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Attributes of Effective Head Start Mental Health Consultants : a Mixed Method Study of Rural and Urban Programs

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ATTRIBUTES OF EFFECTIVE HEAD START MENTAL HEALTH
CONSULTANTS:
A MIXED METHODS STUDY OF RURAL AND URBAN PROGRAMS

by
MARY DALLAS ALLEN

A dissertation submitted in partial fulfillment of the
requirements for the degree of

DOCTOR OF PHILOSOPHY
in
SOCIAL WORK AND SOCIAL RESEARCH


Portland State University
2008


DISSERTATION APPROVAL

The abstract and dissertation of Mary Dallas Allen for the Doctor of Philosophy in Social Work and Social Research were presented May 12, 2008, and accepted by the dissertation committee and the doctoral program.


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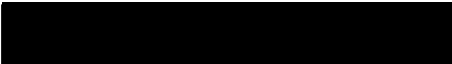

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ABSTRACT

An abstract of the dissertation of Mary Dallas Allen for the Doctor of Philosophy in Social Work and Social Research presented May 12, 2008.

Title: Attributes of Effective Head Start Mental Health Consultants: A Mixed Methods Study of Rural and Urban Programs

Early childhood mental health consultation (ECMHC) is the primary strategy implemented by Head Start programs to address the social and emotional needs of children and their families, but little is known about the attributes of early childhood mental health consultants (MHCs) that contribute to consultants' relationships with Head Start staff and to consultation outcomes. The present study examined how attributes of MHCs contribute to positive relationships between the MHCs and Head Start staff and to improved consultation outcomes. Seven attributes of rural and urban mental health consultants were examined: MHC training, supervision, and support; MHC understanding of consultant role; MHC relationship with Head Start staff; relationships with Head Start families; knowledge of and experience with Head Start; knowledge of early childhood best practices; and cultural sensitivity. This mixed methods study combined a secondary analysis of a national survey (Green, Everhart, Gordon, & Gettman, 2006) of 407 Head Start staff and 57 mental health consultants with a qualitative study using telephone focus groups with 26 rural and urban MHCs who worked with Head Start programs in Alaska and Oregon. Hierarchical linear

models of the national survey of Head Start staff and MHCs suggested that Head Start staff reports of positive relationships with MHCs were associated with MHCs who reported positive relationships with families and staff and who reported that they received training, supervision, and support. Qualitative results indicated that effective MHCs share a mutual understanding of their role with the Head Start staff and provide culturally sensitive services. In addition, the focus groups provided specific information about how MHCs develop relationships with Head Start staff and families and about MHCs' need for training, support, and supervision. Finally, the focus groups revealed that MHCs who provide services in rural areas must understand the role of relationships in rural communities, respect the rural lifestyle, and overcome the challenge of isolation. The findings of this mixed methods study provide valuable information about the nature of relationships between MHCs, Head Start staff, and families and have implications for ECMHC practice, policy, and research.

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CHAPTER 1: INTRODUCTION

Head Start promotes school readiness for low-income children between the ages of three to five by providing comprehensive health, nutrition, disability, mental health, educational, and family services. However, preschool-age children who experience emotional or behavioral challenges may not fully benefit from these holistic early childhood education services and may not be prepared for the transition from Head Start to kindergarten. Early childhood mental health consultation (ECMHC) is the primary strategy used by Head Start to assist families, staff, and programs with identifying the mental health needs of young children who experience emotional and behavioral challenges and providing support (Lopez, Tarullo, Forness, & Boyce, 2000). For many families, particularly families who live in rural areas, the screening, prevention, and intervention services provided by Head Start mental health consultation may be their only access to mental health services (Forness et al., 2000; Lopez et al., 2000). This dissertation is a mixed methods study of rural and urban Head Start programs which examines the attributes of mental health consultants (MHCs) that contribute to positive outcomes of mental health consultation.

The mental health services provided by MHCs are an integral part of the comprehensive early childhood services offered to children and families enrolled in the Head Start program (Jellinek, Bishop-Josef, Murphy, & Zigler, 2005; Piotrkowski, Collins, Knitzer, & Robinson, 1994; Yoshikawa & Knitzer, 1997). Head Start considers the promotion of positive social and emotional development to be essential to fulfilling the goal of school readiness for preschool age children. The Head Start

Performance Standards, which are the mandatory federal regulations that must be implemented to operate a Head Start program, specify the required mental health services including the use of mental health consultants (Administration for Children, Youth, and Families, 1998). According to Section 1304.24 of the Performance Standards, Head Start programs must provide the following mental health services: (a) mental health screening for children within 45 days of the child entering the program, (b) parent and staff support and education on children's mental health, (c) support and special help for children experiencing social and emotional challenges, and (d) referrals for children needing additional mental health services (Administration for Children, Youth, and Families). To implement these mental health services requirements, programs are expected to consult with a mental health professional on a regular basis. For the Head Start program, early childhood mental health consultation is the central component of the mental health services. According to the Head Start Performance Standards, the mental health consultant plays a central role in working with Head Start staff and families to develop and implement the range of mental health services and supports that address the social and emotional needs of enrolled children (Administration for Children, Youth, and Families).

Despite the guidance provided by the Head Start Performance Standards, there are disparities regarding the quality and quantity of ECMHC services that programs provide. The Head Start Performance Standards supply only a brief outline of the components of ECMHC, so implementation of this service delivery strategy varies widely from program to program. Programs differ on a variety of mental health

consultation dimensions, including the frequency and activities of mental health consultation services, the means through which mental health consultants are employed, and the education and training of mental health consultants (Green, Everhart, Gettman, Gordon, & Friesen, 2004).

The Head Start Performance Standards provide general information to guide programs in determining the frequency and activities of mental health consultation. The Performance Standards only specify that consultation be provided with “sufficient frequency to enable the timely and effective identification of and intervention in family and staff concerns about a child’s mental health” (Administration for Children, Youth, and Families, 1998, p. 129). Consequently, services provided by the mental health consultant may range in quantity from a couple of visits a year to daily on-site consultation. Results from a national survey of Head Start programs revealed that 37% of programs provided less than 30 minutes of mental health consultation per child in one year (Green, Everhart, et al., 2004). In addition, the Performance Standards state that programs should: (a) secure mental health consultants who can assist staff and parents with the design of services to support the behavioral and mental health concerns of individual children; (b) provide staff and parent education on children’s mental health topics; (c) assist with providing services to children with atypical behavior or development; and (d) access community mental health services as needed (Administration for Children, Youth, and Families). In practice, Head Start grantees incorporate varying levels of several aspects of ECMHC into the mental health services offered, including classroom observations, in-depth assessments, direct

therapeutic service, meeting with staff teams, staff training, meeting with parents, and supporting staff wellness (Green, Everhart, et al., 2004).

Programs are responsible for securing the services of a mental health professional to provide mental health consultation services, and they accomplish this task in a variety of ways. Some programs employ a mental health consultant as a staff member, while others secure consultant services through a paid contract or *pro bono* memorandum of agreement. Most programs have a limited amount of funding available for mental health consultation services. In fact, Green, Everhart, et al. (2004) reported that Head Start programs spend as little as 3.5% of their total budget on mental health services.

Many Head Start programs have difficulty securing mental health professionals to provide early childhood mental health consultation services (Piotrkowski et al., 1994; Yoshikawa & Knitzer, 1997). Although the Performance Standards do not mandate the qualifications of MHCs, the guidance section of the Performance Standards clarifies that MHCs may have training from a variety of disciplines, including psychiatry, psychology, psychiatric nursing, marriage and family therapy, clinical social work, behavioral and developmental pediatrics, and mental health counseling (Administration for Children, Youth, and Families, 1998). In addition, the guidance section instructs programs to work with the mental health professional to determine the level of qualifications necessary to provide varying levels of mental health services. For example, programs must determine those activities that should be provided by a licensed mental health professional and those that could be provided

without the supervision of a mental health professional. Unfortunately, many programs may not have access to a host of mental health professionals with varying levels of competence.

Access to mental health professionals is a significant concern for Head Start programs in rural and urban areas. In rural America, there is a shortage of qualified and accessible trained mental health professionals, and 60% of the population needing mental health services is underserved (Pion, Keller, & McCombs, 1997; U.S. Department of Health and Human Services, 2004). Because rural areas lack an infrastructure for providing children's mental health services, it is difficult to recruit and retain a qualified workforce, which is compounded by the isolation that rural providers experience (Huang, Macbeth, Dodge, & Jacobstein, 2004). In many rural areas, it is typical for a single mental health professional to be responsible for providing mental health services ranging from individual clinical interventions to group based prevention work (Kowalenko, Bartik, Whitefield, & Wignall, 2003). In fact, the lack of children's mental health services in rural areas has been identified as a significant challenge for children, families, and communities (U.S. Department of Health and Human Services, 2004).

Although children living in large urban areas may be more likely to receive mental health services than children living in rural areas (Cohen & Hesselbert, 1993), children living in urban areas, particularly children of color, also lack access to sufficient mental health services (Gonzalez, 2005; McKay, Stoewe, McCadam, & Gonzalez, 1998). Children of color living in urban environments may be

disproportionally exposed to community violence, crime, drug use, and poverty putting them at risk for mental health challenges, yet despite their complex needs they have low levels of involvement with mental health services (McKay, Lynn, & Bannon, 2005). Access to and engagement in mental health services among children of color and their families who live in urban environments may be negatively influenced by the stigmatization of mental health services, inaccessible locations, lack of knowledge about services, and unresponsive service providers (McKay et al., 1998).

Although the Head Start Performance Standards require ECMHC services for young children and their families, programs implement ECMHC and related mental health services with varying degrees of success (Jellinek et al., 2005; Piotrkowski et al., 1994; Yoshikawa & Zigler, 2000). Even when ECMHC is available, relatively few enrolled children benefit from the skills of the consultant (Piotrkowski et al.; Yoshikawa & Zigler). For example, data from the 2002 Head Start Program Information Report revealed that Head Start staff consulted with a mental health professional regarding only 13% of all enrolled children (Irish, Schumacher, & Lombardi, 2004). Screening and identifying children with social and emotional challenges is also difficult for programs (Lopez et al., 2000). The 2004 Head Start Program Information Report data reveal that only 3% of children determined to have a disability were identified as having a social and emotional disorder (Hamm & Ewen, 2005). This rate of identification is low in comparison to an estimate that as many as 29% of enrolled Head Start children may experience emotional and behavioral challenges (Sinclair, 1993). Finally, Head Start programs may also face difficulty in

referring children who are identified as experiencing emotional and behavioral challenges for mental health services. In 2004, Head Start programs reported that 2% of enrolled Head Start children were referred for mental health services outside of Head Start, and 72% of those children referred actually received the needed services (Hamm & Ewen). It is clear that Head Start programs need additional knowledge and information about how to engage effective mental health consultants in providing early childhood mental health consultation services. Because of differences among rural and urban access to and availability of mental health services, rural and urban Head Start programs may need localized strategies for developing and implementing effective consultation services.

The present study used a mixed methods design to better understand how early childhood mental health consultants provide effective services to rural and urban Head Start programs. A secondary analysis was conducted of a national survey of rural and urban Head Start staff and mental health consultants (Green, Everhart, Gordon, & Gettman, 2006) in order to identify the attributes of mental health consultants that contribute to positive relationships with Head Start staff and to improved child outcomes. A telephone focus group study of 26 rural and urban Head Start mental health consultants was conducted to examine mental health consultants' perceptions of how to best establish those relationships and to determine the challenges rural MHCs experience in their work. The focus group study built upon the findings of the secondary analysis by providing a detailed description of MHCs perceptions of the attributes of effective rural and urban consultants.

CHAPTER 2: LITERATURE REVIEW

Early childhood mental health consultation (ECMHC) services are a core component of Head Start, which is a federally-funded early childhood program that supports the educational, health, nutritional, and social-emotional needs of low-income children ages three to five and their families. Since its inception in 1965, Head Start has identified social and emotional development as a key factor in promoting children's early development and school success (Jellinek, et al., 2005; Yoshikawa & Zigler, 2000). Healthy early childhood social and emotional development, also described as early childhood mental health, supports children's ability to "experience, manage, and express the full range of positive and negative emotions; develop close, satisfying relationships with other children and adults; and actively explore their environment and learn" (Cohen, Onunaku, Clothier, & Poppier, 2005, p. 2). ECMHC services within Head Start are designed to support the positive mental health of all children.

Unfortunately, many preschool age children experience emotional and behavioral challenges. Emotional and behavioral challenges in young children refer to a repeated pattern of behaviors that adversely affect learning or pro-social relationships with peers or adults (Dunlap, Kern, & Ostrosky, 2003). Children from all socioeconomic, cultural, and ethnic backgrounds may experience emotional and behavioral challenges (National Institute for Health Care Management, 2005). However, children enrolled in the Head Start program who experience extreme poverty, exposure to violence, and family risk factors, such as parental mental illness,

drug use, family violence, and strained parent-child relationships, may be at an increased risk of experiencing emotional and behavioral challenges (Ackerman, Kogos, Youngstrom, Schroff, & Izard, 1999; New, Razzino, Lewin, Schlumpf, & Joseph, 2002; Randolph, Koblinsky, Beemer, Roberts, & Letiecq, 2000; Razzino, New, Lewin, & Joseph, 2004; Sinclair, 1993; Webster-Stratton, 1998). In addition, children's neurological and physiological development, communication abilities, problem-solving skills, and the school setting also influence the expression of emotional and behavioral challenges (Division for Early Childhood, 1999).

