three months, respectively. Among unlisted providers in 2019, 3.3 percent of paid providers and 1.6 percent of unpaid providers denied care to a child in the past year for the same reason.⁸

Listed HBCC providers who expelled a child from their program differed in several ways from other listed HBCC providers who did not; they had higher total enrollment, served more children younger than age 5 (versus some older school-age children), cared for more children with disabilities, and were motivated to provide child care because of the convenience rather than building careers or helping children and families (Hooper and Sweiker 2020). Listed HBCC providers who expelled children were also younger and had fewer years of work experience, but they were more likely to have some college education (and not only a high school diploma or less). These factors suggest providers who expel are dealing with potentially more stressful situations without the career experience to cope. They were also disproportionately white and Latinx (and less likely to be Black), suggesting some racial differences in providers' experiences (Hooper and Sweiker 2020).

The COVID-19 pandemic and rising awareness and trauma around racial injustice have exacerbated stressors and negative impacts on HBCC providers' mental health. During the COVID-19 pandemic when child care centers and schools across the country closed, families needing child care relied more on HBCC providers, many of whom continued operating under stressful conditions (Porter et al. 2020). COVID-19 impacted Black, Latinx, and Native American communities at disproportionate rates, with the pandemic as a "crisis on top of a crisis," compounding racism, discrimination, stigma, and implicit bias (Absher, Maze, and Brymer 2021). Providers cared for children and families dealing with the trauma of loss, illness, and employment and housing instability while coping themselves. The stress of the pandemic on top of the trauma, behavioral issues, and mental health challenges that some providers were already experiencing is concerning, especially given the large number of children in their care.

Understanding the Basics of Infant and Early Childhood Mental Health Consultation (IECMHC)

HBCC providers would benefit from proper access to resources and training to support their own mental health and wellness and support the social-emotional well-being of children in their care. One promising strategy is expanding access to IECMHC.⁹ In this section, we describe IECMHC and its key components, how many states offer IECMHC services and the various models used, evidence of program effectiveness, and how services are funded.

What Is IECMHC?

IECMHC aims to build caregivers' (either parents or child care providers) capacity to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age 6 and their families.¹⁰ Mental health professionals provide the services to caregivers to support their work with children and families. Although it is not a direct service to children, IECMHC gives caregivers the tools to improve interactions with children, identify potential challenging behaviors in children and correct them, and enhance children's social skills. Addressing children's behavioral, social, or emotional problems early can set them on a path to perform well in school and beyond. Emotional and behavioral problems increase risk for school suspensions and expulsions, which disproportionately occur among

boys of color (OCR 2014).¹¹ Mental health consultants can help providers understand implicit bias, reflect on their practice, and shift their attitudes, beliefs, and engagement with children.

Emerging in response to the early childhood field’s recognition of preschool suspensions and the need to train and support the workforce in managing difficult behaviors (Perry et al. 2011), IECMHC has evolved and gained attention in recent years as an approach for supporting the mental health and well-being of caregivers—including HBCC providers—and all children, not only those exhibiting problems (Duran et al. 2009; Le et al. 2018; OCC 2021). Improvements in children’s social and emotional skills and behavior can alleviate provider stress and reduce burnout and turnover (Duran et al. 2009; Le et al. 2018). The experts we interviewed commented on how HBCC providers, given work stressors and limited access to supports in most communities, would greatly benefit from mental health consultation.

What Are the Key Components of IECMHC?

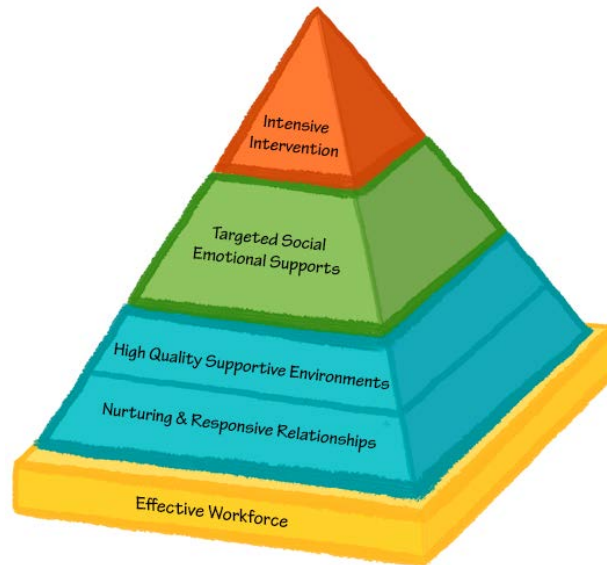
IECMHC can take several forms: *child and family centered*, which focuses on the needs of one child; *classroom or group centered*, which focuses on developing skills in a caregiver that can be applied to all children in care; and *program centered*, which develops the skills of a director or program leader to help all children and staff members at their facility. For this brief, we will focus on services provided to HBCC providers for a single child or whole group, though those services could fall into any category mentioned, as many HBCC settings are simultaneously a “classroom or group” and a “program.”

