Creating a Statewide System of Multi-Disciplinary Consultation for Early Care and Education in Connecticut

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MULTI-DISCIPLINARY CONSULTATION SYMPOSIUM

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ABOUT THE CHILD HEALTH AND DEVELOPMENT INSTITUTE OF CONNECTICUT

The Child Health and Development Institute of Connecticut is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut. CHDI works to assure that children in Connecticut who are disadvantaged will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

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EXECUTIVE SUMMARY

High-quality early care and education programs help prepare children for school and for life. Young children who experience high-quality programs are more self-confident and have better language skills, a greater ability to regulate their behavior, and more advanced cognitive development. While the research provides compelling evidence about these benefits, many young children are still not in the safe, stimulating, and nurturing early care environments that they need. National research confirms that the majority of child care programs do not operate at high-quality levels.

Given the disconnect between what the research shows is necessary for young children and what children currently receive, providers, policymakers and advocates have been identifying promising practices to move quality enhancement to scale. One such promising practice is multi-disciplinary child care consultation.

Child care consultation refers to professional guidance or services delivered on-site at a child care program. The goal of the consultation is to improve child care services (i.e., program level consultation) and/or to address the individual needs of a child and her family (i.e., child specific consultation). The consultation can target one or more disciplines such as health, special education, mental health, early education, and nutrition. The consultation services can be organized to assist the center, the professional and paraprofessional staff, and/or the children and families directly.

Research on child care consultation from the fields of health, mental health, and special education shows the promise of this intervention. Consultation can improve overall program quality as well as specific aspects of programs that contribute to the quality of care provided, such as teacher knowledge and efficacy. Factors that contribute to consultation's success included: having more highly educated consultants and consultants with early childhood backgrounds; offering training for consultants; good program management and leadership in the child care center receiving the consultation; the consultant's ability to make a long-term commitment; and whether or not the consultant's approach was consistent with the program's philosophy.

Unlike many states, Connecticut child care licensing regulations require that child care centers and group day care homes utilize consultants. However, considerable variation exists among centers in their use of consultants: some use them regularly, while others never go beyond the "on-paper" relationship needed for licensure. This variation in usage results from the lack of specificity about consultants' roles and responsibilities in the regulations, limited monitoring by the Department of Public Health, and programs' limited financial resources. Regulations alone have not been sufficient to ensure widespread effective use of child care consultants.

The creation of a Connecticut multi-disciplinary consultation system will benefit from a variety of initiatives and policy efforts that have laid the groundwork. Healthy Child Care America (HCCA), a national campaign funded by the federal Maternal and Child Health Bureau, has highlighted child care consultation as an important strategy to promote children's health and safety for the past ten years. Healthy Child Care Connecticut, an

outgrowth of HCCA, has provided training for child care consultants over the past several years; while the primary training focus was health consultation, Healthy Child Care Connecticut expanded the national training curriculum to include more information on children's mental health and education. Although federal funding for Healthy Child Care Connecticut has ended, the work of the initiative will be continued through the federally-sponsored State Early Childhood Comprehensive Systems Initiative, which in Connecticut is called Early Childhood Partners.

The National Association for the Education of Young Children (NAEYC) accreditation system outlines specific standards child care programs must meet to be accredited. NAEYC will unveil and implement revised program standards and performance criteria in 2006. These revised performance criteria include the use of consultants in early care and education. These new standards will affect a significant number of early care and education programs in Connecticut. All programs that receive funding from the State Department of Education's School Readiness initiative or the Department of Social Services must be accredited. The many other child care programs that pursue accreditation because of their desire to meet high professional standards and attract parents will also be affected. It is likely that any new state-funded early care and education programs, such as Universal Pre-Kindergarten, would also require accreditation.

The initiatives and policy efforts described above pave the way for Connecticut to build a statewide multi-disciplinary child care consultation system. Moreover, Connecticut can benefit from the lessons learned from other existing models of child care consultation that have been implemented locally, in other states, and nationally. Models described in this paper include:

- *The Multi-Disciplinary Team* (MDT), which provides a range of consultation services to child care centers in New Haven, including health, speech and language, emotional and behavioral health, occupational and physical therapy, and social work.
- *Child FIRST*, which works with child care centers, home day care providers, and families in the greater Bridgeport area and focuses on emotional and behavioral health concerns.
- *The Early Childhood Consultation Partnership* (ECCP), a mental health consultation program for child care centers that operates statewide in Connecticut.
- *Day Care Plus*, a mental health consultation initiative available to all child care centers and licensed family child care homes in Cuyahoga County, Ohio, which encompasses the City of Cleveland.
- *The Comprehensive Child Care Services Program* in Rhode Island, which provides nutrition, health, mental health, family advocacy, and educational consulting to child care centers and licensed family child care homes that serve low-income children.
- *The Abbott Preschool Program*, which is available in New Jersey's 30 highest poverty districts and provides preschools the services of curriculum specialists (similar to early childhood education consultants), family workers, nurses, and social workers.

- *Head Start and Early Head Start*, a comprehensive early childhood development program that integrates support services such as consultation into the program.
- *The US Army Child Development System*, which provides experts in a wide range of disciplines such as program administration, curriculum, parent education and involvement, health, and special needs to its child care programs.

Although these models vary in terms of consultation disciplines, settings and age groups served, length of program services, and funding streams, several common themes emerged from their experiences. First, consultants must appreciate and understand early childhood development and early care and education settings to be effective. Second, strong relationships between the child care staff and consultants are critical, take time to develop, and are based on trust. Finally, because change takes time, consultation should be ongoing.

Despite consultation's promise as a quality improvement strategy and previous efforts in Connecticut to ensure that child care programs incorporate consultation, child care consultation in the state remains a patchwork of services. This paper concludes with specific recommendations to transform this consultation "patchwork" into a robust multi-disciplinary consultation system that enhances the quality of early care and education in Connecticut, improves children's developmental outcomes, and is broadly available to and utilized by early care and education programs throughout the state. These recommendations fall into three broad categories:

- **Program design**
  - Include a full range of disciplines in the consultation system, with a focus on health, mental health, and education;
  - Provide both program-level and child-specific consultation;
  - Offer consultation supports to the full spectrum of early care and education settings;
  - Make consultation available to all programs, regardless of the population they serve;
- **Quality assurance**
  - Establish consistent qualifications for consultants;
  - Clarify consultants' roles and responsibilities;
  - Provide training, resources, and networking opportunities for consultants;
  - Promote training and information to help directors make best use of consultation;
  - Incorporate a strong evaluation component;
- **Delivery structure/process**
  - Develop a structure for statewide oversight;
  - Create a regional service delivery system with clear entry points;

- Develop multi-disciplinary teams within each region;
- Deliver consultation based on a program's individual needs; and
- Stimulate public and entrepreneurial funding mechanisms to expand and sustain the system.

The next step in the implementation process will be the design and field testing of a multi-disciplinary consultation pilot. Hopefully, the results of the pilot will show the worthiness of this investment and attract additional public funding so that the multi-disciplinary consultation system can be implemented statewide. A multi-disciplinary consultation system, widely available to and utilized by the full spectrum of early care and education settings, can help ensure Connecticut's youngest citizens receive the high-quality care they deserve.

INTRODUCTION

The early years of life offer an unparalleled window to support children's healthy development, social and emotional wellness, and academic learning. Research demonstrates high-quality early care and education produces children who are emotionally secure and self-confident, proficient in language use, able to regulate impulsive and aggressive inclinations, and advanced in cognitive development.[1] In some instances, high-quality programs offer early detection and coordinate early interventions that address a child's developmental problems – allowing the child to be "ready" for kindergarten. Moreover, children who experience high-quality early childhood programs are more likely to score higher on academic achievement tests, advance through school and remain in regular class settings, and graduate from school.[2]

In Connecticut, 61% (162,000) of children under age six require out-of-home child care.[1] Increasingly, child care programs must address a wide range of issues beyond creating a safe, stimulating, and nurturing environment. Child care programs must address concerns related to health, mental health, and social services, among others. Coordinating these services through the early care and education system makes sense. Unfortunately, the majority of child care programs perform unevenly at best.[3] Reasons for this mediocre performance include limited financial resources, under-qualified and underpaid staff, and limited connections to other community services.

Research suggests that evidence-based practices can contribute to high-quality programs and positive outcomes. A ***multi-disciplinary child care consultation model*** holds significant promise to transform child care services from mediocre to excellent. The model increases access by child care services to multi-disciplinary professionals in health, mental health, and social services, among others. The consultation services can be organized to assist the center, the professional and paraprofessional staff, and/or the children and families directly.

Connecticut's current legislative, policy, and regulatory environment supports the implementation of such a model. A number of child care programs successfully use the child care consultation model, and Connecticut policymakers are examining the feasibility of creating a statewide multi-disciplinary child care consultation system.[2] This paper supports these policymakers and early care and education leaders in their planning process. Specifically, the paper:

a) Describes the concept of child care consultation;

b) Reviews research literature related to the effectiveness of consultation in child care settings;

c) Overviews the current policy context related to early childhood consultation, both nationally and in Connecticut;

d) Describes several different consultation models and reports lessons learned; and

e) Recommends design and implementation considerations to advance a multi-disciplinary consultation system in Connecticut.

[1] Families require child care because it represents the only viable option for parents to attend to responsibilities such as work, education, and/or job training.

[2] See Appendix A for a brief history of child care consultation in Connecticut.

WHAT IS CHILD CARE CONSULTATION?

Child care consultation refers to professional guidance or services delivered on-site at a child care program. The goal of the consultation is to improve child care services (i.e., program level consultation) and/or to address the individual needs of a child and her family (i.e., child specific consultation). The consultation can target one or more disciplines such as health, special education, mental health, early education, and nutrition.

Program-level consultation builds the capacity of child care staff by increasing their skills and knowledge to provide high-quality care. Highly trained child care consultants model effective teaching techniques, explain how to reorganize the classroom's physical space to promote learning, reinforce health and safety practices, and help teachers understand how to create stronger relationships with families. Child care staff receive real-time feedback as they apply their new knowledge and skills in the child care setting. As needed, program-level consultation can focus on a center's administrative practices to help programs develop the capacity to sustain changes.

Child-specific consultation refers to a situation in which a child and her family require specific services that extend beyond the knowledge, skills, and/or experiences of the child care staff. During child-specific consultation, consultant services typically include screenings and/or assessments, direct services or interventions, and/or referrals for more intensive support services. Consultants can help families access services, support greater integration of services, and reduce duplication among different service providers.

Child care consultation has gained momentum in recent years because it offers a way both to improve program quality and to address the needs of individual children within the child care setting. In addition, consultants can offer an outside perspective, expertise in other fields, and community connections that enrich the work of child care staff. The consultation model focuses on capacity-building, and it is a strengths-based intervention that can meet programs wherever they are along the quality continuum. Multi-disciplinary consultation recognizes the overlap among early childhood education, health and safety, and mental health – all intertwined aspects of a child's development.