Social and emotional challenges in young children refer to a broad category of behaviors that includes both internalizing and externalizing problem behaviors. Children with internalizing problem behaviors may exhibit depressed mood, sadness, social withdrawal, fearfulness, and anxiety (Campbell, 1994, 1995). In contrast, externalizing behaviors in young children include overactivity, poor impulse control, aggression toward peers, oppositional or defiant behavior, conduct problems, and tantrums (Campbell, 1995; Keenan, Shaw, Delliquadri, Giovannelli, & Walsh, 1998). Head Start staff and parents become concerned when young children exhibit internalizing or externalizing behaviors to a degree that the behavior begins to negatively affect relationships with adults and peers. ECMHC is a strategy that Head Start utilizes to minimize the effect of internalizing and externalizing problem behaviors on the child, the child's family, and the Head Start staff.

Within Head Start disability services, a child with emotional and behavioral challenges may be considered as experiencing an emotional/behavioral disorder when

“the child's behavioral or emotional responses are so different from those of the generally accepted, age-appropriate norms of children with the same ethnic or cultural background as to result in significant impairment in social relationships, self-care, educational progress or classroom behavior” (Administration for Children, Youth, and Families, 1998, Section 1308.8). To be identified as having an emotional/behavioral disorder, a child must experience one or more of the following characteristics with enough frequency, duration, and intensity to warrant intervention: (a) seriously delayed social emotional development; (b) inappropriate behavior; (c) general pervasive mood of unhappiness or depression, or evidence of excessive anxiety or fears; and (d) a professional diagnosis of serious emotional disturbance (Administration for Children, Youth, and Families, 1998).¹ The Head Start Performance Standards do not require that a child meet the eligibility criteria for emotional/behavioral disorder to receive ECMHC services provided by a MHC.

ECMHC is a universal prevention strategy in which Head Start programs are mandated by the Head Start Performance Standards to partner with a MHC professional who will provide ECMHC services to all enrolled children and families. However, children who experience emotional and behavioral challenges, which includes but is not limited to children identified as having an emotional/behavioral disorder, are often a primary focus of ECMHC services. MHCs work with families

¹ Serious emotional disturbance is the classification for children with emotional, behavioral, or mental disorders under the Individuals with Disabilities Education Act (IDEA), which is the federal policy mandating for the provision of special education services (P.L. 108-446). Because Head Start and IDEA have different criteria for determining the presence of emotional or behavioral disorders, a child who qualifies for Head Start disability education services for an emotional/behavioral disorder does not automatically qualify for special education services for emotional disturbance through the local education agency as mandated by IDEA (P.L. 108-446).

and Head Start staff to create and to support positive learning environments for children with both internalizing and externalizing challenging behaviors. The support of the MHC is important, because emotional and behavioral challenges have a significant impact on the child, the child's family, the child's peers, and the Head Start staff.

Prevalence of Emotional and Behavioral Challenges

Determining the prevalence of emotional and behavioral challenges of preschool age children is challenging. Kaiser, Hancock, Cai, Foster, and Hester (2000) identified several factors that contribute to disparate estimates of the number of preschool age children who experience emotional and behavioral challenges. First, there is variability in the social and emotional development of preschool age children, which often makes it difficult to distinguish typical, developmentally appropriate behaviors from behaviors that warrant concern (Campbell, 1995; Kaiser et al.). Second, identifying emotional and behavioral challenges that are predictive of emerging problems requires time consuming and reliable reports of behavior from parents and teachers (Hoagwood, 2005; Kaiser et al.; Keenan & Wakschlag, 2000). Third, the expectations for behavior held by early childhood care and education staff may differ from expectations held by the parents of children (Kaiser et al.). For example, Gilliam (2005) found that African-American preschool children were twice as likely to be expelled from early childhood settings as European-American preschool children. Finally, parents and staff often both have concern for labeling preschool age children as having an emotional/behavioral disorder or emotional disturbance (Kaiser

et al.). Despite these challenges, efforts have been made to determine the prevalence of children with emotional and behavioral challenges both within the Head Start population and within the general population.

Estimates of the number of Head Start children who experience emotional and behavioral challenges vary (Lopez et al., 2000). Sinclair (1993) found that of the 151 children enrolled in a Head Start program who were evaluated 29% met the criteria for serious emotional disturbance, in contrast to the prevalence rate of 4% that was reported by the Office of Special Education Services during the same year. In contrast, only two-thirds of 1% of children enrolled in Head Start in 1994-1995 were identified by programs as having emotional and behavioral problems (Yoshikawa & Knitzer, 1997). Information from the National Head Start Early Childhood Transition Study reveals that approximately 5% of former Head Start participants who received special education services in kindergarten were identified in kindergarten as emotionally disturbed (Redden, Forness, Ramey, Ramey, & Brezausek, 2002). To get a more accurate picture of the number of preschool age children who experience challenging behaviors, the prevalence of children with challenging behaviors in Head Start can be compared with national data.

Studies that estimate the national prevalence of children with emotional and behavioral challenges vary, but all are consistent in demonstrating the extent of the problem. Analysis of the 2003 National Survey of Children's Health supported other national findings that between 5 and 7% of children between the ages of birth to 17 experience emotional and behavioral challenges (Blanchard, Gurka, & Blackman,

2006; Guevara, Mandell, Rostain, Zhao, & Hadley, 2003). Findings from the National Health Interview Surveys from 2001, 2002, and 2003 reveal that nearly 5% of children ages 4 and 17 in the United States experience emotional or behavioral challenges and that up to 80% of those children exhibit challenges that affect their learning and relationships (Simpson, Bloom, Cohen, Blumberg, & Bourdon, 2005). The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health (2001) reports that 10% of children and adolescents experience mental illness that impairs their ability to function. Roberts, Attkisson, and Rosenblatt (1998) estimated the prevalence rates of psychopathology among children and adolescents by reviewing the rates published in 52 studies written over the previous 40 years. This study found that the median rate of psychopathology for preschoolers was 8%. In a study by Ringel and Sturm (2001), 1-2% of preschool age children were found to utilize mental health services in 1998. A review of the literature on the prevalence of behavioral problems among preschool children revealed that 3-6% of children from the general population are expected to experience behavioral challenges, in contrast to nearly 30% of children from low socio-economic backgrounds (Qi & Kaiser, 2003). Finally, it has been estimated that between 4-6% of preschoolers have serious emotional and behavioral disorders and between 16 - 30% experience challenging behaviors (Raver & Knitzer, 2002).

Attention to the needs of children in rural areas who experience emotional and behavioral challenges is of particular importance, because they are much less likely to have access to mental health services despite the fact that they experience mental

health challenges at a rate similar to suburban and urban children (Howell & McFeeters, 2008; Kelleher, Taylor, & Rickert, 1992; U.S. Department of Health and Human Services, 2004, 2005). The 2003 National Survey of Children's Health reported that the prevalence of social and emotional challenges reported by parents did not differ by geographic location (U.S. Department of Health and Human Services, 2005). In urban areas, 4.8% of parents of preschool children reported moderate or severe socio-emotional difficulties, compared with 4.9% in large rural areas, and 5.2% in small rural areas. Although it is difficult to estimate with accuracy the number of preschool age children or children enrolled in Head Start who experience challenging behaviors, it is clear that it is a prevalent problem in need of attention (Lopez et al., 2000).

Impact of Emotional and Behavioral Challenges

When children enrolled in Head Start experience emotional and behavioral challenges, the health and well-being of the child, the child's family, and the Head Start program staff is compromised. Unfortunately, the stigma associated with social and emotional challenges may prevent Head Start staff or parents from identifying young children and from accessing mental health services for children in need (Fantuzzo et al., 1999; Teagle, 2002). ECMHC is a strategy that supports children with emotional and behavioral challenges, their families, and the Head Start staff. In addition, ECMHC can help ameliorate the negative impact that stigma of emotional and behavioral challenges may have on identifying and providing services for young children who experience such behaviors.

Children who exhibit emotional and behavioral challenges in early childhood are at significant risk for educational and social problems throughout childhood and into adolescence. In a study of preschool age boys with challenging behaviors, Campbell (1994) found that at a two-year follow-up, a large proportion of the 112 boys in the study continued to have the same behavior problems they experienced in preschool, or they had developed new behavior problems. Spernak, Schottenbauer, Ramey, and Ramey (2006) found that by the third grade, former Head Start students who had been treated for a mental, emotional, or behavioral problem had significantly lower math and reading scores. A 25-year longitudinal study of youth in New Zealand found that when controlling for childhood, family, and educational characteristics, conduct problems experienced by children at seven, eight, and nine years of age were associated with negative outcomes in adulthood, including crime, substance abuse, mental health challenges, and poor partner relationships (Fergusson, Horwood, & Ridder, 2005). Young children with problem behaviors are also at increased risk of dropping out of school and delinquency in adolescence (Raver & Knitzer, 2002).

The persistence of social and emotional challenges into the school years have been associated with initial problem severity, cognitive functioning, parenting behavior, and level of family challenges (Campbell, 1995; Campbell & Ewing, 1990). Campbell and Ewing found that aggression and hyperactivity in early childhood were predictive of later externalizing behaviors. Family challenges, such as ineffective parenting, family adversity, stress, and instability, have also been associated with ongoing behavioral problems in young children (Campbell, 1994, 1995). However,

family challenges have not been found to be predictive of persistent social and emotional challenges (Campbell, 1995). The relationship between family adversity and childhood emotional and behavioral challenges is unclear; it is possible that there is a reciprocal relationship between family adversity and childhood emotional and behavioral challenges, such that family adversity contributes to emotional and behavioral challenges which further leads to family challenges.

Families caring for a child with emotional or behavioral challenges may experience significant emotional and financial strain. In both urban and rural areas, approximately 28% of parents of children with socio-emotional difficulties report that their child's condition places a medium to a great deal of burden on the family (U.S. Department of Health and Human Services, 2005). For families of children between the ages of zero to five, this burden is most likely to be reported by parents living in rural areas (25.6%) and least likely to be reported in urban areas (21.6 %; U.S. Department of Health and Human Services, 2005). The difficulty of caring for children with emotional and behavioral challenges may create work and childcare-related stress for parents (Brennan & Poertner, 1997). Obtaining and maintaining quality placement in an early childhood educational setting is a serious concern for families of children with emotional and behavioral challenges and can be a significant financial and emotional burden (Rosenzweig, Brennan, & Ogilvie, 2002). According to findings of the National Survey of Children's Health, families of children with emotional and behavioral challenges are more likely to experience disruptions with work or child care arrangements (Blanchard et al., 2006). Work disruptions are

common for parents of children with emotional and behavioral challenges, because children who exhibit challenging behaviors are at an increased risk for expulsion from early childhood education placements (Gilliam & Shahar, 2006).

The expulsion of young children from early childhood programs as a disciplinary action reflects the stress of educating and providing care for young children with emotional and behavioral challenges. In the first state-wide study of preschool expulsion rates, Gilliam and Shahar (2006) found that 39% of teachers in state supported preschools in Massachusetts had expelled at least one child during a 12-month period as a disciplinary action. In a national study, Gilliam (2005) found that the expulsion rate in prekindergarten was 3.2 times higher than the K-12 rate, although expulsion rates were lower in Head Start programs than in for-profit or non-profit child care agencies.

Providing early childhood care and education for children with challenging behaviors is difficult, and many early childhood staff receive inadequate training and support for addressing those behaviors. Even high quality early childhood programs typically do not have the resources and supports to sufficiently address the emotional and behavioral needs of young children (Collins et al., 2003). Maintaining children with challenging behaviors in a group setting is difficult for many early childhood education programs (Brennan, Ama, & Gordon, 2002). Through training, Head Start staff can become more knowledgeable of early childhood social and emotional development, which will decrease the misidentification of developmentally appropriate preschool behavior as abnormal behavior (Spernak et al., 2006).

Supporting children's social and emotional development may help to improve the quality of the classroom environment and the relationships between children, their teachers, and their peers (Raver, 2002). Head Start program staff report that more children with severe behavioral challenges appear to be enrolling, creating an increased need for information and support on children's mental health issues (Kupersmidt, Bryant, & Willoughby, 2000).

Access to Mental Health Services

Despite the prevalence of emotional and behavioral challenges in children, it is estimated that as few as 1 in 5 of children identified as experiencing challenges will receive mental health services (Gonzalez, 2005; Roberts et al., 1998). Children living in poverty are particularly affected. Children who live in poverty are more likely to be reported as experiencing depression, anxiety, or antisocial behaviors, yet mental health services for children living in low-income areas are inadequate or non-existent (Fantuzzo et al., 1999; Howell & McFeeters, 2008; Samaan, 2000). According to the National Survey of Children's Health, 13% of children living in poverty in urban areas experience moderate or severe socio-emotional difficulties, compared with 6% of children living at 400% or more of the Federal Poverty Level (U.S. Department of Health and Human Services, 2005). This study also found that nearly 18% of children living in poverty in large rural areas experience moderate or severe socio-emotional challenges. A variety of factors contribute to disparities in access to mental health services among low-income preschool age children, children living in rural areas, and children of color.