IECMHC is grounded in the Pyramid Model for Supporting Social and Emotional Competence in Infants and Young Children that has multiple levels of intervention:¹²

1. **Effective Workforce.** The pyramid starts at the bottom with providing the broadest services to the most people by having providers seek informal supports for mental health and development on their own or through their existing networks. These efforts help create an effective workforce that can broadly support children’s social and emotional competence.
2. **Nurturing and Responsive Relationships and High-Quality Supportive Environments.** The next tier in the pyramid includes two types of universal supports for children. Both refer to experiences in the home and care setting and require some level of training, usually in a group.
3. **Targeted Social-Emotional Supports.** This preventative tier describes targeted supports to individual providers that equip them with the tools to support the mental health of children in their care without having a consultant come into the home. The targeted supports are implemented to help children at risk of demonstrating challenging behaviors *before* needing more targeted intervention.
4. **Intensive Intervention.** The top tier of the pyramid is intensive intervention for children who have ongoing problems, which results in a one-on-one intervention with a mental health consultant. When more clinical intervention is necessary, consultants can help refer children to early intervention services available in their state or to counseling or clinical care services.

FIGURE 1

Tiers of the Pyramid Model



Source: National Center for Pyramid Model Innovations, accessed September 1, 2021
<https://challengingbehavior.cbcs.usf.edu/Pyramid/overview/tiers.html>

How Many States Offer IECMHC, and What Models Do They Use?

At least 35 states currently implement IECMHC, most of which offer services statewide and to licensed private child care settings, including family child care providers (Duran et al. 2009; OCC 2021). A national scan conducted in 2009 found only three states provided IECMHC to unlicensed HBCC providers (Duran et al. 2009). Yet more recent data are not available (or were not uncovered in our search) to determine the current number of states reaching unlicensed HBCC. Experts described how IECMHC services look different from state to state, with some implementing a model where a consultant is called out to a child care program to help a provider with an issue. In other cases, states or local communities use a model where a mental health provider is assigned to work with a program regularly and is embedded in the program long term. In both models, however, the consultation is offered to the child care provider. The service is not therapy or counseling, in that the consultant is not offering direct help to the provider to deal with diagnosed mental health problems, such as anxiety or depression. Moreover, the consultant is not working directly with the child. The consultation supports the provider and offers an opportunity for the provider to gain information, insights, and strategies to meet children’s social and emotional developmental needs.

A cross-state study on IECMHC identified five factors critical to effective implementation that are often missing: *solid program infrastructure* (e.g., clear model design, strong leadership, strategic partnerships), *highly qualified mental health consultants*, *high-quality services*, *a positive relationship between the consultant and consultee*, and *the readiness of child care providers and families* (e.g., openness to gaining new skills and knowledge; Duran et al. 2009).

What Is the Evidence of IECMHC Program Effectiveness?

Two randomized controlled trials (RCTs) of IECMHC have been conducted to test for program impacts—one in Connecticut and the other in Ohio. The Connecticut RCT found that children in classrooms where teachers received consultation were rated significantly lower on measures of hyperactivity, restlessness, and other problem behaviors than children in classrooms where teachers did not receive consultation (Gilliam 2007; Gilliam, Maupin, and Reyes 2016). Similar positive findings were found in the Ohio RCT, where children referred to IECMHC and randomly selected peers showed significant improvements in social and emotional skills (Reyes and Gilliam 2021). The peer effects suggest promising effects of IECMHC on teachers' interactions with children broadly and on peer relationships and behavior. Additionally, a large nonexperimental study of children at risk for child care expulsion in Maryland also found significantly fewer problem behaviors and increases in social skills among participating children after they received individualized IECMHC (Perry et al. 2008). The study found less than 7 percent of children were involuntarily removed from their care setting (Perry et al. 2008).