THE EFFECTIVENESS OF CHILD CARE CONSULTATION

Research indicates that child care consultation in the fields of health, mental health, and education can improve the specific aspects of programs that contribute to the quality of care provided, such as teacher knowledge and efficacy, as well as overall program quality. However, no published data exist on the benefits of multi-disciplinary consultation versus single discipline consultation. The following sections highlight research findings on specific types of consultation (e.g., health, mental health).

Health

Demonstration projects and studies conducted over the past 25 years examined the effects of short-term health interventions in child care programs. These interventions included elements of the

consultation model and thus are relevant for our purposes. Selected findings illustrate their relevance.[3]

Children experienced higher immunization levels, fewer safety hazards, better nutrition, and the providers were more knowledgeable about children's health problems and follow-up in centers in which children's health status was actively monitored and comprehensive health services were provided.[4] Similarly, improvements in children's health status were associated with offering health services on-site. Improvements included identification of health abnormalities and referrals to further evaluation, as well as a reduction in episodic visits to primary care providers and decreased lost time at work and school for parents.[5, 6]

Children also experienced positive health outcomes when child care providers' health knowledge was enhanced through training. In one study, a nurse consultant shared primary care information, such as signs and symptoms of illness, infection control, injury prevention, and first aid, with child care providers. The information sharing resulted in a significant decrease in upper respiratory illnesses and accidental injury rates among children in the program.[7] Similar findings relate to hygiene practices.[8]

In addition to training, other supports such as a free audiovisual library, a telephone hot line, linkages to a health professional through a computer registry, quarterly newsletters, and information about training programs also appear to help providers improve their compliance in various areas including food service, sanitation practices, access to fluoride, and nutrition practices. Among the programs linked with a nurse consultant, the self-reported compliance assessments were higher.[9]

Several studies give positive indications of the effectiveness of child care health consultation. Research conducted by Dr. Jonathan Kotch from the University of North Carolina, who directs the National Training Institute for child care health consultants, showed significant improvements in safety scores in child care programs that received health consultation.[10] At the 12-month assessment, the results indicated that more frequent safety consultations produced a significant effect in improving the safety scores. Moreover, consultants with higher levels of education were associated with greater improvements in programs' safety scores. Other research data showed child care health consultants produced positive effects on health policies and practices, child health status, children's access to health care, and immunizations.[11] Additionally, health consultation in child care reduced absences, increased access to care, and resulted in fewer outbreaks, less acute/emergency medical care utilization, lower medical care costs, and less work time lost by parents. [12]

Other smaller studies support these findings. A one-year, quasi-experimental study from California found that staff who received health consultation services for seven months showed a general increase in knowledge regarding the health standards.[13] The intervention child care centers also

[3] To date the literature on health interventions in child care is primarily comprised of demonstration projects and pilot studies rather than rigorous, experimental studies. While demonstration projects provide valuable services to a large population and descriptive information on child care health issues, they do not contribute to definitive outcome data on the effectiveness of specific health interventions in child care settings. However, the literature does reflect a growing sophistication and awareness of the complexity of studying child care health outcomes as related to health interventions and health consultation.

showed a significant improvement in compliance with the National Performance Health Standards compared to centers that did not receive health consultation. A study of a Pennsylvania-based effort that provided child care center staff with early childhood consultants showed that staff substantially improved their feeding and diapering practices.[14]

Research in Connecticut has shown that training health consultants improves the quality of health consultation offered.[15] Evaluation results indicated that, after completion of the 2002 training[4]: consultant knowledge increased significantly in most areas; most health practices and policies improved post training; training improved the consultation experiences as reported by directors and child care health consultants (CCHC); and CCHCs broadened their scope of practice and showed significant increases in utilization of *Caring For Our Children* standards and activities in the areas of behavioral/developmental, staff health, and health promotion.

Mental Health

Children's social and emotional health is inextricably linked to school readiness and provides the foundation for academic success.[16] The recognition of this connection and the increasing numbers of young children with challenging behaviors and emotional problems[17] has fueled a growing effort to provide mental health consultation services in early childhood. Only a limited number of studies on mental health consultation exist. However, the results are promising and shed light on some of the factors that influence the success of mental health consultation.

In a June 2003 evaluation of mental health consultation services in San Francisco, mental health consultation to child care programs improved several aspects of center life, including lower teacher turnover, improved center quality, an increase in teachers' sense of self-efficacy, and an improvement in teachers' communication skills.[18] After receiving mental health consultation in their classrooms, teachers reported an improved understanding of children's difficult behaviors, children's social and emotional development, and how to work more effectively with parents.

Researchers from the Research and Training Center on Family Support and Children's Mental Health at Portland State University have completed several studies on mental health consultation in child care. Their research documented aspects of mental health consultation that make the service more or less successful. For example, one study concluded that using mental health professionals to provide program-level consultation produced more positive outcomes than when consultants provide primarily individual-level, child-focused consultation.[19] In addition, they found that program management and leadership also play an essential role in setting the tone for how an entire program thinks about and approaches early childhood mental health issues, above and beyond the presence of experienced and well-trained staff and consultants.

Another study out of the Research and Training Center on Family Support and Children's Mental Health involving Head Start centers confirms that the quality of the relationship between child care staff and the mental health consultant has a significant impact on the effectiveness of the consultation.[20] Overall, staff who reported a better relationship with their mental health consultant reported more positive program and child outcomes. Head Start staff also reported that the

[4] The Connecticut training was based on an adapted version of National Training Institute for Child Care Health Consultants Training.

characteristics most important to them in their mental health consultant was his or her relevant experience working with young children and low-income families; the ability to make a long-term commitment; and whether their approach was consistent with the program's philosophy and with best practice principles.[21]

Overall, the research suggests that mental health services, including child care consultation services, should be: strengths-based; individualized and culturally competent; family-centered; comprehensive; community-based; coordinated and multi-disciplinary; and focused on developmental needs.[22]

Early Childhood Special Education Consultation

The Inclusion Partners project, implemented from 1993-1996 in North Carolina, sought to determine whether community-based consultants could be prepared to implement on-site consultation in centers and family child care homes and what difference it would make in overall program quality, as measured by the appropriate environmental rating scale.[23] The consultation in this project was grounded in early childhood special education and was more general in nature (not specifically mental health or physical health).

The study used the environmental rating scale to document the overall quality of care at the participating sites before and after consultation. The study found that across all settings (infant-toddler, early childhood, and family child care), the total average scores as measured by the environment rating scales increased after the consultation services. This increase was significant for both the Infant Toddler Environment Rating Scale (ITERS) and the Early Childhood Environment Rating Scale (ECERS). The changes on the Family Day Care Rating Scale (FDCRS) were not statistically significant, likely a result of the small sample size (four family child care homes).

The literature from the early childhood special education field also suggests that child care consultation is a viable option for providing teachers with new knowledge, skills, and support in order to facilitate inclusion.[24]

THE CURRENT POLICY CONTEXT

A statewide multi-disciplinary consultation system in Connecticut will build on a variety of existing initiatives and policy efforts. These efforts include state licensing regulations; the national push for child care consultation as a result of the Healthy Child Care America campaign, and the resulting training opportunities for child care consultants provided by Healthy Child Care Connecticut; new NAEYC accreditation standards that promote child care consultation, which will affect a large number of centers throughout the state; and Connecticut's proposed universal access to preschool initiative. The following section summarizes these initiatives and policies.

Connecticut Child Care Licensing Regulations

Since 1993, Connecticut's child care licensing regulations have required that child care centers and group day care homes utilize a variety of consultants. Specifically, Connecticut requires that child care centers engage the services of an early childhood educational consultant, a health consultant (who can be a physician, physician assistant, advanced practice registered nurse or registered nurse), a dentist or dental hygienist consultant, a social service consultant, and, for programs serving meals, a registered dietitian consultant. Centers must have a written plan for each consultative service that

includes: an annual review of policies; an annual review of in-service education programs; availability by telecommunication for advice regarding problems; and availability, in person, of the consultant to the program. The regulations indicate that consultants should be "available to the operator and staff for advice and support."[5]

The child care regulations outline consultation requirements. However, considerable variation exists among centers in their use of consultants. Some programs value consultants and use them regularly. In a 1996 survey, 84% percent of child care directors and 81% of health consultants considered health consultation visits important or very important for the operation of the program. [25] Typical comments by directors included: "We are very fortunate to have weekly (health consultant) visits…every center should have weekly visits," and "It helps to have 'fresh eyes' view the program. It improves quality and awareness." About three-quarters (78%) of the directors and even more (84%) of the consultants thought that weekly or more frequent visits would be beneficial, if cost were not an issue.

Unfortunately, anecdotal evidence suggests that many centers do not use consultants regularly. Some centers list colleagues from other child care centers or other accommodating individuals on the application form as consultants, and never actually use the consultant's services. This variation in usage reflects the lack of specificity about consultants' roles and responsibilities and the limited monitoring by the Department of Public Health.

Child care programs' limited financial resources present another major barrier to the use of consultants. Currently, many centers cannot afford to cover the cost of consultation services. Given the tremendous pressure on available resources and reimbursement rates, the lack of funding prevents many programs from utilizing consulting services. As the Connecticut experience has demonstrated, regulations alone are not enough to ensure effective involvement of consultants.

Healthy Child Care America

Healthy Child Care America (HCCA) was launched in 1995 by the US Department of Health and Human Services as a partnership with the American Academy of Pediatrics. HCCA forges stronger linkages between health and child care professionals to support the health and safety of children in child care. Three primary goals frame the HCCA campaign:

- Infrastructure Building: The development of a statewide system of child care health consultation, including the provision of training based on a national curriculum aligned with the national health and safety performance standards for child care programs.
- Quality Assurance: Addressing gaps in state child care licensing regulations based on comparison with *Caring for Our Children: National Health and Safety Performance Standards - Guidelines for Out-of-Home Child Care Programs.*

[5] Refer to Appendix B for the actual language from the Connecticut regulations and relevant statutes. Health consultants in programs serving children under the age of three must adhere to more specific responsibilities. State regulations do not provide the same level of specificity for the other types of required consultants for infant and toddler care and provide no specificity about how often any of the consultants should visit or what they should do for centers that serve preschool children.

- Access to Health Care: Utilizing the child care setting as an access point for linking children with health insurance, health care, and a medical home.

Early in the initiative, HCCA produced a "Blueprint for Action." The blueprint outlined five goals and 10 action steps communities could take to pursue the HCCA campaign goals. One of the Blueprint Action Steps was to implement a child care health consultation system. A National Training Institute was created at the University of North Carolina at Chapel Hill to establish curricula and a training-of-trainers system for child care health consultants.