The stigma associated with mental health problems reduces the number of young children who receive services for emotional and behavioral challenges. Many children identified as having emotional and behavioral challenges are never referred to mental health services. Although early childhood programs, such as Head Start, have the potential to provide identification and referral services, early childhood educators and parents may be reluctant to identify children as having emotional and behavioral challenges and to refer them for mental health services because of the stigmatization of mental health. Parents and staff need training to help them recognize when children with emotional and behavioral challenges are in need of mental health services (Teagle, 2002). Both parents and staff may feel the mental health system is untrustworthy, unresponsive, and difficult to access (Sherman, 2002). Consequently, teachers often refer children for unrelated special education services, such as speech and language, because those services are more accessible and less stigmatizing than mental health services (Fantuzzo et al.).

Accessibility, availability, and acceptability of mental health services have been identified as important factors that prevent children in rural areas from receiving mental health services (U.S. Department of Health and Human Services, 2004). The ability to travel to mental health services is a barrier for children and families seeking care for emotional and behavioral challenges. Because many rural areas may lack mental health services, children and families may be required to travel to larger communities to access available services. Finally, many rural mental health providers

are itinerant providers and are not local residents, so there is often a gap in provider knowledge about rural issues and concerns.

Ethnic minority children experience bias in identification, treatment, and access to mental health services (Pumareiga, Rogers, & Rothe, 2005; U.S. Public Health Service, 2000). A study examining racial / ethnic disparities in children's mental health service use in rural and urban areas found that White children living in rural areas are less likely to receive mental health services than urban White children, and that rural African-American and Hispanic children are less likely to receive mental health services than rural White children (Howell & McFeeters, 2008). Disparities in access to mental health access among minority children may be due to family reluctance to access services based on previous discrimination, language and cultural barriers, and feelings of shame regarding mental illness (Pumareiga et al.) Such challenges within the children's mental health system confirm the need for timely and effective mental health services within Head Start. Mental health resources offered through Head Start have the potential to fill a significant gap in available services for low-income preschool children in both rural and urban areas.

Consultation History and Theory:

Influence on Early Childhood Mental Health Consultation

History of Mental Health Consultation

In the 1960s, mental health consultation was included as one of the five mandated services of the Community Mental Health Services Act, which established it as an important means of delivering mental health services in the United States

(Caplan, Caplan, & Erchul, 1995). Gerald Caplan developed mental health consultation as a strategy for providing mental health services to a large number of referred clients (Caplan et al.). He defined mental health consultation as the process in which two professionals, a consultant and a consultee, interact, such that the consultant assists the consultee to resolve a client's mental health problem (Caplan, 1959). As a result, the consultee gains knowledge and skills from the consultation process that could be used in the future (Brown, 1993; Caplan, 1959). Within this model of consultation, psychodynamic theory was the primary theoretical orientation for working with consultees. The consultation process and identified interventions addressed the consultee's challenges in working with the client, so the consultee retained the primary responsibility for addressing the needs of the client (Caplan et al., 1995). The consultant did not directly work with the client. Although the field of consultation was shaped and informed by Caplan's work, the definition of consultation and the role of the consultant have changed over time (Kurpius & Fuqua, 1993). This early influence of consultation affected the newly formed Operation Head Start, which began in 1965.

Mental health consultants were involved in providing mental health services to children, staff, and families from the beginning of "Operation Head Start." A commitment to promoting the social and emotional competence of young children has always been a core value of the program (Knitzer, 2004). Caplan's conceptualization certainly had an influence on the provision of mental health services in Head Start, but from the beginning mental health professionals discussed the challenges of integrating

their services into the Head Start program (Bonkowski, 1968; Goldberg, 1968). While the Head Start program wanted the mental health professional to provide traditional mental health tasks, such as providing screenings for children and giving recommendations to teachers, the mental health professionals found that the teachers, families, communities, and the program also needed considerable support (Bonkowski; Goldberg). Goldberg advocated for an approach to consultation that went beyond educating teachers through consultee-centered consultation, which he envisioned as a comprehensive theory that integrated consideration of the social environment with the traditional duties of the consultant.

Consultation is a model used in early childhood settings not only for delivering mental health supports and services, but also for delivering expertise in special education. Early childhood special education consultants have become necessary in early childhood settings as programs move toward full inclusion of children experiencing disabilities (Harris & Klein, 2002; Klein & Harris, 2004). The specialized skills that early childhood special educators once provided in special education classrooms are now provided through consultation services to early childhood care providers and educators teaching in inclusive classrooms (Klein & Harris). Consultation in early childhood special education shares concepts, approaches, and challenges that are similar to those experienced in early childhood mental health consultation (Buysse & Wesley, 2004).

Defining Consultation

Consultation is a complex process, which is illustrated by the variety of definitions of consultation in the literature (Brack & Brack, 1996). Many of these definitions highlight the idea that consultation is a tridimensional relationship in which the consultant assists the consultee with problem identification, education, and selecting a solution to the problem, which ultimately leads to the goal of helping the client (Brack & Brack; Brack, Jones, Smith, White, & Brack, 1993; Davis & Sandoval, 1991). By learning skills to deal with the identified problem, the consultee will be better prepared to deal with similar problems in the future (Brack & Brack). While this type of generic definition is useful for a basic understanding of consultation, it is not sufficient. Developing and implementing effective consultation services are dependent on the consultants' ability to accurately understand and articulate their definition of consultation (Kurpius & Fuqua, 1993). Therefore, programs should develop an operational definition of consultation that clarifies the exact nature of the triadic relationship, the role of the consultant within the organization, the modes of consultation, and the levels of intervention.

Early childhood mental health consultation (ECMHC) is defined by Cohen and Kaufman (2005) as "a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals with other areas of expertise, primarily child care center staff" (p. 4). Through this collaborative relationship, mental health consultants (MHCs) apply problem-solving and capacity-building

strategies that support the relationships between children and their peers, teachers, and parents to prevent, identify, treat, and reduce the impact of emotional and behavioral challenges among children enrolled in Head Start (Cohen & Kaufmann).

Triadic Relationship

The consultant relationship is a complex, triadic relationship in which the consultant works with a consultee who works with the client (Kurpius & Fuqua, 1993). The relationship is non-linear, and although the consultant works primarily with the consultee, there are times when the consultant may work directly with the client (Kurpius & Fuqua). However, consultation works under the premise that consultation services are more effective and efficient when the consultant works with the consultee to develop an intervention plan, rather than providing direct service. Because the consultees have the most extensive contact with clients, changing their behavior has the potential for creating the biggest impact on clients (Kurpius, 1978). The relationship between the consultant and consultee should be equal, where interactions are give and take, and the consultant should not have more power or authority than the consultee (Brack & Brack, 1996).

This triadic relationship certainly exists within early childhood mental health consultation. Typically the consultant is a mental health professional, who received training in one of a variety of fields, including psychology, social work, counseling, and psychiatry (Green, Everhart, et al., 2004). The consultee may be a Head Start teacher, assistant teacher, or family advocate. The consultee may also be a Head Start parent, supervisor, or administrator. The client is typically a child enrolled in the

Head Start program, although at times the family or program staff members may be considered the client. Early childhood mental health consultants provide indirect services through collaborative relationships with the Head Start staff or family that support the social and emotional wellness of the child. Although there may be times where the consultant provides direct services to the child or family, direct clinical work does not form the core services of early childhood mental health consultation (Hepburn et al., 2007).

Internal vs. External Consultants

While there are advantages and disadvantages to both internal and external consultants, there are important differences between the two (Kurpius & Fuqua, 1993). Internal consultants, who are common in large organizations, are employed by the agency or organization for which they are providing consultation services, so they are more likely to be well-known within the organization. In contrast, external consultants, who are hired or contracted by an organization to provide consultation services, may be perceived as an outsider to the organization. Therefore, internal consultants are likely to have access to information about the organization or the presenting problem that external consultants would not have. Internal consultants may also have a personal interest in the outcome of the presenting problem, and they do not terminate services when the problem is resolved.

Early childhood mental health consultants may also be internal or external to the Head Start program. Internal consultants are employed directly by the Head Start program; a national survey of mental health consultants reported the about 1 in 5

(22%) of the 69 consultants surveyed were employed by the Head Start program (Green, Everhart, et al., 2004). External consultants are a more common model of consultation in Head Start programs. In the national survey of Head Start mental health consultants, 63% of consultants were external consultants: 23% were employed by a non-profit agency, 7% were employed by a government agency, and 33% were in private practice (Green, Everhart, et al.).

Approaches to and Models of Consultation

Consultation can take many forms, so it is essential to establish the approach and model of consultation being implemented. Consultants can approach the consultative relationship from either an expert or a process approach (Kurpius & Fuqua, 1993). In the expert approach, the consultee identifies a problem and contracts with a consultant, who designs and implements an intervention that addresses the problem. In contrast, the consultant and consultee share responsibility for the change in the process approach. The consultant collaborates with the consultee to identify the problem, and design and implement the intervention. Both approaches to consultation are reflected in the various models of consultation identified by Kurpius (1978) and Caplan (1995).

Kurpius (1978) identified four models of consultation: provision, prescription, collaboration, and mediation. The provision model of consultation, which maintains an expert approach, occurs when a consultee identifies a problem and requests the services of the expert consultant for developing and implementing an intervention to address the problem. The prescription model of consultation involves the expert

consultant gathering information from the consultee, identifying the problem, and developing an intervention that the consultee implements. When collaboration is the model of consultation, which is a process approach, the consultant and the consultee work together to define the problem and design and implement the intervention.

Finally, the mediation model of consultation involves the consultant, often an internal consultant, identifying the problem or concern, gathering information about it, and gathering a group of consultees to examine the problem.

In contrast, Caplan (1995) described four different models of mental health consultation for mental health service environments: client-centered case consultation, program-centered administrative consultation, consultee-centered case consultation, and consultee-centered administrative consultation. In client-centered case consultation, the consultant assists the consultee to provide appropriate services to a client. Program-centered administrative consultation refers to services that a consultant provides to a program needing support with administering treatment, prevention, or rehabilitation services. With consultee-centered case consultation, the consultant focuses on the consultee's challenges in working with a particular client, which may include the consultee's lack of understanding, skill, or objectivity. Finally, consultee-centered administrative consultation refers to consultation that helps programs with the interpersonal personnel challenges of administering mental health services. Elements of each of these types of mental health consultation may be found in early childhood mental health consultation.

Although the early childhood mental health consultation literature has not delineated separate models of consultation, collaborative consultation and consultee-centered consultation are most consistent with the definition of early childhood mental health consultation. Collaboration between the early childhood mental health consultant and the early childhood staff or families is considered an essential component of consultation services within an early childhood setting (Cohen & Kaufmann, 2005; Johnston & Brinnamen, 2006). Through this collaborative relationship, the consultant works with early childhood staff to assess the challenge or problem, determine appropriate interventions, and implement a plan of action, similar to consultee-centered consultation (Cohen & Kaufmann).

Levels of Intervention

Finally, when developing an operational definition of consultation it is essential to clarify the level of the intervention (Kurpius & Fuqua, 1993). Consultation can occur at several levels, where the consultee can be an individual, a group or team, an organization, or a social system. The modes of consultation are applicable across levels. In early childhood mental health consultation, common levels of consultation are the individual child, the child's family, the early childhood staff, or the early childhood organization.

In ECMHC, two levels of mental health consultation have been identified: *child- and family- centered consultation and program-focused consultation*. When providing child- and family-centered consultation services, MHCs work closely with Head Start staff to address the mental health needs of individual families or children

(Cohen & Kaufmann, 2000). Child- and family-centered consultation may include consultant activities such as child assessments, direct therapeutic service, and family counseling, and referrals for mental health services (Center for the Study of Social Policy, n.d.; Green, Everhart, et al., 2004). In addition, the mental health consultant may provide parent support groups or opportunities for Head Start parents to learn about children's mental health (Administration on Children, Youth, and Families, 1998; Yoshikawa & Zigler, 2000). In summary, the focus of child- and family-centered ECMHC is supporting the individual needs of children and their families.

In contrast, through program-focused ECMHC, the MHC works with the entire Head Start program to identify and support children with emotional and behavioral challenges (Cohen & Kaufmann, 2000). The MHC assists the staff with improving the overall quality of the program and with increasing their capacity to serve children with emotional and behavioral challenges (Cohen & Kaufmann). In program level consultation, the MHC may work at the classroom level to improve the classroom environment and to support teachers in addressing child behaviors (Cohen & Kaufmann). Program-focused consultation activities may include classroom observations, meetings with staff, training staff, consulting with program directors, and supporting staff wellness (Center for the Study of Social Policy, n.d.; Green, Everhart, et al., 2004). Although two forms of ECMHC have been identified, many Head Start programs may implement aspects of each type. Research is needed to identify the activities that are necessary for effective ECMHC services.

A review of the recent research on early childhood mental health consultation suggested that early childhood programs utilize up to four levels of ECMHC: child-level, family-level, staff-level, and program-level (Brennan, Bradley, Allen, & Perry, in press). Child-level consultation would include activities such as observation and assessment of individual children and providing one-to-one support for a child with emotional and behavioral challenges. Family-level consultation would include parent training on children's mental health or behavioral management techniques, home visits, and other family support services. Examples of staff-level consultation might include training and support for staff, or classroom-based coaching or mentoring, and crisis intervention. Finally, program-level consultation consists of working with staff to improve staff wellness and communication, advising directors on program issues, and suggesting policy changes. According to Brennan et al., early childhood mental health consultation services should include activities from at least two levels of consultation.