How Is Mental Health Consultation Funded?

By definition, IECMHC joins two systems of care: early childhood and mental health. However, there is no clear, consistent place in these service systems where IECMHC exists and no single dedicated funding source for IECMHC. This means funding is typically blended and braided.¹³ Multiple federal funding streams can be used for IECMHC and paired with state general funds, local government funding, and philanthropic support.¹⁴ According to a national scan, the most common sources of funding include state general funds (41 percent of states), the Child Care and Development Fund (CCDF; 34 percent), mental health funding (32 percent), and private funds (28 percent) (Duran et al. 2009). However, available information does not distinguish funding for services in HBCC versus other care settings.

CHILD CARE AND EARLY CHILDHOOD FUNDING STREAMS

New federal child care relief funds in response to the COVID-19 pandemic give states the flexibility to provide grants and assistance to stabilize the workforce, including supporting providers' mental health. The Coronavirus Aid, Relief, and Economic Security Act and the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA) both provided states with flexible funds that could be used for various purposes. An analysis of how states are using the \$10 billion from CRRSA identified multiple innovative strategies to support the workforce's mental health and well-being; Maine, for example, plans to expand the Early Childhood Consultation Partnership, which provides mental health consultation to early care and education programs (Fortner 2021). The American Rescue Plan Act provides an additional \$39 billion investment in the child care sector, offering an important opportunity to build the required infrastructure for future service delivery and expansion. Yet another long-term sustainable source is needed.

As one option, states can use quality set-aside funds from CCDF; states and territories must allocate a minimum of 9 percent of CCDF funding for quality activities, and IECMHC is an allowable activity. Some states embed social and emotional development in their quality rating and improvement system standards and use IECMHC. States are also permitted to transfer up to 30 percent of Temporary Assistance to Needy Families (TANF) dollars to CCDF, and some states have done that and used funds to support IECMHC.

Head Start and Early Head Start funding is also used to support IECMHC. About 10,000 children enrolled in Head Start are served in family child care settings.¹⁵ Providers receiving Head Start or Early Head Start funding must have access to mental health consultants, as required by Head Start Program Performance Standards.¹⁶ Title 1 funding may also be used in cases where family child care providers are offering public prekindergarten services covered at least in part with Title 1 funding. Other federal early childhood funding streams states have leveraged include Preschool Expansion Grant Birth through Five Grants (PDG B-5) and Early Head Start-Child Care Partnerships.

HEALTH AND MENTAL HEALTH FUNDING STREAMS

Multiple funding streams from the health and mental health sector have been used to support IECMHC including the Community Mental Health Services Block Grant, Title V Maternal and Child Health Services Block Grant, the Infant and Early Childhood Mental Health Grant Program from the Substance Abuse and Mental Health Services Administration (SAMSHA), System of Care Expansion and Sustainability Grants from SAMHSA, and Early Childhood Comprehensive Systems Health Integration Prenatal-to-Three Program under the Health Resources and Services Administration (HRSA). Many of these grants target supports to children with serious emotional disturbances or other diagnosed behavioral or mental health disorders.

Medicaid is also a possible funding option but may require a diagnosis for the focal child and determination of appropriate billing codes. In 2018, 69 percent of states (35) reported that Medicaid could pay for an early childhood mental health specialist to provide services in an early care and education program (Smith et al. 2018).

EXAMPLES OF HOW STATES ARE FUNDING IECMHC

Historically, states have used federal funds to launch IECMHC programs and state general funds to sustain the programs. Some states have developed robust IECMHC programs.

For example, Michigan created a program under their Race-to-the-Top Early Learning Challenge grant.¹⁷ The program is designed to serve home-based caregivers and provides them with supports to develop quality relationships with the children in their care, and it builds on an earlier IECMHC model in the state that focused on providing services to family, friend, and neighbor providers (Le et al. 2018). After the funds from the Race-to-the-Top Early Learning Challenge grant expired, Michigan was able to continue funding the program through dedicated state funding.