Healthy Child Care Connecticut

Healthy Child Care Connecticut (HCCC) grew out of Healthy Child Care America. Since its inception in 1997, Healthy Child Care Connecticut has worked to address the three goals of HCCA with funding from the federal Maternal and Child Health Bureau.

Healthy Child Care Connecticut has provided four training series to build the capacity of child care health consultants, and to some extent, education, social service, and mental health consultants as well as child care directors. HCCC used as a foundation for the training the National Training Institute (NTI) curriculum and expanded it to include more information on children's mental health and education.[6] Additionally, HCCC, in collaboration with HCCA grantees in the other five New England states, piloted sessions using teleconferencing technology to make training more accessible.

Healthy Child Care Connecticut also completed a five-year review of state child care regulations to reflect the *National Health and Safety Performance Standards for Out-of-Home Child Care* developed by the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care. Recommended revisions to state regulations are under consideration by the Child Day Care Council and the Department of Public Health and will likely include more specific information about the roles and responsibilities of consultants.

Connecticut Early Childhood Partners

Federal funding for Healthy Child Care Connecticut ended in January 2005. However, states are required to include the three goals of HCCA in their state plans under the State Early Childhood Comprehensive Systems (SECCS) Initiative which is also funded by the federal Maternal and Child Health Bureau. Connecticut's effort is called Early Childhood Partners. This initiative enables state Maternal and Child Health (MCH) departments to collaborate with partner state agencies and other stakeholders in developing a comprehensive early childhood system for children birth to five.

Connecticut was awarded a SECCS planning grant in October 2003 and will begin implementation activities in 2005. Building on current early childhood initiatives in the state, Early Childhood Partners plans to create a family-centered early childhood service system and enable access to a) comprehensive health services and medical homes; b) social-emotional development and mental health services for infants and young children; c) early care and education; d) parenting education; and e) family support.

[6] Although the foundation of the NTI curriculum is health, the Connecticut training sessions embraced a multi-disciplinary approach both in terms of the content of the training and the inclusion of consultants from other disciplines.

The Early Childhood Partners effort has identified multi-disciplinary early childhood consultation as a strategy that fits well into this integrated and comprehensive service approach. The draft ECP plan includes multi-disciplinary consultation and should bring the relevant state agencies together to work on this issue.

NAEYC Accreditation

The National Association for the Education of Young Children (NAEYC) accreditation system ensures the quality of children's daily experiences in early childhood programs and promotes positive child outcomes. NAEYC is the largest accreditation system for early care and education programs in the country and in the world. Connecticut is among the top 10 most active states for NAEYC accreditation, in part because accreditation is required for early care and education programs that receive funding from the State Department of Education's School Readiness initiative or the Department of Social Services. Many other child care programs pursue accreditation because of their desire to meet high professional standards and attract parents.

NAEYC will unveil and implement revised program standards and accreditation performance criteria in 2006. The implementation of the new program standards and accreditation will produce an increased emphasis on the appropriate use of consultants in the child care setting.

Four constructs frame the NAEYC program standards: 1) children; 2) teaching; 3) staff, family, and community partnerships; and 4) leadership and administration. Collectively, the 10 draft program standards describe early childhood programs that consistently promote positive learning and developmental outcomes for all young children. Research and evidence-based criteria transform the standards into quantifiable measures to illustrate how programs can demonstrate compliance with the standards. The NAEYC draft accreditation performance criteria include the use of a variety of consultants in early care and education.

In recognition of child care consultation's usefulness for improving program quality and providing needed services, the draft accreditation performance criteria call for ongoing working relationships with a variety of consultants to "further the program's capacity to meet the needs and interests of the children and families that they serve." Specific consultation services mentioned include*:* a health consultant, a dietitian or public health nutritionist; specialized consultants who can support children with disabilities, behavioral challenges, or other special needs; and family support services and specialized consultants who provide culturally and linguistically appropriate services.

The Connecticut Accreditation Facilitation Project

Established in 1991, The Connecticut Accreditation Facilitation Project (AFP) provides intensive technical support and financial assistance to early care and education programs seeking NAEYC accreditation. The project was originally a collaborative effort between the Hartford Association for the Education of Young Children and the Hartford Area Child Care Collaborative and focused on the greater Hartford area. In 1997, the School Readiness legislation named the AFP as the model for a statewide effort of accreditation support to licensed child care centers.

AFP services include financial support for NAEYC accreditation fees, on-site technical assistance including observation and feedback, staff training, coaching and support for administrators, and monthly support meetings to help programs improve their quality and meet accreditation standards. AFP staff typically offer the type of assistance provided by an early childhood education consultant, working on-site in programs to help them make overall program improvements to become accredited. AFP works with a program for two years; programs can reapply for assistance if they need help beyond that timeframe. AFP currently has six full-time staff. State funding for AFP was cut 40% in 2001, which has limited their ability to serve more programs. To date, the AFP has helped 169 programs become accredited, and another 50 are waiting for action by NAEYC.

Universal Pre-Kindergarten (UPK) on the Horizon

Connecticut, like many other states, is experiencing a groundswell of interest around universal access to preschool. This interest stems in large part from the convincing research that shows the long-term benefits children derive from high-quality early care and education programs. Preschool can also help address the achievement gap, which is a very real concern throughout the state.

The Connecticut State Department of Education (SDE) has proposed that the state make preschool available to all three- and four-year-old children and has offered a preliminary framework for these services. Governor Jodi Rell believes that early childhood should be a priority investment for the State of Connecticut and the Connecticut General Assembly will take up this issue in the 2005 legislative session.

The proposed universal preschool initiative would require that all participating early care and education programs meet certain quality standards.[7] If these standards are similar to those required under the existing School Readiness Program, UPK programs will have to be accredited, and additional expectations will exist about the use of the Connecticut Preschool Frameworks. As more early care and education programs strive to make quality improvements to meet UPK standards, a higher demand will exist for supports such as multi-disciplinary consultation.

Conclusion

This cursory survey of the policy and regulatory forces operating in Connecticut confirms that fertile ground exists to grow a multi-disciplinary child care consultation system: a) state licensing regulations require the use of child care consultants; b) national and state initiatives have highlighted child care consultation as an important strategy to promote children's health and safety; c) new accreditation standards, which will apply to significant numbers of child care programs, incorporate elements of the child care consultation model; and d) the demand for high quality early care and education continues to grow in an environment that promotes academic outcomes.

CHILD CARE CONSULTATION MODELS: LESSONS LEARNED

Various models of child care consultation have been implemented locally, in other states, and nationally. Several of these models are described in this paper and provide practical guidance on design and implementation issues. Although these models vary in terms of consultation disciplines,

[7] As of March 2005, the specific quality standards for UPK programs had not been finalized.

settings and age groups served, and duration and frequency of program services, [8] several common themes emerged from their experiences. The "lessons learned" from these efforts can help Connecticut create a consultation model that builds on and enhances the existing consultation framework to better meet children's needs.

Multi-Disciplinary Team (ACES/New Haven)

ACES, the regional education service center for south-central Connecticut, has been providing multi-disciplinary consultation services to child care centers in New Haven since 1998. Their Multi-Disciplinary Team (MDT) includes specialists in: early childhood, including an infant and toddler specialist; mental health; health; speech and language; occupational and physical therapy; behavioral health; social work; and a bilingual family advocate.

The MDT is available to any child care center in New Haven that serves preschool-age children. MDT services are provided free of charge to centers; the cost of the MDT is covered by various grants, including Quality Enhancement dollars associated with the state-funded School Readiness program and federal and private grant funds. The MDT increases the capacity of early childhood staff and parents to meet children's needs. The MDT may work with an individual teacher, with a small group of teachers, with an entire center, or with a parent group.[9] When the MDT is contacted by a center, the team first determines what other consultants, if any, are working in the program. If the center is working with a consultant, the MDT works with that individual to ensure that they are giving consistent feedback to the program.

The length and intensity of MDT involvement with centers varies depending on the center's needs. No limit exists on how much consultation time the MDT can provide to a given center, other than the overall budget constraints of MDT funding.[10] All centers, whether they receive one-shot assistance, intensive assistance, or somewhere in between, receive follow-up phone calls to see if the program staff have implemented their recommendations and if there is a need for additional support.

In addition to providing on-site consultation, the MDT offers training sessions for child care staff on a variety of topics, based on program needs. Recent topics have included obesity, nutrition in the classroom, stress reduction for staff, depression in young children, and emergent literacy.

Sharon Redmann, the project manager for the MDT, highlighted several lessons learned from six years of providing MDT services, including:

- Building relationships and trust between the consultants and the child care staff is key to the work. The community training sessions have been very beneficial in terms of developing collegial relationships with child care providers.

[8] Appendix D summarizes the models across all of these factors.

[9] Traditionally, the MDT has not conducted child-specific work. The MDT is currently piloting a new model in two child care centers that focuses on mental health issues and includes child-assessments and home visits (in addition to the full range of other MDT services).

[10] This past year, the MDT served 26 of 30 centers in New Haven and provided a total of 160 hours of consultation services. The bulk of the consultation hours were around speech and language issues and mental health.

- The program's flexibility regarding when services can be provided, the length of the consultation, and the issues that can be covered has enabled the MDT to build credibility with the child care community.
- In many centers, structural and organizational issues must be addressed for improvements in practice and quality to take hold. Often, the MDT will be invited into a program for a specific issue, but once they are in a program, the consultants realize there is much more going on around issues such as leadership and supervision, policies, and the relationship between the board and staff. The MDT also tries to address these "systemic" issues so that their recommendations can be implemented and sustained.
- One of the differences MDT consultants have observed in the centers where they have worked is providers' increase in confidence and self-esteem. This confidence has made them more comfortable in participating in discussions with other professionals and trusting their own insights and observations about children.
- The monthly team meetings for consultants have been very important both because they allow the group to process all the cases holistically, but also because they provide significant learning opportunities for the consultants themselves.

Child FIRST Community Consultation (Greater Bridgeport)

Child FIRST (Child and Family Interagency, Resource, Support, and Training Program) is an early childhood system of care which provides a continuum of comprehensive family-focused services to address the emotional/behavioral health, developmental, learning, and health needs of high risk young children and their families (prenatal through age five). Community consultation services have been provided to early care and education programs in Greater Bridgeport since 2000.[11] The model is funded by a combination of federal, local, and private funds; Bridgeport Hospital serves as the fiscal agent. All services are provided free of charge.

Child FIRST currently offers three types of consultation services: intensive classroom consultation; targeted classroom consultation; and child-specific consultation. Consultation is provided by a full-time social worker with a strong early childhood education and mental health background.

Through the *intensive classroom consultation*, programs receive classroom consultation with screening of all children for emotional and developmental concerns; child-specific observations and strategies; and intensive home-based assessment when needed. This intensive consultation is provided to 10 classrooms per year.