Consultation Theory

Theory provides consultants with a guide to the consultation process and with an integrated approach to understanding problems, goals, and interventions (Brack & Brack, 1996). With this guide and an integrated approach, the consultant becomes more effective and is more likely to develop interventions that meet the needs of the consultee (Brack & Brack; Gallessich, 1985). Yet consultation is often seen as an atheoretical and intuitive process, and there is an assumption that underlying principles or theories are unnecessary for engaging in consultation (Gallessich). These

misconceptions may lead to unfocused consultation services that are unclear to the consultee (Brack & Brack). Developing an integrated theoretical approach to consultation will benefit consultants by providing a common vocabulary and perspective, by improving communication between consultants and consultees, and by creating a framework for consultation practice guidelines. Brack and Brack explain that theory should both inform and be informed by consultation practice. Through this integrated theoretical approach, theory guides consultation practice, and practice evaluation provides information necessary to revise and update the theory.

Theory-driven consultation is also a benefit for researchers evaluating the processes and outcomes of mental health consultation. By articulating a theory of change, consultants and programs identify their assumptions about how and why the consultation activities that they implement will result in desired outcomes (Hepburn et al., 2007). The identified theory of change will guide decisions regarding the evaluation of the consultation services, including the selection of research questions, outcomes, and measures (Hepburn et al.).

Theory-guided consultation is a dynamic process, for there is not a single theory that explains consultation (Brack & Brack, 1996). However, the basic concepts of consultation remain constant regardless of the theoretical orientation of the consultant (Gallesich, 1985). Several theoretical approaches to consultation have been identified in the consultation literature, including behavioral theory, social learning theory, psychoanalytic theory, organizational theory, and ecological systems theory (Brack & Brack; Gallesich).

Behavioral Theory

Behavioral theory is the basis for one of the most widely utilized and well known forms of consultation within school settings (Knotek & Sandoval, 2003). Within behavioral consultation, the primary focus is on client dysfunctional behavior and the interactions between the consultee and the client that increase or decrease the frequency of unwanted client behavior. Little attention is paid to the relationship between the consultant and the consultee (Gallesich, 1985). The consultant supports the consultee by providing information, identifying alternative techniques, and reinforcing the consultee's actions (Maital, 1996). The consultant and consultee work together to develop a behavioral definition of the client problem by operationalizing the problem into observable behaviors, and they gather baseline data regarding the frequency of occurrence of the behavior (Brack et al.; Gallesich). The consultant then designs a behavior change plan to reduce the incidence of the problem behaviors and monitors and evaluates the effectiveness of the plan (Brack et al.; Reddy, Barboza-Whitehead, Files, & Rubel, 2000). Behavioral consultation does not address systemic issues contributing to client dysfunction or the consultee's ability to address the client's challenges (Brack et al., 1993). Consultation services are terminated when the consultee effectively addresses client behavior with the support and guidance of the consultant (Brack et al), and the behavior is improved.

Social Learning Theory

Consultation services that are guided by the principles of social learning theory focus on the interactions between behavior, interpersonal factors, and the environment

(Bandura, 1989; Brack et al., 1993; Brown & Schulte, 1987). The goal of consultation is to have an impact on the relationships between the behaviors, the personal factors, and the environment to improve the client's behavior, to improve the consultee's ability to address the behavior, and to increase the likelihood that the consultee can address similar challenges independently in the future (Brown & Schulte). The consultee is encouraged to identify and define the problem situation and participate in selecting an intervention. The consultant works with the consultee to address the identified behavior by increasing the consultee's motivation to develop and implement goals that address the targeted behavior and to increase the consultee's self-efficacy expectations regarding his or her ability to implement the goals (Brown & Schulte). Self-efficacy refers to people's beliefs about the degree to which they can effectively influence the events that occur in their lives (Bandura, 1989). Consultants' beliefs about their ability to effect client change, or their self-efficacy, directly impacts their motivation to engage in implementing the behavior change goals (Bandura). Consultation is terminated when the consultant and the consultee determine that the consultee is able to address the challenge or behavior without support (Brown & Schulte).

Psychoanalytic Approach

Consultants who utilize a psychoanalytic approach to consultation seek to understand the unconscious aspects of behavior. The purpose of consultation is to uncover how the unconscious factors and defenses experienced by the consultee or the client are influencing the identified client challenge (Brack et al., 1993). Because the

consultation is intended to produce change, which is inherently anxiety-provoking and likely to raise the consultee's defenses, psychoanalytically-focused consultants are attuned to resistance to consultation. The consultant seeks to identify and explain these defenses and how they influence the consultee and the consultee's work with the client (Brack et al., 1993).

Organizational Theory

Organizational consultation addresses the division and distribution of authority within an organization, so the consultant works closely with human resources to improve communication, decision making, the organizational climate, and the fit between organizational and individual goals (Gallesich, 1985; Reddy et al., 2000). According to Gallesich (1985), three basic assumptions underlie organizational consultation: (a) It is necessary to examine internal and external forces that affect the organization; (b) organizations tend to stagnate; and (c) the consultant must balance the goal of organizational consultation, which is to promote individual employee growth, with the competing organizational demand for increased worker productivity (Brack et al., 1993). Organizational consultants apply the principles of group dynamics and social psychology to evaluate the organizational setting and to assist consultees with making system-level change (Gallesich, 1985; Reddy et al.)

Principal-agent theory is an organizational theory that helps to explain the relationship between mental health consultants and the Head Start program (Peterson & Hartz, 1998). According to principal agent theory, a principal, in this case the Head Start program, enters into a contract with an agent, in this case the mental health

consultant (Peterson & Hartz). The role of the agent is to implement the goals established by the principal, such that the goals of the principal influence and guide the actions of the agent (Peterson & Hartz). In situations in which there are several principals or agents, there may be conflicts or confusion around the desired goals of the agents and outcomes of the contract (Nilakant & Roe, 1994). The theoretical assumptions of principal-agent theory imply that in order for mental health consultants to effectively implement mental health consultation within a Head Start program, the program must have explicit goals that delineate the roles and responsibilities of the consultant.

Ecological Systems Perspective

The ecological systems perspective of consultation allows the consultant to examine not only the individual level client challenge as identified by the consultee, but also the system-level environmental influences on that client challenge (Brack et al., 1993). Within ecological systems theory, all behavior is considered to have an adaptive function within the environment, so the work of the consultant is to identify healthier adaptations to replace dysfunctional adaptations (Brack et al.). The consultant examines both client and consultee challenges on different levels and in different settings. According to Bronfenbrenner (1979), there are four interconnected systems that influence human behavior: the microsystem, mesosystem, exosystem, and macrosystem.

The first system is the microsystem, which can be defined as the pattern of activities, roles, and interpersonal relations experienced by an individual within a

setting (Bronfenbrenner). According to a systems theory framework developed by Davis and Sandoval (1991), consultation at the microsystem level might address a child- or classroom-level intervention that may involve people within the child's life. Because ecological systems theory is compatible with a number of perspectives, this individual level intervention might utilize the concepts of behavioral theory or social learning theory (Davis & Sandoval; Maital, 1996).

Next there is the mesosystem, which is the pattern of interactions and relationships between two or more of the microsystems. Based on the framework developed by Davis and Sandoval, intervention at the mesosystem level might involve the interactions between the consultant and the consultee while focusing on the challenges of the individual client. The consultant works with the consultee to identify personal challenges, such as lack of knowledge, self-confidence, or skill, that inhibit the consultee's ability to work with the challenging client.

The final two systems levels are the exosystem and the macrosystem. The exosystem includes one or more settings that do not involve the client or individual, but events that occur in these settings affect or are affected by the client or the individual (Bronfenbrenner, 1979). An example of an exosystem would be the work place of a young client's parent. At this level, consultation would attempt to identify and intervene in those systems that do not involve the client or consultee but are affecting client or consultee functioning. Finally, the macrosystem is the overall structural patterns of the culture in which the individual participates, such as the economy or the culture of the community. Within mental health consultation, this

might include the cultural stigmatization of mental health, which influences clients as well as consultees. Consultation at the macro system might address the client problem by examining the impact of macrosystems, such as mental health stigmatization, on client functioning or the services provided by the consultee.

Early childhood mental health consultation notably lacks strong ties to a single theoretical orientation (Brennan et al., in press; Hepburn et al., 2007). Despite the paucity of theoretical discussion in the early childhood mental health consultation literature, Brennan et al. have proposed a theory of change, which reflects the ecosystems approach: mental health consultants provide indirect services to early childhood staff through a collaborative relationship. Through this relationship, the teachers experience changes in attitudes, skills, and behaviors that increase their ability to address children's social and emotional needs within the classroom and families' need for support. In turn, children experience fewer externalizing and internalizing behaviors and more prosocial behaviors. The mental health consultant provides the indirect services at the microsystem level through observing children, developing strategies, and meeting with families. But it is through the collaborative relationship between the mental health consultant and the staff, which exists at the mesosystem level, that the early childhood staff develop the skills and behaviors necessary to support positive social and emotional development within the classroom. The mental health consultant may develop additional program level changes at the exosystem and macrosystem level that support the early childhood staff in their ability to support the social and emotional wellness of children. It is through these mental

health consultation supports at the micro-, meso-, macro-, and exosystem levels that enhanced child-level outcomes may result. The mental health consultants may bring their own theoretical orientation, such as behavioral theory, psychodynamic theory, or social learning theory, in order to affect change at each of these levels.

Implications of Theory for Empirical Research

The proposed theory of change for early childhood mental health consultation is unique in that it incorporates models of change across the levels of intervention provided by the consultants. First, it is necessary to understand the consultants' theoretical approach to understanding and addressing child emotional and behavioral challenges at the microsystem level. Behavioral theory, social learning theory, and ecological systems perspective are common approaches in consultation for understanding and addressing social and emotional challenges within the context of the child's most immediate settings, such as the early childhood classroom. Second, the theory of change provides information about how change occurs through interactions between mental health consultants and Head Start staff and families at the mesosystem level. Mental health consultants may apply the principles of social learning theory, psychoanalytic theory, and ecological systems theory to guide their approach to working with the Head Start staff and families on the identified challenge. Finally, organizational theories, such as principal-agent theory, explain how, at the exo- and macro-system levels, the contract or understanding of consultant responsibilities between the mental health consultant and the Head Start program may influence the outcomes of the consultation. Because early childhood is a complex

process in which change may be measured at the child, family, staff, and program levels, it is essential for research to identify the theoretical pathways through which change occurs at each level.

Research in Early Childhood Mental Health Consultation

Early childhood mental health consultation has long been a central component of mental health services within Head Start programs, yet the field is in the early stages of developing an evidence base (Brennan et al., in press). Within the field of children's mental health, evidence based practices refer to a scientific knowledge base about the impact mental health service practices or interventions on the mental health outcomes of children and youth and their families (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). According to Wesley and Buysse (2006), evidence based practices in early childhood settings should be established by pairing research findings with family and professional wisdom and values. An established evidence base will provide consultants and early childhood programs with knowledge about the components of consultation necessary for effective practices, and it will provide consultants with opportunities to evaluate the effectiveness of their services (Berkovitz, 2002). The lag in outcome research establishing the effectiveness of consultation in general, and early childhood mental health consultation specifically, may be due to the challenges inherent in evaluating consultation services.

Challenges

Conducting evaluations of early childhood mental health consultation services is complicated by many of the same factors that create challenges in evaluating

consultation services in schools and other settings. First, there are many definitions and models of consultation services that are implemented by programs, so it is often difficult to compare consultation services across programs or settings or to determine which aspects of the intervention contributed to the outcomes (Brennan et al., in press; Hepburn et al., 2007; Kurpius & Furqua, 1993; Reddy et al., 2000). Mental health consultants may provide services at the child, family, staff, and program levels to varying degrees (Hepburn et al.). At the child and family level, consultants may conduct individual child observations, design and implement strategies for addressing the needs of an individual child, support staff with child behavior and classroom management. With families, MHCs may provide training on children's mental health issues, conduct home visits, advocate for parents, or support parents in their efforts to manage child behaviors. MHCs may also provide consultation services to staff, such as conducting classroom observations, training staff on early childhood mental health topics, and supporting staff working with children with challenging behaviors. When providing program level consultation services, MHCs may promote staff wellness and team building, participate in staff meetings, consult with the director, and advise on program policy. Programs that develop a logic model with a guiding theory of change are best prepared to design and implement an evaluation that captures the specific aspects of consultation that contribute to the measured outcomes (Brennan et al.; Hepburn et al.). Reports of evaluation studies must provide sufficient information about the details of the consultation services to determine the aspects that influenced the outcomes (Brennan et al., in press).

Second, consultation and early childhood mental health consultation services influence a variety of variables and relationships, and it can be difficult to choose which outcomes to measure (Brennan et al., in press; Gallesich, 1985). Even when common outcomes are measured, evaluation studies use a variety of different outcome measures, which makes it difficult to compare results across studies (Brennan et al.). Four levels of outcomes have been suggested as useful for establishing the consultation evidence base in early childhood settings: child level, family level, staff level, and program level (Brennan et al.; Wesley & Buysse, 2006). Developing a theory of change and a logic model will help programs, consultants, stakeholders, and researchers determine the outcomes that should be measured.