Maryland took a different approach and created a statewide IECMHC program using funds from the State Department of Education (Etter and Capizzano 2019). The program serves various early care settings, including center-based care and prekindergarten, as well as family child care homes.

Arizona set up a dedicated funding stream through a citizen’s initiative called First Thing’s First to fund early childhood services through a tobacco tax (Shivers 2015). The program implemented with the funds, Smart Support, serves licensed center- and home-based providers. Smart Support worked with the state’s largest network of family, friend, and neighbor providers—Kith and Kin—in multiple demonstrations to support this population of providers (Le et al. 2018). From our review, IECMHC and HBCC clearly need to be a priority at the state level for funding to reach these populations under the current system.

Colorado has used CCDF quality set-aside funding to implement IECMHC and recently allocated funds from its PDG B-5 grant to expand access to a range of child care providers. Colorado also creatively used TANF funding after making the case that parents enrolled in TANF training programs would have to leave work when their children were suspended or expelled from child care. IECMHC meant children’s developmental needs could be met so parents could work.

Michigan identified its Child Care Expulsion Prevention program as a Medicaid-covered Prevention Direct Service model, because IECMHC reduced the need for individuals to seek treatment through the public mental health system (CoE n.d.).

Additionally, one expert pointed to emerging evidence from the National Survey of Children’s Health that found children were more likely to be expelled from preschool if a parent was addicted to opioids. Given a possible connection between opioids and preschool expulsion (though more research is needed on this), states might make the case to use money from legal settlements from opioid addiction cases to fund IECMHC. Early childhood services such as public prekindergarten and home visiting are commonly funded through “sin taxes” such as lotteries and tobacco taxes. The expert noted it is not a far stretch to argue supporting mental health services through sin taxes as well.

Possible Impacts of Expanding Mental Health Consultation to HBCC

Evidence from RCTs in center-based preschool settings points to positive impacts of IECMHC. Similar impacts are likely to be observed in HBCC settings if key program components (i.e., strong infrastructure, trained staff, quality services with a clear model, rapport with the provider, provider’s readiness to change) are in place.

Important outcomes for providers include

- improved interactions with children and families;

- reduction in implicit bias stemming from effects of structural racism in early care and education settings; and
- reduced stress and greater provider wellness and attachment to the field, which could improve workforce retention.

Measurable impacts on children and families include

- reduction in problem behaviors;
- increased positive child interactions toward caregivers and peers;
- fewer expulsions from child care settings; and
- greater child care stability for families.

Given the evidence about the potential impact of IECMHC on expulsion rates, one question is what the potential impact of providing IECMHC to all listed HBCC providers would be. For this estimation, we focus on listed providers (those that appear in state licensing or registry lists) who, according to past research, are more likely than unlisted HBCC providers to refuse care to a child because of problem behaviors (Hooper and Sweiker 2020). We make the following assumptions to determine the level of impacts on expulsion rates using the most recent available data:

- In 2019, 91,200 listed HBCC providers were in the US (NSECE Project Team 2021).
- 11.7 percent of these listed HBCC providers expelled a child in the past year, according to our analysis of 2019 NSECE data.
- HBCC providers that expelled a child in the past year expelled on average one child.
- 10,670 children (11.7 percent of 91,200) are expelled from a listed HBCC program each year.
- 93 percent of children at risk of expulsion who experience IECMHC will avoid expulsion from their child care program (Perry et al. 2008).
- **Approximately 9,923 children (93 percent of 10,670) will avoid expulsion from their child care programs each year if all listed HBCC providers have access to IECMHC.**

These estimates are larger when accounting for children in unlisted HBCC settings whose providers may be eligible to receive IECMHC. Additionally, providers could expel more than one child in a year, so our estimate is conservative. Research also suggests IECMHC can have “spillover” or “peer effects,” meaning nonfocal children enrolled in the program (those not displaying the problem behavior that triggered consultation) will also demonstrate benefits (Reyes and Gilliam 2021).

Challenges and Considerations for Expanding IECMHC

Increasing access and participation in IECMHC among HBCC providers relies on overcoming numerous challenges (Duran et al. 2009; Le et al. 2018). Some challenges are specific to HBCC and others are more general problems facing the mental health field.