Consultation strategies are based on the results of the DECA (Devereux Early Childhood Assessment), which is completed on all children by the teachers and parents. The assessment enables the consultant to create a profile of the classroom and identify areas of need and best practices that can be implemented in the classroom. The DECA also identifies areas of low resiliency and problem behaviors for specific children. The consultant conducts focused

[11] Child FIRST has a memorandum of agreement with and provides services to the School Readiness providers in Bridgeport, as well as any other early care and education or home day care provider in Greater Bridgeport who requests assistance.

observations of these children's behavior, interactions with teachers and peers, play, and developmental capacities. The consultant then helps the teachers develop and implement strategies that are responsive to a child's individual needs, often in conjunction with one or more meetings with parents at the early education setting or home. If the child care program is already working with other consultants, the Child FIRST consultant includes them in the planning and implementation of these strategies. When a child has more complex emotional and behavioral concerns that do not respond to the strategies implemented through classroom consultation, families can transition to an intensive, home based family assessment (as described below in child-specific consultation). The consultant also provides ongoing staff training.

Targeted classroom consultation addresses specific areas of classroom need, requested by any early care and education provider, including home-based providers, with flexible length of involvement.

Any care and early education provider, parent, or early childhood service provider may request a *child-specific consultation* for a child with emotional, behavioral, or developmental concerns through a referral to Child FIRST. Each family is assigned a consultant and care coordinator, who work as a team to support the child and her family.[12] The consultant observes the child within the early education classroom and works directly with the classroom teacher to understand the child's behavior and development. Home-based assessments of the strengths and needs of the child and family occur simultaneously. The assessments examine the child's health, development, and behavior; parent-child interactions; and parental challenges which impede the parent's ability to nurture and support the development of her/his child, which may include parental depression, violence, and substance abuse.

Based on the results of the assessments, the consultant and family develop jointly a comprehensive family plan. The plan outlines services that will address the family's priorities, needs, strengths, and culture, such as: child and adult health services (including nutrition, dental, and mental health); early intervention and special education; parenting support and education; substance abuse; domestic violence services; adult education, literacy, and job training; and physical needs such as housing, food, books, toys, and furniture. The care coordinator helps the family access these services and address barriers to service access.

A program evaluation conducted by the Yale Consultation Center demonstrated positive results for teachers and children involved with Child FIRST. In programs that received Child FIRST services, teachers' level of confidence in understanding and implementing strategies to address children's social-emotional development increased significantly. Twenty-seven percent (27%) of the children served by the program were identified as "of concern" on the DECA. Of those, 60% showed improvement after implementation of the universal and child-specific classroom strategies.

According to Darcy Lowell, MD, Director of Child FIRST, the lessons learned from Child FIRST implementation include:

- The success of the model depends in large part on the relationship and trust between the consultant, the classroom teachers, and the center management.

[12] The Consultant is a Master's level position; the Care Coordinator has a Bachelor's degree.

- It is critical to build on the strengths of the teachers and classroom.
- It is extremely valuable for the consultant to have an early childhood education background with classroom experience to engender legitimacy with program staff.
- When a child's emotional or behavioral problem is more complex, it is extremely important to transition to a more comprehensive assessment of the child's relationships within the home and the challenges experienced by the family.
- Care coordination is extremely valuable to help families access needed services and supports.
- This model can be used to provide consultation in pediatric healthcare (facilitating the Medical Home), home visiting programs, family support and resource centers, and with other service providers that work with young children and their families.

Early Childhood Consultation Partnership (Connecticut)

The Early Childhood Consultation Partnership (ECCP) is a mental health consultation program designed to meet the social/emotional needs of children birth to five by offering support, education, and consultation to center-based providers. Created in 2002, ECCP has an annual budget of approximately $1 million and has been funded by the Department of Children and Families, the State Department of Education, the Community Mental Health Strategic Investment Board, the Children's Fund of Connecticut, and the Connecticut Health Foundation. The State Department of Education has proposed a budget option of $1 million for fiscal year 2006 for ECCP and the Department of Children and Families has included $700,000 in their budget for the program.

The ECCP is managed by Advanced Behavioral Health, a non-profit managed behavioral health organization, which in turn has subcontracted with non-profit, community-based organizations to hire consultants. The program has 11 full-time, Master's level consultants throughout the state.

The ECCP builds the capacity of early care providers and families to more effectively address the social and emotional needs of children ages birth to five and decrease the suspension/expulsion rates of children with behavioral and social/emotional needs in early care settings. In addition, ECCP promotes and facilitates the early identification of young children's mental health needs and helps child care centers respond with appropriate services and referrals to other service providers before they escalate and become a mental health crisis. ECCP also helps child care providers, educators, and families understand and promote early childhood mental health.

ECCP services are offered free of charge and are available to any licensed child care center. Services are available along a continuum that includes brief phone consultation, child-specific, core-classroom, and intensive center-based services.

Child-specific services tend to be reactive in nature; programs typically call for help when issues with a specific child and his or her family have become so intractable that the program is close to removing the child from the program. ECCP consultants provide up to eight hours of consultation to a program, including conducting an observation, developing an action plan based on the classroom's strengths and areas of concerns, and indicating specific goals and strategies to address the situation.

For *core classroom services*, the focus of the intervention and support is the teacher. The consultant first conducts two assessments in the classroom, the Arnett and the appropriate environment rating scale (either for infant and toddler settings or preschool settings). The consultant then meets with the staff and any other consultants working with the program to develop an action plan for the classroom. The consultant works with the classroom over an eight-week period for four hours per week to help the teaching staff implement the action plan. In classrooms receiving core services, consultants will also offer help on up to two child-specific cases and one staff-wide training related to early childhood social and emotional health. At the conclusion of the eight weeks, the ECCP consultant transitions the technical assistance to the program's existing consultants, who continue working with the center on implementing the action plan.

The third level of services, *intensive*, is very similar to the core classroom services, but is expanded to work with up to four classrooms at a center.

According to Elizabeth Bicio, ECCP Program Manager, several "lessons learned" emerge from the early years of ECCP implementation:

- It is important to have a consistent framework for a statewide program so that similar services/expectations exist across the state;
- The relationship between consultant and staff is key to the model's success;
- A shorter period of time for the consultation work may actually lead to greater improvements in quality than when services are stretched out over a longer period of time. The ECCP project found that classrooms in which services were provided over a two-month period demonstrated greater quality improvements than the classrooms in which consultants provided services over a six-month period. Program staff surmised that the consultant's impact might diminish as he or she becomes more integrated into the center culture. In addition, with a longer timeframe, programs tend to take longer to implement the quality improvement action plan and the pace of progress is somewhat slower; and
- The child-specific services are generally not as effective as the core classroom services, particularly in terms of the ratio of intensity of resources required and degree of impact upon other children within the classroom. The core classroom services tend to be more preventive in nature, while the child-specific services are reactive and tend to occur when issues have already reached a crisis point.

Early data indicate that the program has produced a positive impact.[13] An experimental evaluation of ECCP is underway and will examine the impact of ECCP services on program quality and child outcomes. Dr. Walter Gilliam from the Yale Child Study Center is spearheading the evaluation, which will include 100 classrooms randomized across comparison groups.

[13] Between January 2003 and June 30, 2004, the ECCP served 212 early care and education centers, providing services to 649 teachers and assistant teachers. Using pre- and post-assessments, 95% of the classrooms served by ECCP showed improvement. During this same time period, ECCP also served almost 300 children who were at risk of expulsion from child care. Ninety-seven percent of the children who received child-specific services were not expelled.

Day Care Plus (Cuyahoga County, Ohio)

Day Care Plus is a mental health consultation initiative available to all child care centers and licensed family child care homes in Cuyahoga County, which encompasses the City of Cleveland. Day Care Plus was initiated in January 1997 as a collaborative project of the Cuyahoga County Community Mental Health Board, Starting Point for Child Care and Early Education (the local child resource and referral agency), and Positive Education Program, a community-based agency that provides mental health services to children and youth.

Day Care Plus's mission is to maintain young children with challenging behaviors in their existing child care settings. The initiative has three goals: 1) improve the social, behavioral and emotional functioning of at-risk children in child care; 2) increase the competencies of parents and caregivers of at-risk children in child care; and 3) increase the competencies of child care staff.

Day Care Plus offers two types of consultation services: 1) the Intensive Program, which provides ongoing consultation for a limited number of centers; and 2) the Response Team, which provides periodic, time-limited assistance to a larger number of programs based on specific requests for help. The Intensive Program lasts for one year and programs are invited to participate. Any child care center or licensed family child care home can request help from the Response Team. Response Team members work with sites on average for two months, but the length of time can vary depending on how long it takes to resolve the specific problem.

Sites that are invited to participate in the Intensive program must sign an initial agreement to participate. Child care staff then work with their assigned consultant to develop a plan of action for the center. Day Care Plus services for intensive sites include:

- Ongoing on-site technical assistance for directors and staff, generally one scheduled day each week, focused on: individual child study and intervention; center/family communication; developmentally appropriate activities and materials; and staff/management communication and relations;
- Providing or linking centers with resources, such as a coordinated arts program, art therapy, hearing screenings and health referrals, programs for families, financial support for centers to acquire materials, and additional staff; and
- Training and professional development, such as centralized Saturday staff training activities, center-based evening training activities for families and staff, promoting enrollment in formal coursework toward a degree, mentoring CDA candidates, and taking child care providers to the annual state conference on early childhood.

Programs access the Day Care Plus Response Team services by calling and asking for help. It is free for any program in the county.[14]

[14] There are 620 center-based programs in the county; in 2003, Day Care Plus provided consultation services in 93 of them. Day Care Plus has chosen to work with fewer centers through the Intensive Program over time in order to free up more resources for the Response Team. Day Care Plus is funded by the county budget.

Day Care Plus uses a pool of dollars for additional wrap-around services, such as a short-term one-on-one aide to work with a child, or to make environmental changes (like buying a fence) to improve the program's ability to address a child's needs. In addition, Day Care Plus staff provide training for parents and providers. Day Care Plus provides training and implementation support for developmentally appropriate programming for classrooms, including a music and motion program designed to help reduce children's stress and through the Storytelling series, which helps staff learn creative ways to increase literacy in child care settings and for the children to experience fun ways to explore literacy.

Day Care Plus employs consultants who have multi-systems experience or multiple credentials. The Program Director indicated that when a consultant has only one area of expertise, he or she is not as effective in the field because providers tend to present multiple issues during an on-site visit. For example, Day Care Plus looks for individuals with a mental health background and an early childhood background so that they have respect for the early care and education setting and understand the difficulties of the job. Day Care Plus requires that consultants have a Master's degree plus teaching certificate in special education, or social work license, or be a licensed professional clinical counselor.

According to Ann Bowdish, the Early Childhood Project Director, several factors contribute to and influence the effectiveness of the consultation approach:

- The director's openness about center needs and willingness to respond or reciprocate;
- The degree of agreement between the consultant and director about what needs exist and how they should be addressed;
- The degree of communication and agreement between the director and her staff; and
- The director's and staff's comfort with and confidence in the consultant personally, which is critical and depends in part on the "goodness of fit."