Third, early childhood education programs are complicated settings that contain a number of independent variables that may influence the outcomes of early childhood mental health consultation (Berkovitz, 2001; Forman, 1995; Gallesich, 1985). Variables that have been hypothesized to influence consultation outcomes occur at the child and family level, the consultee and classroom level, the program level, and the consultant level. Evaluations may have difficulty accounting for the variables at each of these levels. For example, a study of the effect of mental health consultation on decreasing the expulsion rate of children with challenging behaviors in an early childhood setting was unable to measure the overall quality of childcare environment due to cost constraints (Perry, Dunne, McFadden, & Campbell, 2008). In addition, MHC services are often provided within programs that are receiving additional supportive services that may also be influencing consultation outcomes

(Brennan et al., in press). For example, consultation may be implemented as part of a larger intervention, such as the Incredible Years parent education program (Lehman, Lambarth, Friesen, MacLeod, & White, 2004).

Finally, it is often difficult or unethical to establish randomized control groups within early childhood education settings, particularly settings that serve children at risk for emotional and behavioral challenges (Berkovitz; Osterweil & Plotnik, 1989). This point is illustrated by a recent review of the research on early childhood mental health consultation (Brennan et al., in press), which found only two studies that utilized a randomized control design (Gilliam, 2007; Raver et al., in press). Ethical implementation of control groups requires either that there is no empirical reason to believe that the intervention will be better or worse than the control condition and that there is disagreement within the early childhood community about which intervention is most effective (Fisher et al., 2002). Many programs, particularly those serving low-income, minority children, may feel that the consultation services provided are the best available services, and that it would be unethical to implement a randomized control group (Fisher et al). Without a randomized control group it is difficult to determine if the intervention was responsible for any measured changes in the outcome variables. A brief review of outcome and predictor variables at each of these levels will provide a useful overview of the current state of research in early childhood mental health consultation.

Outcome Variables

Child Outcomes

Because the primary purpose of early childhood programs is supporting the social, emotional, and educational growth of young children, child and family outcomes are common measures of client-centered consultation effectiveness (Berkovitz, 2001; Forman, 1995). Affecting change in young children's behavior during the preschool years is important, because without intervention challenging behaviors have been found to persist and even accelerate over time (Campbell & Ewing, 1990). MHCs providing child-level consultation services may approach their work from a variety of theoretical approaches, including behavioral theory, social learning theory, and ecological systems perspective. Regardless of the theoretical approach, three types of child outcomes are commonly measured in the early childhood mental health consultation literature: internalizing behaviors; externalizing behaviors; and prosocial behaviors.

While the studies reporting child outcomes provide important information about the effect of mental health consultation on children, there are critical weaknesses that are consistent across the studies. There is a reliance on teacher or parent report of child behavior. Of the studies reviewed in a recent synthesis of the current research, only one study measuring child outcomes included the direct observation of child behaviors before and after the intervention (Raver et al., in press). In addition, only two of the studies included a randomized control group (Raver et al., in press; Gilliam, 2007).

Internalizing behaviors. Internalizing behaviors refer to those behaviors that are not overtly displayed, and they reflect the internal states of children (Stacks & Goff, 2006). Children who exhibit challenges with internalizing problem behaviors may experience depressed mood, sadness, social withdrawal, fearfulness, and anxiety (Campbell, 1994, 1995). As many as 37% of Head Start children are estimated to experience internalizing behaviors (Qi & Kaiser, 2003). Reduced internalizing behaviors are important outcomes for mental health consultation in early childhood settings, because internalizing behaviors affect young children's ability to engage and learn in the early childhood setting. When young children experience internalizing behaviors, they are less likely to engage in the classroom environment and to persist with tasks and classroom assignments (Ackerman, Izard, Kobak, Brown, & Smith, 2007). A review of current research on early childhood mental health consultation programs (Perry, Brennan, Bradley, & Allen, 2006) reported that several studies found a significant relationship between consultation services and decreased internalizing behaviors (Bleecker, Sherwood, & Chan-Sew, 2005; Green et al., 2006; Hennigan, Upshur, & Wenz-Gross, 2004; Raver et al., in press). One of the two randomly controlled studies did not find improvements in child internalizing behaviors following consultation (Gilliam, 2007).

Externalizing behaviors. In contrast to internalizing behaviors, externalizing behaviors reflect delinquent and aggressive behaviors (Stacks & Goff, 2006). In young children externalizing behaviors include overactivity, poor impulse control, aggression toward peers, oppositional or defiant behavior, conduct problems, and

tantrums (Campbell, 1995; Keenan et al., 1998). It is important to address externalizing behaviors in young children through early childhood mental health consultation, because studies show that these types of behaviors are somewhat stable over time and are predictive of social and emotional challenges later in life (Campbell, 1994; Campbell & Ewing, 1990; Raver & Knitzer, 2002). Several studies of early childhood mental health consultation (Perry et al., 2006) have reported that consultation services were associated with decreased externalizing behaviors (Bleecker et al., 2005; Gilliam, 2007; Green et al., 2006; Hennigan, et al., 2004; Perry et al., 2008; Raver et al., in press).

Prosocial behaviors. Improving child prosocial behaviors is a common child level outcome in early childhood mental health consultation research. Prosocial behaviors are considered to be voluntary behaviors that are performed with the intent of benefiting another person (Garner, 2006). Increasing children's expression of prosocial behaviors through mental health consultation is valuable, because prosocial behaviors have been found to be indicators of positive interactions with peers and ability to develop friendships (Denham, McKinley, Couchoud, & Holt, 1990). Several evaluations of early childhood mental health consultation interventions (Perry et al., 2006) have found associations between mental health consultation services and increased social skills and social development in young children (Bleecker et al., 2005; Field, Mackrain, & Sawilowsky, 2005; Green et al., 2006; Kupersmidt & Bryant, 2003; Perry et al., 2008; Tyminski, 2001)

Family Outcomes

Early childhood mental health consultation addresses the needs of families with children enrolled in early childhood education programs, such as Head Start. Consultation services often seek to support the families who have children who experience emotional and behavioral challenges at home and in the classroom by providing training and education, home visits, community based referrals, and advocacy (Hepburn et al., 2007). Through these activities, early childhood mental health consultation services seek to affect the following family outcomes: decreased parent stress, improved parenting skills, and parent satisfaction with consultation services. A review of child and family outcomes in early childhood mental health consultation research found mixed results for the impact of consultation on family outcomes (Perry et al., 2006). Three studies found that after working with a MHC parents reported improved parenting skills (Bleecker & Sherwood, 2004; Bleecker et al., 2005; Perry et al.), but one study found no change in parenting skills following consultation (Shelton, Woods, Williford, Dobbins, & Neal, 2002). One study found that parents reported decreased stress following consultation (Lehman et al., 2006). The differential conclusions of these studies points to the complexity of determining the effect of mental health consultation on family outcomes. Clearly additional evaluations of the influence of consultation on family outcomes need to be conducted to obtain more conclusive findings.

Staff Outcomes

Head Start and other early childhood program staff are considered the consultees in some models of early childhood mental health consultation, so they work closely with the consultant and are typically the primary recipient of the services provided by the consultant (Cohen & Kaufmann, 2005; Donahue, Falk, & Provet, 2000). The underlying premise of consultation services is that through the collaborative relationship, the consultant supports the consultee to promote the social and emotional development of children. The consultant may approach work with the staff using psychoanalytic theory, social learning theory, or ecological systems theory. As a result of supporting staff with addressing the social and emotional needs of children, the mental health consultant is able to affect more change than could be obtained by providing services directly to the children (Kurpius & Fuqua, 1993). Therefore, measuring staff outcomes of mental health consultation services should be a central component of consultation evaluations (Berkovitz, 2001; Wesley & Buysse, 2006). Common staff level outcome variables include: developing new skills (e.g., increased use of methods to address challenging behaviors); increased knowledge (e.g., better understanding of child's behavior); and changes in attitude (e.g., less harsh; Brennan et al., in press; Reddy et al., 2000). A significant weakness of evaluations reporting on the effect of ECMHC on staff level outcomes is the reliance on self-report data; only one study used observational data to determine the association between consultation and staff level outcomes (Brennan et al.; Raver et al., in press).

A recent review of the research base on early childhood mental health consultation revealed that consultation has been shown to affect staff outcomes (Brennan et al, in press). A randomized control trial of a manualized consultation program found increased classroom management skills among teachers in the intervention classrooms, which received eight weeks of consultation services for 4-6 hours per week (Raver et al., in press), but three other studies did not find support for improved teacher competence (Gilliam, 2007; Bleecker & Sherwood, 2003; Lehman et al., 2004). In contrast, ECMHC was associated with changes in staff attitudes, including improved staff self-efficacy, increased staff confidence in working with children (Brennan, Bradley, Ama, & Cawood, 2003; Hennigan et al, 2004; Shelton et al., 2002), improved sensitivity (Bleecker & Sherwood, 2004; Alkon, Ramler, & MacLennan, 2003), and reductions in job-related stress (Langkamp, 2003; Olmos & Grimmer, 2004).

Program Outcomes

Often early childhood programs benefit from the services of the mental health consultation. Program level consultation services may promote staff wellness, support team building, encourage communication, or advise on program policy (Hepburn et al, 2007). MHCs may use the concepts of organizational theories, such as principal-agent theory, to guide and focus their consultation services for addressing program level outcomes. Program level effectiveness is often difficult to measure and is sometimes overlooked in consultation evaluation (Forman, 1995). However, a review of the current research on staff and program outcomes in early childhood mental health

consultation research found that evaluations of center quality and staff turnover were common measures of program level outcomes (Brennan et al., in press). Early childhood center quality refers to safe and effective physical and social environments and positive classroom activities (Brennan et al.). Studies report mixed results regarding the impact of consultation on improved center quality. Although some studies have found a relationship between consultation services and improved center quality (Alkon et al., 2003; Bleecker & Sherwood, 2003; Langkamp, 2003; Raver et al., in press), other studies did not find significant effects of consultation on improved center quality (Gilliam, 2007; Tyminski, 2001). The research review also revealed support for an association between reduced staff turnover and consultation services (Alkon et al., 2005; Bleecker et al., 2005; Hennigan et al, 2004; Olmos & Grimmer, 2004). A significant challenge in measuring program level outcomes is the lack of valid and reliable tools for detecting the influence of consultation (Brennan et al., in press). It is possible that the current measures of center quality may not be sensitive to the changes in environment introduced by early childhood mental health consultation (Brennan et al, in press).

Predictor Variables

Because early childhood mental health consultation is a dynamic process that is implemented within a complex environment, researchers have met challenges in choosing the variables and relationships that are most important to evaluate (Gallesich, 1985; Wesley & Buysse, 2006). Mental health consultation outcomes in Head Start and other early childhood programs may be influenced by variables at the child,

family, consultee (staff), program, and consultant level (Berkovitz, 2001). Accounting for the influence of these variables is critical for establishing significant and meaningful measurement of early childhood mental health consultation effectiveness.

Child and Family Characteristics

Head Start programs are legislated to serve low-income children and families, as well as children experiencing disabilities. Young children living in poverty, particularly young low-income children of color, experience disparities in assessment, treatment, and access to mental health services (Yoshikawa & Knitzer, 1997).

Therefore, it is essential that the mental health consultation services provided by Head Start programs are effective for low-income children of color. The number of children in the Head Start program with disabilities, which includes those children who qualify for special education services under IDEA, and the severity of those disabilities may also be factors that influence the outcome of consultation services. Mental health consultants have described feeling less confident in providing services to young children with severe or multiple disabilities and their families (Wesley & Buysse, 2004).

Family characteristics may also influence the outcomes of mental health consultation. A review of the research on child behavior problems in preschool children found that parents of children with challenging behaviors are likely to exhibit inconsistent, negative, or uninvolved parenting behaviors (Campbell, 1995). In addition, mental health challenges in children are also associated with experiencing parental loss, such as death, divorce, or separation from parents, or being affected by

parent health, mental health, or substance abuse problems (Luster & McAdoo, 1994; McKay et al., 2005; Tolan, Gorman-Smith, Huesmann, & Zelli, 1997). Children are more likely to experience mental health concerns when their families experience high levels of challenges, yet research shows that the more challenges families experience, the less likely they are to engage in mental health services (Campbell, 1995; Gonzalez, 2005; McKay et al., 2005).

Consultee (Early Childhood Program Staff) Characteristics

Head Start program staff, who are considered the primary consultees in early childhood mental health consultation services within Head Start, bring a range of knowledge and experience to their work with the mental health consultant. Because early childhood mental health consultation is a dynamic process that requires collaboration between the early childhood staff (consultee) and the mental health consultant, characteristics of the staff may influence consultation outcomes (Weissenburger, Fine, & Poggio, 1982). Years of experience in early childhood education and level of education may influence Head Start staff's knowledge of early childhood education, understanding of children's mental health, and interactions with the mental health consultant. A study of the effect of teacher variables on teacher attitudes toward school-based consultation services found that the greater the number of years teachers taught, the less they preferred consultation, and that the greater number of years that they taught in a single school, the more they preferred consultation (Gutkin & Bossard, 1984). Position within the Head Start program (teacher, assistant teacher, family advocate, or administrator) may influence the staff

members' understanding of the consultant role and the amount of interaction with the consultant, which may in turn affect their perceptions of the consultant. Gender and ethnicity of Head Start staff may also affect perceptions of the consultation relationship (Green et al., 2006). Despite the potential importance of these variables in mediating consultation outcomes, relatively few studies of early childhood mental health consultation effectiveness report this type of information (Reddy et al., 2000).