Availability of IECMHC Services Varies across States and Communities

The demand for mental health services is high, especially as the country recovers from the pandemic, but current service availability cannot keep up with this demand. Rural areas, in particular, are less likely to have mental health consultation opportunities available to them. Creating models that are accessible regardless of location can help an underserved population of providers. Experts suggested taking advantage of available technology and lessons learned during the pandemic around telehealth to offer some consultations virtually. Initial visits are best in person to build rapport with the caregiver and observe children in their care setting, but subsequent meetings and trainings for consultants could be handled with web conferencing technology (if reliable internet connection is available) to maximize reach and the number of caregivers served. Additionally, a more efficient way to meet the demand for mental health services is not to provide direct services to every child who might need them but to bring in consultants to work with HBCC providers and build their skill set so providers are prepared to apply approaches to multiple children in their care. Experts also pointed to the fact that, in many parts of the country, no robust system of clinical intervention exists for young children. This places pressure on mental health consultants that are unable to effectively refer children to the clinical services they need.

Capacity of the Available Workforce Is Limited

Before the pandemic, but especially now, there are not enough trained mental health consultants to provide the level of services needed. In some states, the consultants must be licensed or have master's degrees in social work or a related field. Other states have lesser requirements such as some training in mental health. Hiring staff with the required skills and knowledge is challenging in some communities with a shortage of qualified job candidates.

Mental Health Consultants Work in Various Settings with Different Types of Clients and Often Lack Specific Knowledge of HBCC

No standardized agency houses mental health consultants, with most employed by community health organizations or universities. Family child care networks can also employ mental health consultants. One expert we interviewed discussed a well-resourced HBCC network that was successful in administering services because the network was already embedded in the community. However, this is not always the case. Often, few prerequisites are in place for receiving a grant for implementation of mental health consultation services. This can result in the most well-resourced networks receiving grants without having the infrastructure to execute the program. The location of mental health consultants can influence who is reached by services and how. The service agency can also shape consultants' familiarity with early care and education and HBCC specifically. Even consultants who are

trained to provide services to child care providers may not be trained to understand the nuances of HBCC, which can affect the consultant's ability to appropriately deliver services. Experts identified this challenge and pointed to the need to develop training modules and resources to educate and prepare mental health consultants to work with HBCC providers.

The IECMHC Field Is Still Evolving and Lacks a Large Body of Evidence of Effectiveness from Experimental Studies

One expert we interviewed explained how the field has not yet fully identified itself. Various models are used with different levels of research evidence—some lacking core components identified as critical for program success. Mental health professionals draw on many frameworks and curricula considered effective. Past RCTs were conducted in center-based care settings, but less is known about the effectiveness of IECMHC for HBCC. Current standards and metrics used to evaluate efficacy of early childhood interventions are not always applicable to mental health consultation and HBCC. For example, one expert suggested that simply completing the program is a good benchmark for success among HBCC providers because the provider persevered through the program.

Knowledge of Services May Be a Barrier to Participation, Especially Among Unlicensed Providers, in Communities Where Services Do Exist

Providers are often reached through their existing connections, whether those are formal connections with state child care agencies or local organizations that send information to providers, or informal connections like a church or community center. Yet experts commented that services are often not advertised because they are not readily available. Providers in some communities may know about IECMHC services but also know the demand is high and waiting period is long so they do not seek services.

Providers Typically Do Not Seek Out IECMHC Services until the Situation Escalates

Experts mentioned how providers do not make the call to seek consultation when they first start noticing problems, or when things start becoming challenging. They often wait until the situation is so bad that they are out of options and maybe even considering dismissing the children from their program. Usually this means the relationship with parents has already been strained. The consultant's job is to build and repair relationships and then remove themselves from the environment. Providers may wait to make the call because they know services are in high demand. They may also be hesitant to seek professional help. Overcoming the stigma of mental health and seeking professional help is a societal barrier, not only specific to HBCC providers. Making IECMHC services more accessible and approachable would reduce the number of problems that escalate into emergencies.

Recommended Actions

Our assessment of the published literature and interviews with key experts identified several steps that state policymakers and agency staff can take to connect HBCC providers with IECMHC.