The county's overall early childhood initiative, now called Investment in Children, is funded for the next five years at close to $20 million/year. Of that sum, $1 million is earmarked for an outcomes study, which will be conducted by Chapin Hall and Case Western Reserve. The study, while examining outcomes of the initiative, will not be an experimental design. To date, the project only has descriptive and qualitative research.

The Comprehensive Child Care Services Program (Rhode Island)

The purpose of the Comprehensive Child Care Services Program (CCCSP) is to support families in preparing their preschoolers, ages 3 through entry into kindergarten, for school success. Child care providers (including centers and licensed family child care homes) have come together to create networks that agree to meet certain standards. In return, the networks receive funding to provide additional services for low-income children in their programs. CCCSP is modeled after the federal Head Start program (described below) and targets very low income children (family income below 108% of the federal poverty level). Networks receive $77 per week per eligible child to provide these "wraparound" services; current levels of funding ($1.5 million) cover services for 300 children statewide.

Currently four networks operate in the CCCSP program; these four networks include a total of 29 centers and five licensed family child care homes, which together serve the majority of the children eligible for the program. CCCSP services include a mix of direct services to children and families and consultation and training for staff. Services are only available to eligible children in each child care setting (differential service delivery) and are only available for preschool classrooms.

Individual networks hire CCCSP staff. The CCCSP services include nutrition, health, mental health, family advocacy/social services, and educational mentoring. In addition, each Network has a Network manager who oversees the project. The Networks also help providers get their CDA credential and college credit in early childhood by paying for courses and course materials, providing CDA Advisors, and covering the cost of the CDA fee.

The program does not have evaluation data about the impact of the CCCSP, although staff are analyzing considerable descriptive data about the program. Anecdotal evidence and satisfaction reports indicate that providers in the networks find the mental health services most valuable, along with the help in getting credentialed.

According to Reeva Murphy and Sue Libutti, the Department of Human Services staff responsible for the program, the Rhode Island experience produced several lessons learned:

- It is very important to build relationships between the programs and the specialists, and it takes time for programs to get comfortable with allowing outsiders into their programs;
- Directors and staff first have to trust the specialists before they will accept advice;
- It has been a challenge to find mental health providers who also understand early childhood, but this "cross-discipline" knowledge is essential;
- Program directors must communicate about the program with their line staff, since they are the ones directly affected by the presence of the specialists; and
- The state sees the value of these services for children and child care teachers and would like to expand the program in terms of income eligibility guidelines (to cover other children who are poor but not currently income-eligible) and age range (to cover infants and toddlers).

The Abbott Preschool Program (New Jersey)

On May 21, 1998, the New Jersey Supreme Court landmark decision in *Abbott v. Burke* mandated that three- and four- year-old children in the 30 highest poverty districts in the state receive a high-quality preschool education. Both the preschool program and the 30 districts are now commonly referred to as "Abbotts."

New Jersey's Abbott preschool program is ranked one of the highest in the nation for the level of quality, the resources committed to it and the proportion of children served.[26] Child care consultation is one required element of the Abbott program, although in the Abbott model, these positions are staff positions within the school district and/or individual early care programs.

Districts must provide one curriculum specialist, called a master teacher, to mentor teachers for every 10-20 classrooms, depending on classroom teacher experience. The master teacher provides technical support and assistance to the district classroom teachers and community preschool programs, functioning in many ways like an educational consultant.

Recommended qualifications for the master teacher include a Master's Degree in Early Childhood Education and three to five years experience in preschool programs; experience in facilitating workshops and program improvement for preschool teachers; experience in design and implementation of developmentally appropriate early childhood curriculum; and experience with developmentally appropriate early childhood assessments.

The New Jersey Department of Education has developed a comprehensive training for master teachers to clearly define the master teacher role and to ensure that master teachers have the skills they need to foster change and improve classroom quality. Specifically, the master teacher training focuses on three areas: (1) in-depth training in curriculum, including research–based program guidelines; (2) assessing classroom quality through the use of structured program evaluation instruments; and (3) coaching and mentoring strategies for adult learners.

Abbott programs are also required to provide one full-time family worker for every 45 children being served by the center. The family worker provides information, referral services and follow-up to families on obtaining necessary health and social services or arranging for emergency assistance or crisis intervention services based on request and individual need. The family worker operates as a team member with classroom staff, master teacher, and other professionals to support the child and family.

The school nurse assists students, families, and staff in attaining and maintaining optimal health, including children served through the Abbott preschool programs (both school-based and community-based). Abbott districts must have a nurse for every 300 students. Abbott districts must also conduct health examinations to include, at a minimum, vision, hearing, dental, height and weight screenings of each Abbott-eligible child upon entry into the school district.

The social worker collaborates with the classroom teachers, master teachers, and other district professionals to reach out to families, determine their needs, provide advocacy services, and help obtain community services. Responsibilities also include assisting parents in learning about child development, nutrition, providing a safe environment, and how to support the curriculum chosen by the district. Districts must have one social worker (MSW) per 250-300 children.

The first two years of evaluation findings from the Abbott program indicate that program quality is increasing. Results from the ECERS-R, one of the measures used to rate program quality, showed that gains have been particularly strong in the practices most likely to impact a child's readiness to start school, including "language and reasoning," "teacher-child interactions" and "program structure."[27] In addition, the early literacy abilities of kindergarten students in Abbott districts are improving. Research has also shown that children in the Abbott programs have better social skills, better communication skills, and better problem-solving skills.

The Abbott results are encouraging and support our understanding that quality early education makes a difference in children's outcomes. However, given that the consultation services of the Master Teacher, family worker, social worker, and nurse are part of an overall design that incorporates a multitude of high-quality characteristics, it is difficult to tease out the specific contributions of these positions to the improved program quality and outcomes for children.

Head Start and Early Head Start (National)

First launched in 1965, Head Start is an early care and education program for three- and four-year-olds from low-income families. In 1994, Early Head Start was established to serve low-income children birth to age three and pregnant women. In 2002, over 1 million children received Head Start and Early Head Start early care and support services at some point in the program year, including over 8,000 children birth to five in Connecticut.[28] A hallmark of Head Start is the provision of comprehensive services that address children's emotional, social, health, nutritional, and education needs. This comprehensive approach to early childhood development sets Head Start apart from most early childhood programs and places Head Start at the far end of the continuum of early care and education in terms of the degree to which support services are fully integrated into the early education program.

All Head Start programs, including Early Head Start, must adhere to the federal Head Start Program Performance Standards, whether the program is center-based, home-based, or a combination. These standards are very specific about what services are required, including comprehensive health and developmental screenings, health care referrals, and follow-up; special services for children with disabilities; nutritious meals; vision and hearing tests; immunizations; on-site family caseworkers; and home visits. About 20 percent of the Head Start budget is spent on health, nutrition, and social services combined.[29]

The Head Start Program Performance Standards require that children in the program be screened for developmental, sensory, and behavioral concerns within 45 calendar days of their enrollment. In addition, within 90 calendar days of enrollment, programs must determine whether families have an ongoing source of continuous, accessible health care and must assist parents in securing a source of health care, if necessary. Other health-related services provided through Head Start include follow-up with families on children's health-related issues, tracking all of the health services Head Start children receive, and individualizing how the program and staff respond to children's needs. Through Head Start, children also receive dental exams and preventive dental services. Requiring these services and providing them through the early care and education setting appears to be effective. Research shows that Head Start children are more likely to receive health and development screening than other poor children (even though such screening is provided through Medicaid); appear to be more up-to-date in their immunizations than other children; and are more likely than other poor children to receive dental care.[30]

Head Start Program Performance Standards specify the qualifications that content area experts must have to provide services in the program:

- Education and child development services must be supported by staff or consultants with training and experience in the theories and principles of child growth and development, early childhood education, and family support;

- Health services must be supported by staff or consultants with training and experience in public health, nursing, health education, maternal and child health, or health administration;
- Nutrition services must be supported by staff or consultants who are registered dietitians or nutritionists;
- Mental health services must be supported by staff or consultants who are licensed or certified mental health professionals with experience and expertise in serving young children and their families;
- Family and community partnership services must be supported by staff or consultants with training and experience in field(s) related to social, human, or family services;
- Parent involvement services must be supported by staff or consultants with training, experience, and skills in assisting the parents of young children in advocating and decision-making for their families; and
- Disabilities services must be supported by staff or consultants with training and experience in securing and individualizing needed services for children with disabilities.

The local agencies that run the Head Start programs determine the appropriate staffing pattern for their children and families. The way in which these services are delivered varies. Some Head Start programs have personnel on staff to provide these services, while others create linkages with community organizations and use outside consultants. These individuals, whether on staff or consultants, provide child-specific services as well as program-level consultation.

US Army Child Development System (National and International)

The Department of Defense (DoD) military child development system provides services for the largest number of children on a daily basis of any employer in the United States, providing care for 200,000 children ages 0-12 daily in 800 centers in over 300 geographic locations, both within and outside of the continental United States.[31] Over 99% of all DoD centers are currently accredited by NAEYC.[32] The military child care system is considered a model program, with useful "lessons learned" for civilian child care.

Military child care was not always such a model program. In the late 1980s, in response to concerns over the impact of sub-par child care on workforce preparedness and child development, Congress passed the Military Child Care Act of 1989 (MCCA), which mandated improvements in military child care.[33] Specifically, the goal of the MCCA was to improve the quality, availability, and affordability of military child care.

To achieve these goals, the DoD:

- Established consistent standards for child care programs across the Armed Services that encompass health and safety, staff/child ratios, and staff training;
- Implemented a stringent inspection and enforcement process that includes four unannounced inspection visits each year and significant penalties for non-compliance;

- Required child development centers to become accredited by NAEYC, providing additional assistance to programs to help them improve in those areas in which they are found lacking;
- Provided systematic, ongoing training for staff, increased staff compensation, and linked wage increases over time to the completion of successively higher levels of training;
- Created a staff position to focus exclusively on issues related to training and curriculum;
- Encouraged parent involvement through the creation of parent boards;
- Developed a sliding fee scale for parents to ensure that personnel with the lowest incomes can afford child care;
- Supported the construction of new and expanded facilities to increase the number of child care slots available; and
- Increased the financial resources available to child care, going from $89.9 million in FY1989 (prior to enactment of the MCCA) to $352 million in FY2000.

While the MCCA established consistent standards across the Services, the individual branches of the military have taken slightly different approaches to implementation. Most relevant to this paper's focus on consultation services is the Army Child and Youth Services provision of consultation to its child care programs. The US Army refers to their experts in the various disciplines as "proponents." The Army has Child Development Centers in 26 states and nine countries. Each Army installation has access to local, regional, and state level proponents to provide technical assistance and help programs achieve compliance with military standards and NAEYC accreditation standards.