Program Characteristics

Organizational structure is often ignored as a characteristic that influences consultation outcomes (Forman, 1995). However, program characteristics, such as program size and program location may have significant effects on the provision of mental health consultation services. Head Start program size, and more specifically individual classroom size, may have an impact on the need for mental health consultation services. Classrooms with a larger child enrollment may place more demands on teachers, which creates increased teacher stress and may lead teachers to expel children with challenging behaviors (Gilliam & Shahar, 2006). In fact, large classroom enrollments have been associated with higher expulsion rates (Gilliam & Shahar). Related to classroom and program size is child-teacher ratio, which refers to the number of classroom teachers or adults per child in the classroom. Smaller child-teacher ratios are associated with more positive caregiving, which leads to positive child outcomes (NICHD Early Childcare Research Network, 2006). It is possible that small and large Head Start programs have very different (or similar) mental health consultation needs.

Location of program in either rural or urban areas may also affect the outcome of mental health consultation services. Rural and urban communities and Head Start programs differ according to population characteristics, economic conditions, determinants of poverty, and access to and availability of services, all of which may influence the type, quality, and quantity of mental health consultation services provided (Puma et al., 2001). Additional program level characteristics that may differ between rural and urban programs and mediate consultation outcomes include: the norms, policies, and values of the program; the financial resources of the program dedicated to mental health services; and the openness of the program to infusing services with a mental health approach (Brack & Brack, 1996). Because process and outcome evaluation research on early childhood mental health consultation research has not examined rural and urban program differences, the influence of this variable is currently unknown.

Consultant Characteristics

Mental health professionals who work with Head Start or early childhood programs bring a range of education, knowledge, and experience into their work with programs. In addition, there is a wide variation in the amount, frequency, and types of consultant activities they provide (Green, Everhart, et al., 2004). Consultants also vary according to how they are employed; some Head Start programs employ a mental health consultant, while others contract for services (Green, Everhart, et al.). Therefore, these may be important variables to examine when determining the effectiveness of early childhood mental health consultation on child, family, staff, or

program outcomes. Including MHC characteristics in evaluations of consultation effectiveness provides the detail necessary for determining the consultation services that are necessary for achieving positive consultation outcomes (Brennan et al., in press).

Characteristics of early childhood mental health consultants may vary according to their location in rural and urban communities. In rural areas, mental health professionals are less likely to have specializations in areas such as children's mental health and specialized training is often unavailable or inaccessible (Boydell et al., 2006; Fahey et al., 2003). Because of the challenges of geographic distances and transportation, mental health consultants in rural areas may provide fewer hours of consultation services to Head Start programs. Because consultation process and outcome research has not examined rural and urban differences among early childhood mental health consultants, the influence of this variable on the attributes and the effectiveness of consultants is unknown.

The collaborative relationship between the mental health consultant and the Head Start or early childhood staff is a hallmark characteristic of early childhood mental health consultation services (Cohen & Kaufmann, 2005; Donahue et al., 2000; Johnston & Brinamen, 2006; Wesley & Buysse, 2007). Therefore, understanding the skills and attributes that a mental health consultant brings to this relationship may be central to understanding the nature of effective early childhood mental health consultation services. In fact, Green and her colleagues (2006) found that when mental health consultants interacted more frequently with Head Start staff, the staff

reported a more positive relationship with the MHC. These staff-reported positive relationships between the mental health consultant and the Head Start staff were the most significant predictor of staff reports that consultation services improved child outcomes, including reducing internalizing and externalizing behaviors and increasing prosocial behaviors. Because this study relied on self-report survey information and the results are cross-sectional, additional studies are needed to replicate this finding (Green et al., 2006). Experts in the field of consultation in early childhood settings have identified the need for a better understanding of the attributes of mental health consultants that contribute to positive relationships with Head Start and early childhood staff and ultimately to child, family, staff, and program outcomes (Brennan et al., in press; Green et al.; Hepburn et al., 2007; Wesley & Buysse, 2006).

Understanding the attributes of MHCs that contribute to positive child, family, staff, and program outcomes is essential for developing effective ECMHC services. In a national study of MHCs and Head Start programs, Green et al. (2006) found that several characteristics of MHCs, including MHC level of education, organizational affiliation, gender, and race/ethnicity, were not significantly related to the Head Start staff reports of the effectiveness of mental health consultation. However, various personal and professional attributes of MHCs have been proposed as contributors to positive ECMHC outcomes (Johnston & Brinamen, 2006). These attributes include knowledge of and experience with Head Start and early childhood education; relationships with parents; cultural competence; relationships with staff; knowledge of early childhood mental health best practices; and adequate training, supervision, and

support (Cohen & Kaufmann, 2000; Donahue et al., 2000; Johnston & Brinamen, 2006). Knowledge of how these attributes contribute to ECMHC outcomes will provide important information to Head Start programs on how to best integrate and support MHCs within Head Start programs.

Knowledge of and experience with Head Start and early childhood education.

It is essential for MHCs to understand the challenges and constraints of early childhood group care and education (Johnston & Brinamen, 2006). Although MHCs are trained mental health providers, it is important that they also have knowledge of early childhood education and early intervention systems (Cohen & Kaufmann, 2000; Piotrkowski et al., 1994). Understanding the skills and knowledge base of early childhood educators may help MHCs to recognize the strengths that early childhood staff bring to the table, thereby avoiding an “expert stance” (Johnston & Brinamen, 2005). Doing so allows the mental health consultant to support early childhood staff with recognizing their individual contribution to addressing the identified challenge (Johnston & Brinamen). MHCs improve the collaborative relationship with early childhood staff when they recognize and acknowledge the important roles that these individuals play in the lives of young children, as well as the knowledge and expertise required in those roles (Johnston & Brinamen). Although knowledge and experience of Head Start and early childhood education has been identified as an important attribute of mental health consultants, current research has not examined whether it contributes to ECMHC outcomes.

Relationship with parents. MHCs should have knowledge of family systems and feel comfortable working with parents of children enrolled in early childhood settings (Cohen & Kaufmann, 2000; Collins et al., 2003). Consultants should have had prior experience interacting with parents, so that they feel confident in identifying and addressing the physical, emotional, and mental challenges of parenting (Johnston & Brinamen, 2005, 2006). According to Collins et al., family involvement is an essential component for positive outcomes in ECMHC. For MHCs working with Head Start programs, parent involvement is central to the provision of mental health services within the program (Administration on Children, Youth, and Families, 1998; Yoshikawa & Zigler, 2000). Positive relationships between the MHC and the parent are particularly important for young children, because they are dependant on their parents for accessing mental health services. While it is clear that mental health consultants do involve families in a variety of ways, such as conducting parent training (Sanford & Illback, 2004) and meeting with individual families (Alkon et al., 2003; Green, Everhart, et al., 2004), it is not clear how confident MHCs are about providing these services to parents and what effect the level of confidence has on child outcomes.

Cultural sensitivity. A strong case has been made for the importance of MHCs having a deep understanding of how the cultural histories of early childhood staff and parents contribute to communication styles, parenting practices, and perspectives on child development and child mental health (Johnston & Brinamen, 2005, 2006; Yoshikawa & Zigler, 2000). Cultural competency is particularly important when

providing ECMHC services in Head Start programs, which employ diverse staff and serve children and families with different cultural backgrounds (Yoshikawa & Zigler). When MHCs are culturally competent, they have the skills to distinguish between early childhood staffs' and parents' unwillingness to change and a desire to continue practicing culturally appropriate activities (Cohen & Kaufmann, 2000). An important component of cultural competency is that MHCs must understand and acknowledge how their own culture influences and colors their world view (Donahue et al., 2000). Although little research has examined the role of cultural competence in the provision of ECMHC services, Green, Everhart, et al. (2004) reported that the majority of parents who responded to a national survey of Head Start programs felt that the MHC respected their culture. Further research is needed to uncover the degree to which MHC cultural competency affects the relationship between the MHC and Head Start staff and whether it affects ECMHC outcomes (Yoshikawa & Zigler).

Relationships with staff. An ability to develop positive working relationships with staff is considered an important attribute of mental health consultants (Donahue et al., 2000; Johnston & Brinamen, 2005, 2006). The MHC must be able to work effectively with early childhood staff that have varying levels of education, experience, and cultural histories (Johnston & Brinamen, 2005, 2006). Through these staff relationships, the MHC provides training to staff, consultation to individual teachers or groups of staff, and support for staff wellness (Alkon et al., 2003; Green, Everhart, et al., 2004; Yoshikawa & Zigler, 2000). Developing a better understanding of MHC and staff relationships is crucial, because the degree to which MHCs and

early childhood staff develop positive relationships does appear to be related to ECMHC outcomes (Green et al., 2006; Green, Simpson, Everhart, Vale, & Gettman, 2004). Positive relationships between MHCs and staff are associated with staff perceptions that mental health services are effective (Green et al., 2006).

Early childhood mental health consultants' relationships with early childhood staff can be understood by examining the relationship from three separate but related lenses. First, the literature base on the therapeutic alliance between counselors and clients provides valuable information about how MHCs may use their clinical training to establish relationships with early childhood staff. Second, early childhood mental health consultant expert practitioners have described the consultative stance as the interpersonal approach that MHCs take when working with and developing relationships with early childhood staff (Johnston & Brinamen, 2006). Finally, the definition of early childhood consultation places collaboration between the MHC and the early childhood staff as a key component of MHC services, so it is necessary to understand the nature of collaboration between MHCs and early childhood staff. Examining the differential influence of each of these concepts for explaining the relationship between the MHC and early childhood staff will provide a starting point for understanding the nature of their relationship.

The therapeutic alliance is a concept that describes the relationship between a therapist, in this case the mental health consultant, and a client, in this case an early childhood caregiver. Therapeutic alliance refers to the interactive, collaborative aspects of the relationship between the therapist and the client that occurs within a

positive bond (Castonguay, Constantino, & Holtforth, 2006). Bordin (1979) conceptualized the therapeutic alliance as applicable not only across different types of relationships, such as between consultant and teacher, but also across counseling approaches, such as behavior therapy or psychoanalytic therapy. Regardless of type of relationship or therapeutic approach, Bordin considered the working alliance to be the central component of the change process.

The working alliance is conceptualized as an integrated relationship that consists of three components: tasks, bonds, and goals (Bordin, 1979; Horvath & Greenberg, 1989). Tasks are the behaviors and exchanges within the relationship that are assigned to both the counselor and the client (Bordin; Horvath & Greenberg). When the counselor and client have a strong working alliance, they accept mutual responsibility for performing the tasks of the relationship. Bonds refer to the nature of the relationship between the counselor and the client; they are the degree to which the relationship is based on trust, acceptance, and confidence (Bordin; Horvath & Greenberg). Finally, in a strong working alliance, both the counselor and the client work toward mutually agreed upon goals, which are the outcomes that are addressed through the intervention (Horvath & Greenberg).

The therapeutic alliance is considered a central component of positive client change (Horvath, 2006; Horvath & Green, 1989; Werner-Wilson, Michaels, Thomas, & Thiesen, 2003). Strong working alliances have been found to be positively correlated with improved treatment outcomes, especially when working alliance is measured early in the relationship (Castonguay et al., 2006). These findings suggest

that counselors should begin developing the alliance from the very beginning of the relationship (Castonguay et al.). In a summary of research on therapeutic alliance, Castonguay et al. (2006) reported that characteristics of both counselors and clients may influence the quality of the therapeutic alliance. Counselor characteristics, such as warmth and flexibility, are positively associated with healthy alliances, and other characteristics, such as rigidity and being critical, are negatively associated with healthy alliances. Clients who are characterized by an expectation for change are positively associated with strong alliances, while clients who are avoidant or have interpersonal challenges are negatively associated with strong alliances. Therefore, it is important to understand the qualities that both the mental health consultant and the early childhood staff bring to the relationship, and the degree to which they develop mutually acceptable tasks, bonds, and goals.

Johnston and Brinamen (2006) refer to the early childhood mental health consultants' contribution to the consultation relationship with early childhood staff as the "consultative stance." MHCs who use a consultative stance approach interactions with early childhood staff using ten concepts common to the consultative stance (Johnston & Brinamen, p. 14 - 20):

1. The MHC approaches consultation as a mutual endeavor in which the early childhood staff contributes to the formulation of the problem and the response to the problem. Early childhood staff are more likely to participate in consultation when the consultant encourages the staff to provide their perspective and viewpoint.

2. The MHC avoids approaching the consultation relationship as the expert. Instead, the MHC gathers the perspectives of all participants in the consultation process and conveys the importance of each participants' voice. As a result, the early childhood staff gain confidence in their own expertise and become active participants in determining solutions.
3. MHCs recognize consultation as a process and enter with the attitude of "wondering, not knowing." By wondering and not knowing, the MHC allows the early childhood staff to find their voice as the expert and to feel competent to affect change. Wondering and not knowing models for the early childhood staff an attitude that not knowing is not a fault, but rather a step in finding a solution.
4. The MHC recognizes and understands the early childhood staff's subjective experience as an early childhood caregiver. By understanding the attitudes, beliefs, and practices of early childhood educators, MHCs are better able to address the challenges that staff members experience.
5. The MHC recognizes the various influences that affect early childhood staff members' understanding of child behavior and interactions with children, which may include program philosophies, interpersonal relationships among early childhood staff and program administrators, and relationships with parents.