Build the Infrastructure and Workforce Needed to Expand Access to IECMHC

States should consider ways of allocating available funding to build the infrastructure required to expand mental health consultation services to reach all licensed HBCC providers and even licensed-exempt providers regularly caring for children. This means scanning current local capacity for service delivery and options for grantmaking to local service organizations and academic institutions. States might consider establishing new and existing HBCC networks to administer and/or advertise services and help with recruitment. Expanding access may mean long-term investments in strengthening the pipeline of mental health consultants qualified to work with HBCC in communities with staffing shortages. Improving access also means investing in broadband internet services and electronic devices to support televisits and online training for new consultants. To encourage such investments at the level needed to make significant change, and to address the stigma of mental health programs, one expert suggested launching a public health campaign to highlight the importance of early childhood mental health and the child care workforce's needs.

Develop a Coherent Strategy for Building Partnerships across Early Childhood Systems to Link HBCC Providers to Mental Health Supports

Providers connected with some systems (i.e., licensing, child care subsidy, Child and Adult Care Food Program, state Quality Rating and Improvement System, formal family child care network) have the potential to get connected to services through these systems with improved cross-system coordination, though only a fraction of HBCC providers are connected in some way. License-exempt providers, such as relatives and neighbors caring for one child or a small group, have perhaps the highest need (given population size and qualifications) yet are the least served in IECMHC. To engage them, experts suggest hosting informal gatherings such as play groups or coffee clubs (Duran et al. 2009) and reaching providers where they typically gather, such as in churches, libraries, and community recreational facilities.

Establish Communities of Practice or Networks to Connect HBCC Providers to IECMHC

As demonstrated in the Pyramid Model, there are various points of entry for mental health consultation for HBCC. One of these entry points is in a peer group setting, whether through a staffed family child care network, an informal network through a local community group, or a peer community of practice outside the network structure. A peer group setting lends itself to attracting and retaining providers. According to several experts, during the COVID-19 pandemic, connection to others going through similar experiences became a lifeline for providers. This was a theme that emerged throughout

interviews: HBCC providers are drawn to peer groups that offer them the opportunity to connect with others with a shared experience, and they become invested in each other's successes. Approaching mental health consultation through these networks may make providers more willing to participate because it is in an environment they trust. The consultation could be provided directly to a group of providers, such as a training on social-emotional learning, with follow-up one-on-one consultations for providers desiring more intensive services in their homes.

Adapt and Strengthen the Mental Health Consultation Model and Professional Training to Fit HBCC Providers' Unique Needs

Several experts identified consultant training specific to HBCC as an area ripe for improvement. Tailoring training can make participation more appealing to HBCC providers who may be skeptical of the program and its utility. Like all programs designed to reach child care providers, differentiating training for home-based care, and by licensure, is key to providing appropriate services to providers and the children in their care. Previous work has identified the skills, competencies, and credentials of effective consultants and the training and support they need (Duran et al. 2009). Building on this work, several experts identified the need to create training modules and resources for the field to prepare mental health professionals to work with HBCC providers who could range from relative caregivers to licensed providers running a business.

Provide Resources to Ensure Mental Health Professionals Have the Training and Tools to Provide Culturally Responsive Services

Mental health consultants need to be prepared to engage with providers in a way that is accessible, trustworthy, and responsive to their culture. Providers are welcoming consultants into their homes, which means respect for culture is critical. This may also mean providing services in the provider's preferred language. In many settings, HBCC providers closely reflect the children they care for in terms of culture, so providing culturally and linguistically appropriate consultation will also help the children and families they serve (Le et al. 2018). Linguistic and cultural match between mental health professionals and HBCC providers can also help break down the stigma of mental health in different communities. It is well documented that communities of color in the US face barriers to accessing mental health supports. These barriers stem from systemic failures and cultural norms and expectations.¹⁸ Privacy concerns, fear of personal weakness, and societal expectations have been cited as reasons for not seeking professional help in Black, Latinx, Indigenous, and Asian-American and Pacific Islander communities. Ensuring services are accessible to providers through a trusted and appropriate consultant can make seeking IECMHC more appealing. Numerous organizations have gathered resources to begin the process of ensuring appropriate mental health service delivery, including the National Alliance on Mental Illness and the US Department of Health and Human Services.¹⁹ Using these resources can help recruit and train culturally competent consultants.