Through the proponents, the Army offers consultation services to its programs in a wide range of disciplines, including: program administration and curriculum; food service; parent education and involvement; health and special needs (including mental health supports, children, family and exceptional family member supports); safety; and facilities.

Overall Lessons Learned

Several key themes emerged from these various consultation models. These themes, which are described below, should inform and influence Connecticut's efforts to develop a multi-disciplinary system.

Consultants must appreciate and understand early childhood development and early care and education settings. Having knowledge in a specific discipline such as health or mental health is not sufficient to be an effective consultant. Cross-discipline knowledge is essential: consultants must understand early child development. In addition, consultants need to understand the particular challenges endemic to child care (e.g., low staff wages and education levels, high turnover) and know how to work in an early care and education setting.

Relationships are key. A consistent lesson from the consultation models is the importance of relationship-building between the child care staff and consultants. Given that the effectiveness of the consultation services appears to rest, in large part, on the quality of the relationship between the consultant and child care staff, it is important to understand what personal qualities are necessary for

an individual to be an effective consultant. The literature indicates that these necessary personal attributes include: the ability to communicate warmth, acceptance, and concern; the ability to engage in self-examination and reflection; the ability to share control with others; a high threshold for frustration; a passion for problem-solving; an orientation to life-long learning; and self-direction, flexibility, and vision. [34] A study of health consultation in Connecticut confirmed that open and active communication, commitment, mutual respect, and congruent philosophy and values promote a collaborative relationship between child care directors and health consultants and enhance the effectiveness of consultation.[35]

Consultation should be ongoing. Change takes time. Child care consultation requires relationship-building, modeling, and mentoring, all activities that need to be ongoing to ensure success. Consultation should not be designed as a "one shot" intervention, but as an ongoing support to enhance and sustain program quality. Additionally, characteristics of early care programs, families, and children change over time, requiring consultation to change as needs evolve over time.

RECOMMENDATIONS FOR CREATING A STATEWIDE MULTI-DISCIPLINARY CONSULTATION SYSTEM

The consultation model holds significant promise as a quality improvement strategy for early care and education. As a result, there have been efforts in Connecticut to ensure that child care programs incorporate consultation. Despite these efforts, child care consultation is still a patchwork of services that are, on the whole, uncoordinated. Consultation in the state currently differs according to region, discipline, and funding source.

This section outlines specific recommendations to transform this consultation "patchwork" into a robust multi-disciplinary consultation system that is broadly available to and utilized by early care and education programs throughout the state.[15] These recommendations include system goals and the specific components that should be included.

System Goals

The overall purposes of the multi-disciplinary consultation system are to enhance the quality of early care and education in Connecticut and to improve children's developmental outcomes. The specific goals for Connecticut's consultation system should include:[16]

1. Enhance teachers' ability to provide high-quality care by strengthening their expertise and improving their own health and mental health.
2. Help staff bring best practices to children and families.

[15] These recommendations were informed by the research literature, surveys of Connecticut child care center directors and consultants, and lessons learned from other models, as well as a day-long symposium on child care consultation held in December and sponsored by the Connecticut Head Start-State Collaboration Office, the University of Connecticut School of Family Studies, and the Child Health and Development Institute. A broad cross-section of key stakeholders attended the December symposium and provided feedback about key design elements for a multi-disciplinary consultation system.

[16] These goals were originally drafted by a planning committee that included representatives from the Child Health and Development Institute, the Accreditation Facilitation Project, the Yale School of Nursing, and the Head Start Collaboration Office. These goals were discussed at the December 9, 2004 Consultation Symposium.

3. Provide access to resources that help programs offer high-quality early care and education.
4. Ensure that all children's individual health, mental health, and learning needs are supported.
5. Support the early identification of children's special health, mental health, and learning needs.
6. Promote healthy child and family development.

System Components

A number of important components comprise the long-term vision for Connecticut's multi-disciplinary consultation system. Implementation of this system will not occur overnight, but will require careful planning and sufficient funding.

Consultation Disciplines and Types

Include a full range of disciplines in the consultation system, with a focus on health, mental health, and education. The Connecticut multi-disciplinary system should build on the existing licensing framework with a focus on strengthening consultation capacity in the areas of health, mental health, and education. Other consultation, including nutrition, social service and dental that are required by state regulations, and occupational and physical therapy, special education, and family outreach, are also valuable to early care and education programs and should be brought in to complement and enhance the work of the "core" consultant team as necessary.

Include both program-level and child-specific consultation. Program-level consultation is a priority use of limited resources in that it affects a larger number of staff and children. Existing consultation models demonstrate the effectiveness of consultation as a quality improvement strategy for classrooms and programs. Some children and families will require child-specific consultation services and the system should be able to respond to those needs. The availability of resources will likely dictate the amount of child-specific services the system can provide, given that these services are more resource-intensive.

Early Care Settings to be Served

Offer consultation supports to the full spectrum of early care and education settings. Connecticut's young children are in community-based and corporate child care centers; public school preschool programs; licensed family child care; and in informal care with kith and kin. All of these settings would benefit from consultation that helps teachers and caregivers improve their ability to support children's overall development. Presently, only settings licensed as child care centers or group day care homes are required to use consultants. Public school programs, family child care homes, and kith and kin caregivers should have access to consultation with the goal that all settings incorporate their use at some future time. Consultation should be flexible to accommodate the varying needs of these different programs and may require different skill sets or approaches on the part of consultants.

Make consultation available to all programs, regardless of the population they serve. Some of the child care consultation models described in this paper limit consultation services to specific

programs and/or children based on the age of the children served and whether they meet certain eligibility requirements. In Connecticut, the multi-disciplinary consultation system would offer consultation services to all early care and education programs regardless of the age group or economic mix of children they serve. This universal availability builds on the current licensing regulations which require that all centers and group day care homes use child care consultants. Consultation can improve the teaching practices of those who work with infants, toddlers, and preschoolers and can benefit children and families from across the economic spectrum.

Consultant Roles, Responsibilities and Support

Establish consistent qualifications for consultants. The quality of the consultation system will depend in large part on the quality of the consultants. As part of the development of the multi-disciplinary consultation system, minimum standards or qualifications for consultants should be established that are relatively equivalent across disciplines. These standards should require professional credentials and may include developing new certification or endorsement processes (depending on the field). The new certification or endorsement would ensure that consultants have expertise in their specific discipline and early childhood knowledge, as well as an understanding about how to work in a multi-disciplinary environment. Higher education will be an important partner in this process.

Clarify roles and responsibilities of consultants. Licensing regulations should expand on the roles and responsibilities of required consultants to guide consultants and directors in working together. For early care settings and consultants in disciplines not included in regulations, other mechanisms should be identified to clarify roles and responsibilities of consultants.

Provide training, resources, and networking opportunities for consultants. The support system for consultants should include an infrastructure of mentoring and networking (both in person and online); on-call support; access to best practices information; and ongoing training. These supports can ensure that consultants feel connected to their particular field, such as mental health, as well as the larger world of early care and education and other complementary quality improvement efforts, such as accreditation. The training for consultants should build on the National Training Institute training modules and expand to include a more in-depth focus on additional disciplines beyond physical health. Training activities should address basic consultant roles and responsibilities, the foundational content of consulting in their fields, and advanced and specialty consultation skills.

Child Care Director Training

Promote training and information to help directors make best use of consultation. The child care director is the linchpin in the child care consultation process. The director must be able to identify the needs in her program, access the appropriate consultation resources, establish a good working relationship with the consultant, and support her staff throughout the quality improvement process. Because the consultant spends limited time in the child care program, it falls to the program director to make sure staff follow through with the consultant's recommendations. Thus, the effectiveness of consultation depends in large part on the qualifications and competence of child care center directors. Modules that address consultation should be included in the director's credential. In

addition, the consultant training system should include opportunities to engage directors with their consultants in team building and problem solving experiences.

Consultation System Infrastructure

Develop a structure for statewide oversight to ensure uniform policies and a consistent framework for the multi-disciplinary consultation system. A neutral entity could be identified to bring together the relevant state agencies to develop, support, and oversee the multi-disciplinary consultation system. Alternatively, an interagency memorandum of understanding could be created that spells out the roles of the state agencies. Whatever the structure, early care providers, child care consultants, and parents should be involved in setting policies and designing the program framework. The state-level entity should ensure that the consultation system is not fragmented, but is coordinated across systems. To support this integration and coordination, the multi-disciplinary consultation system should be incorporated into all relevant state-level plans regarding early care and education. In addition, the statewide organization should maintain a database of consultants who meet the state standards regarding qualifications, building on the database maintained by the Department of Public Health.

Create a regional service delivery system with clear entry points. Consultation is more likely to be utilized if child care providers can easily access the system. Creating a regional delivery system for consultation puts the locus of services closer to the child care programs. The coordinating entity might vary from region to region. However, the organization would have to be trusted by the local early childhood community, with highly-skilled professionals. The regional coordinating entity could serve as an entry point for child care programs looking for consultants and connect these programs with multi-disciplinary consultant teams in the region. The regional entity could also provide support to consultants through networking and training events and could help coordinate the work of the consultants so that they function as a team.

Develop multi-disciplinary consultation teams within each region. At a minimum, multi-disciplinary teams should include consultants from the fields of health, mental health, and early childhood education. Consultants from other fields could be called in to complement and enhance the team's work when necessary. Consultants who are already working with child care programs and meet the established qualifications should be invited to participate as team members. In some regions, additional consultants will need to be identified and/or trained to create a sufficient number of teams. Regardless of discipline, all the consultants should have child development knowledge and demonstrate the ability to work from a family support perspective. To ensure that the consultants' services are effective, they must be coordinated and complementary; child care staff should not have to sift through conflicting recommendations from different members of the consulting team. It will be important to create information-sharing mechanisms that can facilitate this coordinated effort.

Deliver consultation based on a program's individual needs. Consultation should be responsive to the priority needs in each program. In a multi-disciplinary approach, consultants will need a way to ensure that the consultation they provide is coordinated and consistent across the team. One solution is for consulting teams to develop, in conjunction with program directors and teachers, a quality improvement plan that outlines areas of focus. This plan could then serve as a framework to

guide the entire team. Quality improvement plans should be developed annually and revised as needed.

Evaluation

Incorporate a strong evaluation component with clearly defined program, family and child outcomes, as well as quality assurance mechanisms, into the consultation system. As this paper highlights, limited research exists on the impact of consultation on program quality and child outcomes. Therefore, including an evaluation in the system design would be a significant contribution to the field. It would also be important for ongoing program refinement and to show the value of this investment. The specific outcomes and appropriate indicators for such an evaluation should be defined concurrently with the design of infrastructure components.