6. The consultant seeks to hear and incorporate the ideas, voices, and perspectives of all involved in the consultation process, particularly the children's voices. MHCs ensure that the children's perspective are heard and considered.
7. The MHC recognizes the importance of relationships within a child's development. The consultant not only works to strengthen the relationship between the children and the early childcare staff, but also between parents, among parents and child care staff, and between the providers within the early childhood setting.
8. The MHC incorporates the concept of parallel process by modeling respectful, empathic interactions with early childhood staff, so that the early childhood staff will in turn exhibit more respectful and empathic interactions with children.
9. MHCs understand that changes in the behavior of early childhood staff, parents, and centers may take time, so they approach change in the system with patience and understanding.
10. Finally, the consultant maintains hope for the early childhood care providers and family members. The MHC recognizes that early childhood staff face demoralizing challenges, such as demanding children, low pay, and long hours. As an outsider, the MHC is able to hold hope for the staff and to provide an outsider's perspective of the potential for positive changes within the system.

The consultative stance includes the attitudes and qualities of MHCs that support positive relationships with early childhood caregivers. Approaching their work with

early childhood staff using a consultative stance allows the MHC to transform the relationship into a positive collaboration (Johnston & Brinamen, 2006).

Collaboration is a central tenet in the definition of early childhood mental health consultation: “Mental health consultation in early childhood settings is a problem-solving and capacity-building intervention implemented within a collaborative relationship...” (Cohen & Kaufmann, 2005, p. 4). Within this collaborative relationship, the consultant does not have supervisory authority over the early childhood staff, so the staff may accept or reject the suggestions posed by the MHC (Cohen & Kaufmann; Kurpius, 1978). The MHC and the early childhood staff work together, but the early childhood staff are ultimately responsible for implementing change (Kurpius; Schulte & Osborne, 2003). In a truly collaborative relationship, the MHC recognizes and encourages the expertise of the early childhood staff (Cohen & Kaufmann; Schute & Osborne). Collaboration is considered essential for developing the relationship between the MHC and the early childhood staff, because it requires the MHC to communicate with the early childhood staff about roles and shared goals (Cohen & Kaufmann).

Knowledge of early childhood mental health best practices. Cohen and Kaufmann (2000) suggest that MHCs should have the knowledge and skills necessary to integrate early childhood mental health best practices across Head Start program components, to provide training and support to parents and staff on early childhood mental health best practices, and to access community based mental health services for children and families that incorporate best practices. Early childhood mental health

best practices refers to mental health services that reflect the following characteristics

(Simpson, Jivanjee, Koroloff, Doerfler, & Garcia, 2001, p. 95 - 98):

1. Services are family centered. Families participate in identifying their strengths and needs and in developing the supports and services to address those needs. The concept of “family” is defined by program participants and reflects diverse family patterns.
2. Services are individualized to address children and families’ unique needs and strengths. Individualized services include screening, assessment, and evaluation tools that are culturally and developmentally appropriate.
3. Services are comprehensive, so that they incorporate prevention and intervention services that address the developmental, health, and mental health needs of children and their families.
4. Services are community-based. They build upon existing services provided to young children and their families, and they are located within children’s and families’ natural environments.
5. Services are coordinated across disciplines and providers serving young children and their families.
6. Services encourage family participation in all levels of service delivery, including designing, implementing, and evaluating programs.
7. Services are developmentally appropriate and focus on the developmental needs of children across developmental domains.

8. Services are strengths-based and focus on the resilience of children and families by focusing on child and family strengths.

MHCs with a strong foundation in early childhood mental health best practices can effectively work with Head Start program staff to jointly develop a shared vision of mental health services within the program and to provide effective services for children (Johnston & Brinamen, 2006). Green, Everhart, et al. (2004) found that MHCs had a significant influence on the degree to which Head Start staff reported a clear mental health program philosophy, and established that having a shared vision of mental health services is crucial to effective mental health services (Green, Simpson, et al., 2004).

Adequate training, supervision, and support. Mental health consultants often enter the field of ECMHC with a strong foundation in mental health and represent a variety of professional affiliations, including social work, psychology, marriage and family therapy, psychiatry, and counseling (Brennan et al., 2003; Cohen & Kaufmann, 2000; Green, Everhart, et al., 2004). Although the consultant may have the requisite knowledge and skills, all MHCs should receive regular, ongoing support and supervision (Donahue et al., 2000). Supervision should address not only clinical skills in working with children and families, but it should also support the relationships between the MHC, the early childhood staff, and the program directors (Donahue et al.; Johnston & Brinamen, 2005). In addition, the MHC should have opportunities to engage in regular professional development trainings on topics such as assessment, cultural competency, or early childhood mental health best practices (Donahue et al.).

Training and support for MHCs working in rural areas may be particularly important, because they are often geographically isolated from colleagues and supervisors (U.S. Department of Health and Human Services, 2004). Although it is clear that supervision and training are essential for maintaining and supporting the work of MHCs in early childhood settings, research has not examined the degree to which MHCs receive supervision or training or the degree to which MHC supervision and training influences ECMHC outcomes.

The Current Study

Early childhood mental health consultation is a problem-solving and capacity-building intervention in which a mental health professional collaborates with early childhood staff to build the capacity of the staff, families, and programs to effectively identify and address the social and emotional needs of young children (Cohen & Kaufmann, 2005). Based on practice knowledge and previous research, the collaborative relationship between the mental health consultant and the early childhood staff (the consultees) is of primary importance in producing positive child, family, staff, and program outcomes (Green et al., 2006; Wesley & Buysse, 2006). Because the collaborative relationship between the mental health consultant and the Head Start staff has been identified as contributing to staff reports of positive child and staff outcomes (Green et al., 2006), the present mixed methods study seeks to determine the attributes of mental health consultants that are associated with positive relationships with Head Start staff and with staff reports of positive consultation outcomes. The study will combine a quantitative secondary analysis of a national

survey of Head Start staff and mental health consultants (Green et al., 2006) with the practice and professional wisdom of Head Start early childhood mental health consultants gained through a qualitative study of rural and urban consultants conducted using telephone focus groups. The findings of the secondary analysis will inform the development of the focus group study, and together the findings of both phases will provide a more complete understanding of the attributes of effective Head Start mental health consultants. The study will identify not only the attributes of effective consultants that are associated with staff reports of improved child outcomes, but it will also describe staff perceptions of the skills and characteristics that consultants need to develop positive relationships with Head Start staff in rural and urban settings.

CHAPTER 3: RESEARCH QUESTIONS

The aim of the present study was to identify and explore the attributes of effective early childhood mental health consultants who work with rural and urban Head Start programs. Using a mixed methods design, the study examined two interrelated aspects of mental health consultant (MHC) attributes: the relationship between MHC attributes and consultation outcomes in rural and urban programs, and rural and urban consultants' beliefs about the attributes of effective MHCs. Phase I of the study utilized a quantitative, secondary analysis of a national survey of mental health consultants, and Phase II implemented a qualitative focus group study.

The purpose of Phase I was to identify the attributes of effective mental health consultants that are associated with positive child and staff outcomes in early childhood mental health consultation with rural and urban Head Start programs. The first research question for Phase I examined the association between attributes of MHCs and teacher reported changes in child internalizing, externalizing, and prosocial behaviors. This research question stated: *What attributes of MHCs are most strongly associated with teacher reported effectiveness of mental health consultation improving child outcomes for rural and urban Head Start programs?* The purpose of the second research question was to examine the association between attributes of mental health consultants and Head Start teacher reports of positive relationships with the mental health consultant. The second research question for Phase I was: *What attributes of mental health consultants are most strongly associated with the quality of mental health consultant and staff relationships for rural and urban Head Start programs?*

Phase II was a telephone focus group study of rural and urban Head Start mental health consultants. The aim of Phase II of the mixed methods study was to gain a more complete and in-depth understanding of the attributes of MHCs that were examined in Phase I by asking rural and urban MHCs about their beliefs about the attributes of effective MHCs. The first research question for Phase II explored rural and urban MHCs ideas about how MHCs develop relationships with Head Start staff. This question stated: *What are early childhood mental health consultants' perceptions of how to best develop relationships with Head Start staff in programs?* The second research question examined rural and urban MHCs beliefs about the professional skills, attributes, and supports of MHCs, and this question was: *What professional skills, attributes, and supports do early childhood mental health consultants need to build positive relationships with Head Start staff and to produce positive consultation outcomes?* The final research question for Phase II explored rural MHCs beliefs about and experiences with providing consultation services in rural areas. The third and final research question was: *What are the challenges and barriers to providing mental health consultation in rural areas?*

CHAPTER 4: METHODS

Overall Design

This study investigated the attributes of Head Start mental health consultants (MHCs) that contributed to staff reports of improved child and staff outcomes. This investigation utilized a mixed methods research design and was conducted in two phases. Phase I of the project consisted of a secondary data analysis of a national survey of Head Start MHCs and staff, which included both urban and rural programs (Green et al., 2006). Phase II of the project was a qualitative, focus group study with MHCs who work with urban or with rural Head Start programs.

Mixed method research design refers to the combination of quantitative and qualitative methods within a single study for the purpose of gaining a better understanding of the research question (Creswell, 2003; Ivankova, Creswell, & Stick, 2006; Sale & Brazil, 2004; Tashakkori & Teddlie, 2003). Quantitative and qualitative research methods were combined in this study to address both the scope and the depth of the proposed research questions. For this study, mixed methods was a sensible research strategy, because analysis of a large, national sample of urban and rural Head Start MHCs and staff yielded generalizable information regarding the MHC attributes that influence child and staff outcomes, while data from qualitative methods provided a deeper understanding of urban and rural MHCs' attributes, activities, attitudes, and perceptions (Hanson, Creswell, Clark, Petska, & Creswell, 2005).

There were two primary purposes for utilizing a mixed methods design for this research study, which were development and complementarity. The developmental

purpose for utilizing mixed methods for this project was to use the results of the quantitative analysis of the national survey of Head Start MHCs and staff to inform the development of the focus group questions (Greene, Caracelli, & Graham, 1989). Phase I of the project consisted of a secondary data analysis of a national survey of Head Start MHCs and staff (Green et al., 2006) to uncover the attributes of mental health consultants that are most strongly associated with teacher-reported effectiveness of ECMHC and teacher-reported positive relationships with the MHC. Based on the findings of those consultant attributes that were associated with consultation outcomes in Phase I, focus groups were conducted in Phase II to make meaning of the quantitative data by asking rural and urban consultants their beliefs about the attributes of effective MHCs. Consequently, using mixed methods to develop the focus group questions increased the meaningfulness and usefulness of those questions for the study (Greene et al.).

Complementarity was the second reason for utilizing a mixed methods design for this study. Complementarity refers to using quantitative and qualitative methods to study an overlapping aspect of an issue to develop a rich, complex understanding of that issue (Erzberger & Kelle, 2003; Greene et al., 1989; Morgan, 1998). In this dissertation project, the focus groups of rural and urban MHCs were designed to clarify and expand upon the knowledge gained through the secondary quantitative analysis of the national survey of MHCs and staff. The focus groups served as a means of increasing the validity and interpretability of the mental health consultant attributes that were examined in Phase I of the study (Greene et al.).

The present mixed methods study utilized a sequential explanatory mixed method design. As a sequential explanatory design, the quantitative data were collected and analyzed before the qualitative data (Hanson et al., 2005; Morgan, 1998). Data collection was conducted in two separate phases: Phase I was an analysis of a national survey of mental health consultants; and Phase II was content analysis of the focus group data. Quantitative and qualitative data analysis occurred independently, although the quantitative results informed the qualitative analyses, and the information provided by the two methodologies has been integrated in the discussion section of the final dissertation report (Hanson et al.).

Research Questions

The quantitative data, which were based on a national survey of mental health consultants working with Head Start programs (Green et al., 2006), were analyzed in Phase I of the project using hierarchical linear modeling. Hierarchical linear modeling is a statistical analysis technique that allows estimates of clustered or nested data, as in this case teachers within Head Start programs. Secondary data analysis of this national survey using hierarchical linear modeling sought to answer two important research questions: (a) What attributes of MHCs are most strongly associated with teacher reported effectiveness of mental health consultation improving child outcomes for rural and urban Head Start programs? and (b) what attributes of mental health consultants are most strongly associated with the quality of mental health consultant and staff relationships for rural and urban Head Start programs?

The results of the secondary data analysis were used to inform the questions asked in Phase II, the qualitative phase of the study. Focus groups were implemented in this phase. Focus groups are a “research technique that collects data through group interaction on a topic determined by the researcher” (Morgan, 1996, p. 130). In Phase II, focus groups were conducted to answer the following research questions: (a) What are early childhood mental health consultants’ perceptions of how to best develop relationships with Head Start staff in programs? (b) what professional skills, attributes, and supports do early childhood mental health consultants need to build positive relationships with Head Start staff and to produce positive consultation outcomes? and (c) what are the challenges and barriers to providing mental health consultation in rural areas?

Phase I: Secondary Analysis

Population and Data Collection

The national survey of Head Start mental health consultants was developed with a stratified random sampling technique, which was based on the procedures utilized by the national Head Start Outcome Study (Puma et al., 2001). The Head Start Outcome Study sampling plan first clustered programs by geographic proximity, then grouped the clusters into strata based on state childcare policy, race/ethnicity of enrolled children, urban / rural location, and region. From these strata, eligible programs were selected for inclusion (Puma et al.). The goal of the stratified random sample was to select core Head Start programs from across the 50 states that were representative across race/ethnicity, geographic location, and program size (Green et

al., 2006; Puma et al.). Because specialty Head Start programs, including Early Head Start, migrant Head Start grantees, and Tribal Head Start grantees, have specific enrollment criteria and serve specialized groups of children and families, they were excluded from the sampling frame.