Areas for Further Investigation

Our assessment identified several areas for future research to fill identified gaps in knowledge.

Questions needing to be addressed include the following:

- How does IECMHC look different in the HBCC context versus center-based care? What considerations should be made when the provider is related to the child versus a nonrelative?
- What specialized knowledge do mental health consultants need to work with different types of HBCC providers? Are there examples of states and communities that already have trainings for mental health consultants to see what works or what does not?
- What are the impacts of IECMHC on HBCC providers? What can be learned from future evaluations of implementation and outcomes (such as through an RCT)?
- What metrics are most appropriate for measuring outcomes of IECMHC for HBCC providers and children in their care?
- What is the optimal dosage (i.e., duration of services and intensity) for IECMHC in a HBCC setting? Limited available evidence shows models are effective when they are intensive and short term rather than checking in once a month over a longer period. Future studies could examine pairing a short-term, intensive model with a “booster” program to provide follow-up support.
- What lessons can be learned from states and local communities successfully providing IECMHC to licensed and/or unlicensed HBCC providers? What strategies for recruitment and service delivery work well? What approaches work with different types of providers? What are lessons learned that can be shared with other localities?

Conclusion

Historically, public concern for the child care workforce’s well-being has been absent. The COVID-19 pandemic may have shed some light on the plight of child care workers, especially HBCC providers, with pressure to serve families under stressful and risky conditions. New federal aid under the American Rescue Plan Act offers states resources that can be used to support mental health. Supporting child care providers with a significant expansion and integration of IECMHC in the early childhood system can help improve their emotional well-being and the well-being of young children in their care. Addressing possible mental health problems early on can set children on a healthy path.

Notes

¹ Gina Adams, “Finding Solutions to Support Child Care During COVID-19,” *Urban Wire (blog)*, Urban Institute, September 22, 2020, <https://www.urban.org/urban-wire/finding-solutions-support-child-care-during-covid-19>.

- 2 Companion briefs published by the Urban Institute discuss HBCC providers' participation in the child care subsidy system (Adams and Dwyer 2021a), the Child and Adult Care Food Program (Adams and Hernandez-Lepe 2021a), home visiting services (Sandstrom and Dwyer 2021), the Small Business Administration (Adams and Hernandez-Lepe 2021b), and HBCC networks (Adams and Dwyer 2021b). See all briefs at "Expanding Participation of Home-Based Child Care Providers in Federal Programs and Services," Urban Institute, accessed November 9, 2021, <https://www.urban.org/policy-centers/center-labor-human-services-and-population/projects/expanding-participation-home-based-child-care-providers-federal-programs-and-services>.
- 3 Weighted estimates from the NSECE, 2019, Home-Based Public-Use Data File, Inter-University Consortium for Political and Social Research [distributor], October 26, 2021, <https://www.childandfamilydataarchive.org/cfda/archives/cfda/studies/37941/>.
- 4 Weighted estimates from the NSECE, 2019, Home-Based Public-Use Data File, Inter-University Consortium for Political and Social Research.
- 5 Weighted estimates from the NSECE, 2019, Home-Based Public-Use Data File, Inter-University Consortium for Political and Social Research.
- 6 Weighted estimates from the NSECE, 2019, Home-Based Public-Use Data File, Inter-University Consortium for Political and Social Research.
- 7 Weighted estimates from the NSECE, 2012, Center-Based Public-Use Data File, Inter-University Consortium for Political and Social Research.
- 8 Weighted estimates from the NSECE, 2019, Home-Based Public-Use Data File, Inter-University Consortium for Political and Social Research.
- 9 IECMHC is sometimes referred to as "early childhood mental health consultation" and sometimes simply as "mental health consultation," acknowledging the consultation benefits the child and adult.
- 10 "Defining Early Childhood Mental Health Consultation," Georgetown University Center for Child and Human Development, accessed April 13, 2021, https://www.ecmhc.org/tutorials/strengthening/mod2_2.html.
- 11 Although Black children make up only 18 percent of the preschool population in public schools, they make up 42 percent of preschoolers suspended once and 48 percent of preschoolers suspended more than once. Black boys receive more than three out of four out-of-school preschool suspensions (US Department of Education 2014).
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