Finance

Stimulate both public and entrepreneurial funding mechanisms to expand and sustain the system. Presently, the majority of child care consultation is paid for through child care program budgets. However, insufficient funds limit programs from using consultants. When consultation needs are great but budgets are tight, programs need additional funds to cover the costs of consultation.

The consultation models described in this paper identify several different financing alternatives. For example, the ECCP has operated with the support of a state grant, thus enabling programs to engage mental health consultants without cost. The MDT is supported by state Quality Enhancement funding and is also offered free of charge. Larger scale programs like Head Start incorporate the cost of consultation in the funding formulas of system allocations and project grants. Rhode Island's Comprehensive Child Care Networks are supported through grants to agencies, which employ and deploy multi-disciplinary teams and claim reimbursements for services when possible to help support overall operating costs. While all of these models use different funding mechanisms, they have all relied on public funding to make child care consultation more widely available and available at a greater level of intensity than individual programs could afford on their own.

Next Steps in Developing a Statewide Multi-Disciplinary Consultation System

Many steps have been taken in recent years toward the development of a statewide multi-disciplinary consultation system in Connecticut. However, designing and implementing such a system is a large undertaking and many details still need to be finalized. The following specific steps can move this concept closer to reality.

First, the consultation workgroup[17] that planned the December 9, 2004 symposium and helped guide this paper should utilize what has been learned from both these projects to finalize the design of a pilot that will test the efficacy of the multi-disciplinary consultation model. As part of the design process, the planning group will need to:

[17] The workgroup includes representatives from the Child Health and Development Institute, the Accreditation Facilitation Project, the Yale School of Nursing, the Head Start Collaboration Office, the ECCP, the Department of Children and Families, and the University of Connecticut at Stamford.

- Identify the key evaluation questions that should be answered through the pilot;
- Determine how the pilot will build on and/or interface with the existing consultation system outlined in regulations and operating in the state;
- Determine the training needs of the consultants and directors participating in the pilot to ensure high-quality consultation;
- Determine how the pilot effort can be used to inform the development of training programs and other educational efforts that provide appropriate credentials and/or endorsements for consultants in partnership with higher education; and
- Determine how the results of the pilot can be informative to the development of the larger statewide system of multi-disciplinary consultation appropriate to the range of early care setting and populations ideally incorporated into the system.

The workgroup should share their draft plan for the consultation pilot with a broader group of stakeholders, including other state agencies, organizations that have experience in providing consultation services, and child care directors who have used consultation services. This broader group should have the opportunity to comment on the draft design and make suggestions. The Early Childhood Partners planning group offers one potential mechanism for securing input from the state agencies and potentially a way to support the coordination and collaboration that will be necessary to ensure that the pilot results are adopted on a larger scale.

Once the design has been finalized, the workgroup and its partners will need to secure funding for the pilot and the evaluation. After the funding is in place, the workgroup will then need to identify a qualified entity (or entities) to manage the project. Specific suggestions of organizations that could serve this role include the Regional Educational Service Centers (RESCs), the Accreditation Facilitation Project, and higher education.[18]

Early in the pilot's implementation phase, the workgroup should also begin developing a strategy for expanding the pilot statewide and ways to sustain the system. Specifically, the workgroup should work with the different state agencies involved with early care and education to identify the appropriate entity to provide statewide oversight for project management and coordination when the consultation system is implemented statewide. This groundwork will be essential for the model's growth over time.

After the pilot has been implemented, the evaluation findings should be shared with the relevant state agencies and the legislature. Ideally, the results of the pilot will show the worthiness of this investment and attract additional public funding so that the multi-disciplinary consultation model can be implemented statewide. In addition, the lessons learned from the pilot can help inform ongoing refinement of the roles and responsibilities of consultants for both licensing and training.

[18] These suggestions came from participants at the December 9, 2004 Symposium.

CONCLUSION

A growing consensus exists in Connecticut that multi-disciplinary consultation holds significant promise as a quality improvement strategy in early care and education. This intervention incorporates adult learning theory, respects the realities of working in the classroom, and brings outside expertise into the often isolated world of child care providers. The team approach – combining the complementary fields of health, mental health, and education – reflects a holistic approach to child development. In addition, child care consultation can address the needs of early care and education programs wherever they are along the quality continuum, making it a universally applicable intervention.

The difficult part is moving from concept to reality. Implementation requires clear direction, careful planning, strong leadership, effective partnerships, and adequate funding. Many of these elements exist, to some degree, in Connecticut and will hopefully be strengthened through the experience of the multi-disciplinary consultation pilot project. The pilot project will help inform the development of a statewide multi-disciplinary consultation system, a system that can help ensure Connecticut's youngest citizens receive the high-quality care they deserve.

APPENDIX A. HISTORY OF CHILD CARE CONSULTATION IN CONNECTICUT

Pre-1995	DPH regulations require child care centers to have consultants in the areas of health, education, social services, dental and, when serving meals, nutrition; and require weekly visits by health consultants when enrolling infants and toddlers; public schools exempt; education consultants must be approved by State Department of Education Regional Education Services Centers (RESCs, e.g., EASTCONN, LEARN, ACES) for a period of time had Early Childhood Networks that provided some support and consultation for children with special needs in child care; discontinued prior to 1995 Head Start and Early Head Start programs have managers that coordinate and support comprehensive service components, including health, oral health, mental health, disability, nutrition, education, family partnerships, and transportation services
1995	Release of Healthy Child Care America national campaign for health and safety supports to child care, use of child care as an access point for children's health services, and development of a national system of child care health consultation training and support
1997	Dr. Angela Crowley, Yale University, begins sharing findings of research on child care health consultation in Connecticut through the Healthy Child Care Connecticut project and at statewide conference *It Takes a System: Bringing the Best Practices in Maternal and Child Care to Connecticut* co-sponsored by the French-American Foundation, CT Children's Health Council, CT Commission on Children, and the American Academy of Pediatrics - CT Chapter
1998	The Special Needs Work Group of the Governor's Collaboration for Young Children/CT Head Start State Collaboration Office chaired by Dr. Maribeth Bruder, University of CT Medical Center, released the results of a statewide survey of child care centers, family child care homes, and parents that suggested the need for consultation and on-site technical assistance especially for children with behavioral challenges
1999	A survey on health support needs of School Readiness programs in Connecticut conducted by Healthy Child Care CT suggests consultation support for children with challenging behaviors as highest priority Healthy Child Care CT, Education Development Center (Head Start Quality Improvement Center for New England), and CT's MAPS to Inclusive Child Care State Team (formerly the Special Needs Work Group) co-sponsored a day-long *State Forum on Early Childhood Consultation and Technical Assistance* that included a presentation by *Day Care Plus*, a multi-disciplinary child care consultation project serving Cuyahoga County, Ohio, and regional and statewide strategic planning

1999 Healthy Child Care CT sponsors *Promoting Emotional Wellness of Children in Early Care and Education Settings, A State Forum on Child Care and Mental Health* at the State Capitol, featuring Dr. Jane Knitzer from the National Center on Children in Poverty and a panel presentation on the multi-disciplinary child care consultation model

The CT Head Start State Collaboration Office received a one-year grant from the Head Start Bureau with matching funds from the Graustein Memorial Fund to contract with a consultant to convene stakeholders, develop a more complete database of child care consultants, and hold regional networking events for child care consultants across disciplines

2001 The State Department of Education begins convening education consultants working with School Readiness sites to help implement the *Preschool Curriculum Framework and Benchmarks for Children in Preschool Programs* released in 1999

Healthy Child Care CT received a grant from the Child Health and Development Institute of CT to revise the National Training Institute/University of North Carolina Child Care Health Consultant training curriculum and make it more state-specific and certain sections generic for consultants across disciplines

The CT Head Start State Collaboration Office receives a second grant from the Head Start Bureau to continue to engage stakeholders in developing a statewide child care consultation system especially for mental health and other special needs and hold a statewide conference on child care consultation

2002 Healthy Child Care CT sponsors a 5-day training, Connecticut's first training utilizing the NTI/UNC curriculum national model, and offers it to 18 child care health consultants and 24 of their colleagues in child care and Head Start including directors and consultants in other disciplines; training satisfaction, training content retention and training influence on practice behavior are evaluated by Dr. Angela Crowley, Yale University, and Dr. Jonna Kulikowich at the University of CT through a grant from the Child Health and Development Institute of CT

Resulting from the Governor's Blue Ribbon Task Force on Mental Health, the Mental Health Strategic Investment Board funds the Department of Children and Families to provide mental health consultation services to early care and education programs. Through Advanced Behavioral Health, the Early Childhood Consultation Partnership is established, with a statewide coordinator and 11 child care mental health consultants.

Department of Public Health, Community Regulations Division continues to refine and expand the centralized database of child care consultants in the state; United Way/Child Care Infoline continues to keep a database of active child care health consultants; the State Department of Education continues to keep a database of

active education consultants; these databases are increasingly used to include consultants in relevant mailings

Healthy Child Care CT is funded by the Department of Children and Families to develop a training curriculum for child care mental health consultants based on the state version of the national NTI/UNC child care health consultant model curriculum, and begins a 4-day training for 22 participants including the 11 new mental health consultants, health consultants, Head Start managers and others in early care and education

2003

Healthy Child Care New England and Education Development Center collaborate and pilot a one-day, six-state interactive video training for child care health consultants, Head Start health managers and others in the early care and education field and receive a regional incentive grant from the Child Care Bureau to plan a full 4-day training to occur in the summer

The Child Health and Development Institute of CT, the CT Head Start State Collaboration Office, and the University of Connecticut School of Family Studies co-sponsor a two-part Child Development Faculty Institute to begin discussion on national trends and resources and career paths in early care and education

The Child Health and Development Institute of CT and the CT Head Start State Collaboration Office co-sponsor a one-day working conference *Supporting Quality Programs through Consultation, A Full-day Working Conference for Early Childhood Directors and Consultants* for more than 150 participants

The Child Health and Development Institute and Healthy Child Care CT co-sponsor a two-part Nursing Faculty Institute to discuss national trends and embedding child care health consultation into nursing education programs and offer development grants to nursing faculty. Nursing faculty from other Northeast states attend Day 1

Healthy Child Care New England, with region-wide incentive grant from the Child Care Bureau through the VT Chapter of AAP, implements the full 4-day training of child care health consultants based on the NTI model. HCCCT holds the training for 18 health professionals at the Yale School of Nursing and provides the keynote presentation via teleconference on Day 1

Through a grant from the Child Health and Development Institute of CT and as a follow-up to the faculty institutes, three participants, representing college faculty in nursing and family studies and the Department of Public Health, are funded to attend NTI training in North Carolina

2004

Healthy Child Care Connecticut and the University of Connecticut host Session II of the 2004-2005 University of North Carolina's NTI training cohort at the University of Connecticut Stamford for participants from around the United States

The Child Health and Development Institute of CT funds the University of Connecticut Stamford School of Family Studies to expand the UNC NTI curriculum to include modules that meet the learning needs of child care education consultants and that address the content areas of early childhood curriculum recommended by the State Department of Education

Healthy Child Care CT and the Child Health and Development Institute collaborate with Healthy Child Care New England to support the University of Connecticut as host to replicate the New England-wide telecast NTI training in a 5-day format and to test the implementation of the education consultant curriculum. Funds are received from a second Child Care Bureau regional incentive grant to cover partial training costs. Over 80 people in Connecticut register for the training and 45 are accepted, including 15 health consultants, 13 education consultants, 7 directors, and 10 others (e. g., mental health consultants, licensing specialists, and college faculty). Five Connecticut NTI trainers deliver the various modules

Healthy Child Care New England plans a 1-day training to test web cast technology. The November 1st training is on legal aspects of administering medications in early care settings and involves state Healthy Child Care projects, state Boards of Nursing and state Nurses' Associations across New England with Connecticut serving as the lead training state. Over 100 health professionals participate across New England, including 40 health professionals in Connecticut who report that their consultation impacts more than 8,000 children in child care throughout the state.

The Child Health and Development Institute and the Connecticut Head Start State Collaboration Office partner with the University of Connecticut to hold a daylong symposium on multi-disciplinary consultation. National speakers present the consultation model and over 30 participants work in small groups to define aspects of developing a statewide multi-disciplinary consultation system for Connecticut.

The Child Health and Development Institute of CT explores the possibility of funding multi-disciplinary child care consultation teams to pilot implementation of the team consulting model

Grace Whitney, March 28, 2003, Updated December 31, 2004
Partial listing of activities related to building a statewide multi-disciplinary child care consultation system

APPENDIX B. REFERENCES REGARDING CONSULTANTS IN THE CONNECTICUT STATUTES AND REGULATIONS FOR LICENSING CHILD DAY CARE CENTERS AND GROUP DAY CARE HOMES[36]

The following are taken from sections of state regulations for reference purposes only:

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(21) "Early childhood education consultant" means an individual who is a credentialed early childhood specialist with a Child Development Associate Credential, Associate in Arts, Bachelor of Arts, Master of Arts, Doctor of Education, or Doctor of Philosophy in early childhood education, child development or human development or a four (4) year degree in a related field with at least twelve (12) credits in child development or early childhood education, who has two (2) or more years experience administering a licensed child day care center that meets standards comparable to those in Connecticut.

Page 3

(54) "Social service consultant" means a person who holds a baccalaureate degree in social work with at least one (1) year of social work experience under social work supervision, or a baccalaureate degree in a field that the Commissioner deems related to social work with at least two (2) years of social work experience under social work supervision.

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(j) The operator shall provide to the Department copies of all service contracts or current agreements with consultants, practitioners and agencies used on a regular or consultative basis in the delivery of services within ten (10) days after execution of said contract or agreement. Any changes in said contracts or agreements shall be reported to the Department within 10 days.

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(h) A written plan for consultation services shall be developed and implemented.

(1) These services shall include:

(A) an early childhood educational consultant available to the operator and staff for advice and support regarding the educational content of the program; anyone approved as an early childhood consultant prior to January 1, 1994, will continue to be an approved early childhood educational consultant, except for good cause shown;

(B) a physician, physician assistant, advanced practice registered nurse or registered nurse consultant available to the operator and staff for advice regarding the health of the children and the health program;

(C) a dentist or dental hygienist consultant available to the operator and staff for advice regarding the dental health of children or a dental health education program;

(D) a social service consultant available to the operator and staff for advice regarding the emotional needs, staff support and the social service program;

(E) a registered dietitian consultant available to the operator and staff for advice regarding nutrition and food service for those programs that serve meals.

(2) The written plan for each consultative service shall include but not necessarily be limited to:

(A) annual review of policies;

(B) annual review of in-service education programs;

(C) availability by telecommunication for advice regarding problems;

(D) availability, in person, of the consultant to the program.

(3) Program staff may not serve as consultants for programs in which they provide direct care or direct program supervision.

Section 19a-79-10. Under three endorsement, pages 29 - 30

(h) Health consultant

(1) A health consultant who is a physician, physician assistant, advanced practice registered nurse or registered nurse shall visit the program on the days and times children under the age of three (3) are present. The scheduled times of the visits shall be arranged so that all children under the age of three (3) are observed. The health consultant shall prepare and maintain signed documentation of visits which shall be kept on the licensed premises.

(2) The health consultant shall visit the program according to the following schedule:

(A) once a week for children up to twenty-four (24) months of age,

(B) once a week for children two (2) to three (3) years of age attending a full day,

(C) once a month for children two (2) to three (3) years of age attending part day programs.

(3) The responsibilities of the health consultant shall include but not necessarily be limited to:

(A) maintaining health records,

(B) maintaining first aid kits,

(C) evaluating toys and/or equipment for safety,

(D) observing diaper changing area and diaper changing procedures,

(E) observing and providing health screening for individual children,

(F) sharing supplementary materials with staff and parents,

(G) communicating with staff and parents about specific problems,

(H) providing consultation and acting as a resource person to staff and parents,

(I) providing in service education,

(J) identifying child abuse or neglect.

(4) The health consultant shall document the activities and observations required in this subsection in a health consultation log. The health consultation log shall be kept on file at the facility for two (2) years.

APPENDIX C. DRAFT DESCRIPTIONS OF CONSULTATION POSITIONS

The Child Care Health Consultant Role in an Ecological Model[37]

1. Supports a healthy and safe environment for children, families, and staff by:
    - Developing and implementing comprehensive health and safety policies.
    - Reducing the incidence of illness due to infectious disease transmission.
    - reducing injuries due to environmental hazards and assuring emergency preparedness.
    - Adapting the environment to meet the health and developmental needs of all children including those with special needs.
    - Promoting nutritious meals and snacks.
    - Adopting safe medication administration procedures.
    - Promoting mental health strategies.
    - Identifying and addressing the health needs of staff.
    - Sharing health information and community health resources.

2. Promotes child and family health and development by:
    - Ensuring that all children have an identified primary care provider and are enrolled in an insurance plan, and promoting other family members' access to health services.
    - Ensuring that all children receive comprehensive and timely well-child care including Early Periodic Screening, Diagnosis and Treatment services.
    - Identifying children with chronic illnesses and special needs and developing a plan of care with parents and staff.
    - Coordinating and communicating health information and services across settings (home, child care, primary care, and other health/intervention services) to promote continuity of care.
    - Supporting positive parenting skills and information sharing.
    - Collaborating with other child care consultants, such as, education, mental health, nutrition, dental, and social service.

Mental Health Consultant in Early Care and Education

I. Mental Health Consultation

1. Provides case-centered consultation to teachers with questions or concerns about children at the center.
2. Observes children in the child care setting to assess functioning, relationships with teachers and other children, and "fit" in the program.
3. Meets on-site or at home with families to complete assessments, provide developmental guidance and referrals, including linkage to clinical services.
4. Meets regularly with child care staff individually and in groups to discuss individual children.

II. Programmatic Consultation

5. Observes the child care setting to become familiar with the program offered to children.

6. Meets regularly with the child care staff and the site director to address programmatic concerns, as requested.
7. Provides consultation to center staff on programmatic issues that affect the quality of care provided to the children, as requested.
8. Discusses effective mechanisms of working with parents, as requested.
9. Assists staff to build and maintain productive collegial relationships with one another, as requested.

III. Clinical Services

10. Provides responsive, clinical services to families, as indicated.
11. Provides case management services as needed and collaborates with schools and community agencies as indicated.
12. Facilitates parenting groups and workshops at child care centers and at other sites as requested.

IV. Administrative

13. Maintains up-to-date records.
14. Charts regularly and accurately.
15. Participates in the Project evaluation, as requested.
16. Represents the Project in the community, as requested.
17. Complies with all standards of performance set by the Agency of employment and the Training Program.
18. Completes other tasks as assigned.

Early Childhood Education Consultant

The Education Consultant's role is to provide advice and support regarding the educational content of a center's program. Specific responsibilities include:

- Annually review the center's policies.
- Give specific feedback related to the educational environment in the center.
- Provide feedback to the director and staff regarding observed interactions between teachers and children.
- Deliver or share information about workshops.
- Help staff develop program goals, objectives, and an action/improvement plan and assess the implementation of the plan.
- Provide guidance to the director and staff by making recommendations for additional services, when needed.
- Become familiar with the center's curriculum and provide resources and support to improve the curriculum.
- Provide in-service to staff (or recommend presenters), train staff in developmentally appropriate practice, and use appropriate strategies and child screening and assessment tools.
- Give guidance for accreditation, school readiness, and special education requirements.
- Develop and/or attend parent meetings and workshops.

APPENDIX D. COMPARISON OF HIGHLIGHTED CONSULTATION MODELS

Consultation Model	Ages Served	Disciplines Included	Settings Served	Duration and Frequency of Service	Eligibility Requirements
ACES	Primarily preschool classrooms; very limited child-specific services	Speech/language, occupational and physical therapy, health, mental health, behavioral health, early childhood, social work, family advocate	Centers	As needed; no specified limit (ongoing services dependent on funding)	Any licensed center in New Haven may participate
Child FIRST	0-5	Social worker with mental health and early childhood education background	Centers, licensed family child care homes	Intensive classroom services: one year; targeted classroom services: flexible length of involvement; child–specific services: flexible	Any child care program or family in the Greater Bridgeport area
ECCP	0-5	Mental health	Centers	Child-specific services: Up to 8 hours Core classroom: 8 weeks, four hours week	Any child in the program eligible for services
Day Care Plus	0-5	Mental health and special education or social work or early childhood	Centers and licensed family child care homes	Response Team Services: as needed (average: 2 months) Intensive Services: one year relationship, weekly visits	Any licensed center or family child care home may receive Response Team services; certain centers are invited to participate in the Intensive program
Rhode Island Comprehensive Child Care Services Program	3-5 (not yet in kindergarten)	Health, nutrition, mental health, education, family advocacy	Centers and licensed family child care homes	As needed; no time limit (ongoing services once in Network)	Must belong to Network to receive services; only low-income children are eligible for child-specific services
Abbott	3 -5 (not yet in kindergarten)	Education, health, family advocacy and support, social worker	Centers	Requirements about frequency of classroom visits vary depending experience level of classroom teacher	Must be in one of 30 Abbott Districts and participating in the Abbott program
Head Start and Early Head Start	0-5	Health, nutrition, mental health, education, family advocacy, disabilities	Centers and licensed family child care homes	Ongoing; as much as needed to meet performance standards and address needs of enrolled children and families	Must be an Early Head Start or Head Start program, which serves low-income children
Army	0-5	Administration; curriculum; food service; parent education and involvement; health and special needs (including mental health supports, children, family and exceptional family member supports); safety; facilities	Centers	Ongoing	Must be an Army Child Development Center

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