Of the 131 Head Start programs that were contacted by telephone and letter, 79 (60.3%) agreed to participate in the study. The originally selected programs that did not participate were not statistically different on any stratification variables (race/ethnicity, geographic location, and program size) from those programs that chose to participate in the study (Green et al., 2006). The most frequent reasons for declining to participate were that programs were currently involved in a different research project or that they were undergoing the Head Start Federal Review process (Green et al., 2006).

According to Green et al. (2006), a total of 1,273 Head Start Mental Health Services Surveys were mailed to Head Start staff members. Staff members within each program who received surveys included a random sample (based on program size) of potential participants including 12-18 teachers, assistant teachers, and family advocates; the program director; the mental health services coordinator; and the individual providing the most mental health consultation. This sample size was selected to ensure a representative sample of Head Start staff (Green et al.). A total of 802 surveys were returned for an overall response rate of 63%. Of the 802 participants returning completed surveys, respondents included 140 administrators (17.5%), 69 mental health consultants (8.6%), and 593 direct service staff (73.8%).

The programs ranged in size from 60 children served to more than 3,600 (Green et al.). For the purposes of the present study, a subsample of mental health consultant and direct service staff surveys was developed.

Sample

To be included in the present study, participant surveys had to meet several requirements. First, surveys were excluded if their associated program did not submit a minimum of four staff responses, a director survey, and a MHC survey ($n = 116$). This exclusion criterion was necessary to meet the demands of hierarchical linear models. Second, the analyses for this study utilized only Head Start direct service staff (teacher, assistant teacher, and family advocates) and mental health consultant surveys, so manager and director surveys were excluded ($n = 140$). Only direct service staff were included, because they are the Head Start staff members who work directly with children and who are typically considered the “consultee.” Because the purpose of this study was to examine relationships between mental health consultants and direct service staff, and because managers and directors were likely to have a different view of the relationship with the MHC, they were not included in the analyses. Often managers and directors perform their work duties at a location that is separate from the Head Start centers where mental health consultation takes place, so they may have little to no contact with mental health consultants. Third, only one mental health consultant per program was included, because HLM analyses requires that each level-2 group includes only one unit. When a program had more than one mental health consultant survey, the surveys of MHCs providing the least number of

consultation hours were excluded ($n = 3$). Because several of the MHC variables were ordinal level variables, it was not useful to average all consultant responses to achieve one consultant response per program. Finally, cases with missing data for the variables included in the HLM analysis were excluded from the analyses, because missing cases must be excluded in order to run HLM analyses ($n = 79$). Of the 338 respondents excluded from the present analyses, 140 were administrators (41%), 12 were mental health consultants (4%), and 185 were direct service staff (55%).

Exclusion analysis. A total of 464 respondent surveys were included in the present analyses. The subsample for this study included 57 mental health consultants and 407 Head Start direct service staff (teachers, assistant teachers, and family advocates). T-test and chi-square analyses were conducted to determine if the subsample was representative of the larger sample.

Comparison of those mental health consultants included in the HLM analyses with those who were excluded revealed no statistically significant differences between the gender, ethnicity, education level (analyzed as dichotomous variable with categories 'PhD' and 'no PhD'), position description (analyzed as dichotomous variable 'employed by Head Start' and 'contract with Head Start'), time in current position, or time with the organization (see Table 1). For the direct service staff, there were no statistically significant differences between the gender, education level (analyzed as dichotomous variable with categories 'some college' and 'no college'), position description (analyzed as dichotomous variable with categories 'teacher/assistant teacher' and 'family advocate'), time in current position, or time

Table 1
 Characteristics of Mental Health Consultant Subset

MHC Characteristics	Total (<i>n</i> = 69)		Excluded (<i>n</i> = 12)		Included (<i>n</i> = 57)		<i>t</i> test/ χ^2 *	<i>p</i>
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%		
Gender							.00	.96
Female	49	72.1	8	72.7	41	71.9		
Male	19	27.9	3	27.3	16	28.1		
Race/ethnicity							2.00	.16
White	49	72.1	6	54.5	43	75.4		
Person of Color	19	27.9	5	45.5	14	24.6		
Education							0.00 ^a	.98
4 year college degree	4	5.9	2	18.2	2	3.5		
Master's degree	39	57.4	5	45.5	34	59.6		
Doctoral degree	25	36.8	4	36.4	21	36.8		
Position description							5.16 ^a	.08
Therapist employed by Head Start	14	20.3	3	25.0	11	19.3		
Therapist employed by non-profit	16	23.2	2	16.7	14	24.6		
Therapist employed by government agency	5	7.2	1	8.3	4	7.0		
Therapist in private practice	17	24.6	2	16.7	15	26.3		
School-based therapist/counselor	4	5.8	1	8.3	3	5.3		
Other	12	17.4	2	16.7	10	17.5		
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Years of experience in current position	5.76	5.32	4.20	5.34	6.06	5.31	.43	.67
Years of experience with organization	7.63	6.57	7.48	8.54	7.65	6.21	.02	.98

Note.

^aDichotomous variables were created for the chi-square analyses.

* All tests were non-significant.

with the organization for the direct service staff who were included in the analyses and those who were excluded (See Table 2). However, direct service staff who identified as a person of color were more likely to be excluded from the HLM analyses.

Approximately 36% of the direct service staff in the original sample who identified as persons of color were excluded from the subset, compared with 24% of the white direct service staff ($\chi^2(1) = 8.86, p < .01$). Nonetheless, the HLM sample remained quite diverse with 50% of the direct service staff identifying as African-American, Asian/Pacific Islander, Hispanic, Native American, or biracial.

Program demographics. Of the 57 Head Start programs that were included in the analyses, 25 were designated by administrators as serving primarily rural areas (44%), and 32 of the programs were designated as serving primarily urban/suburban areas (56%; see Table 3). The rural programs served significantly fewer children ($M = 393.24, SD = 319.80$) than the urban/suburban programs ($M = 906.75, SD = 816.96; t = -3.25, p < .01$, equal variances not assumed). Rural and urban/suburban Head Start programs did not differ significantly on the number of classrooms or the number of employed or contracted mental health consultants. The 57 rural and urban/suburban programs had an average of 19 half-day classrooms ($M = 18.67, SD = 41.87$) and 16 full-day classrooms ($M = 16.31, SD = 28.97$). The programs employed or contracted with an average of 4 mental health consultants ($M = 3.70, SD = 2.59$), although programs had as few as one and as many as 12.

Respondent demographics. In the present analysis, the 464 respondents included 407 direct service Head Start staff and 57 Head Start mental health

Table 2
Characteristics of Direct Service Staff Subset

Staff Characteristics	Total (<i>n</i> = 592)		Excluded (<i>n</i> = 185)		Included (<i>n</i> = 407)		<i>t</i> test/ χ^2	<i>p</i>
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%		
Gender							1.25	.26
Female	568	97.3	174	96.1	394	97.8		
Male	16	2.7	7	3.9	9	2.2		
Race/ethnicity							8.86*	.00
White	293	50	71	41	222	54		
Person of Color	287	50	102	59	185	46		
Education							0.75 ^a	.39
High school diploma	98	16.9	31	17.1	67	16.8		
2 year degree/ certificate	111	19.1	34	18.8	77	19.3		
Child development associate	185	31.8	62	34.3	123	30.8		
4 year college degree	162	27.9	44	24.3	118	29.5		
Master's degree	25	4.3	10	5.5	15	3.8		
Position description							4.78 ^a	.09
Teacher	349	59.2	106	57.9	243	59.7		
Assistant teacher	117	19.8	40	21.9	77	18.9		
Family advocate / family services specialist	124	21.0	37	30.2	87	21.3		
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Years of experience in current position	5.22	5.61	4.86	5.82	5.38	5.51	.57	.57
Years of experience with organization	7.46	6.97	7.08	6.92	7.62	6.99	.46	.65

Note:

^aDichotomous variables were created for the chi-square analyses.

**p* < .01.

Table 3
Characteristics of Head Start Programs

Program Characteristics	Total (<i>n</i> = 57)		Urban (<i>n</i> = 32)		Rural (<i>n</i> = 25)		<i>t</i> -test	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Number of children served	681.53	692.38	906.75	816.96	393.24	319.80	-3.25*	.00
Number of ½ day classrooms	18.67	41.87	26.58	54.17	8.46	9.73	-1.83	.08
Number of full day classrooms	16.31	28.97	19.43	36.39	12.42	15.36	-0.88	.38
Number of MHCs	3.70	2.59	4.00	2.62	3.29	2.55	-1.02	.32

Note:

**p* < .01.

consultants from both rural and urban programs. The direct service staff included 243 Head Start teachers (60%), 77 assistant teachers (19%), and 86 family advocates / family services specialists (21%; see Table 4). Rural and urban staff did not differ according to gender or level of experience. Of the 407 direct service staff included in the analyses, 98% were female. The direct service staff who were surveyed had a wide range of years of experience in their current position ($M = 5.38$, $SD = 5.51$, range 0.25-35 years): 137 direct service staff had been in their current position for 0-3 years (34%); 171 had been in their position for 4-10 years (42%); and 97 had been in their position for 11-37 years (24%). They also had a range of experience within their organization ($M = 7.62$, $SD = 6.99$, range 0.25-37 years): 43% had 0-3 years of experience, 39% had 4-10 years, and 13% had 11-35 years of experience with the organization.

The Head Start urban and rural direct service staff in the sample varied significantly on level of education and diversity (analyzed as a dichotomous variable with categories 'white' and 'person of color') of staff (see Table 4). Urban programs were significantly more educated and diverse. Sixty percent of the staff from urban and suburban areas had a college degree or higher (analyzed as dichotomous variable with categories 'some college' and 'no college'), while only 44% of the rural Head Start staff had a college degree or higher ($\chi^2(1) = 5.30$, $p < .01$). Although the 407 direct service staff included in the analyses were quite diverse (27% of respondents were African-American, 55% were Caucasian, 11% were Hispanic/Latino, 3% were Native American, and 3% identified as biracial or of other ethnic backgrounds), the

Table 4
Characteristics of Head Start Direct Service Staff

Staff Characteristics (<i>n</i> = 407)	Total		Urban		Rural		<i>t</i> test/ χ^2	<i>p</i>
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%		
Gender							2.43	.12
Female	394	98	203	96.7	191	97.8		
Male	9	2	7	3.3	2	2.2		
Race/ethnicity							13.79 ^{***}	.00
African-American	108	26.5	64	30.2	44	22.6		
Asian/Pacific-Islander	7	1.7	6	2.8	1	0.5		
Hispanic	46	11.3	40	18.9	6	3.1		
Native American	12	2.9	1	0.5	11	5.6		
Other or biracial	12	2.9	4	1.9	8	4.1		
White	222	54.5	97	45.8	125	64.1		
Education							5.30 ^{***}	.02
High school diploma	67	16.8	30	14.4	37	19.3		
Child development associate	123	30.8	52	25.0	71	37.0		
2 year college degree/ certificate	77	19.3	46	22.1	31	16.1		
4 year college degree	118	29.5	72	34.6	46	24.0		
Master's degree	15	3.8	8	3.8	7	3.6		
Position description							1.52	.68
Teacher	243	59.7	129	60.8	114	58.5		
Assistant teacher	77	18.9	37	17.5	40	20.5		
Family advocate / family services specialist	87	21.1	46	21.2	41	21.0		
Years experience in current position							.32	.85
Low: 0-3 years	137	33.8	74	35.1	63	32.5		
Medium: 4-10 years	171	42.2	87	41.2	84	43.3		
High: 11-37 years	97	24.0	50	23.7	47	24.2		
Years of experience with organization							1.44	.49
Low: 0-3 years	193	48.1	97	46.4	96	50.0		
Medium: 4-10 years	156	38.9	87	41.6	69	35.9		
High: 11-35 years	52	13.0	25	12.0	27	14.1		

Note:

^aDichotomous variables were created for the chi-square analyses.

* *p* < .05. ***p* < .01.

urban and suburban staff were also significantly more racially/ethnically diverse ($\chi^2(1) = 13.79, p < .01$). Fifty-four percent of the urban/suburban respondents identified as African-American, Asian/Pacific Islander, Hispanic, Native American, or biracial, whereas only 36% of the rural respondents identified as a person of color.

Fifty-seven mental health consultants were included in the present analyses (see Table 5). Among those MHCs included in the survey, 24.6% of MHCs identified as African-American, Asian/Pacific-Islander, Hispanic, Native American, or biracial. MHCs serving urban Head Start programs were significantly more diverse (37.5% identified as a person of color) than rural programs in which 8% of the MHCs identified as a person of color ($\chi^2(1) = 6.59, p < .01$; analyzed as a dichotomous variable with categories 'white' and 'person of color'). Rural and urban mental health consultants did not differ according to education (analyzed as dichotomous variable with categories 'PhD' and 'no PhD'), gender, position description (analyzed as dichotomous variable 'employed by Head Start' and 'contract with Head Start'), or years of experience with the organization. The mental health consultants were highly educated, with 34 having a master's degree (59.6%), and 21 having a doctoral degree (36.8%). Head Start programs employed 11 of the consultants (19.3%), 14 MHCs were employed by a non-profit organization (24.6%), 15 were in private practice (26.3%), and the remaining 17 were employed by the government, schools, or other agencies (29.8%). MHCs in rural and urban programs did not differ regarding the average number of years of experience working with the organization ($M = 7.65, SD = 6.21, \text{range } 0.05\text{-}26 \text{ years}$): 40.4% had 0-3 years of experience, 42.1% had 4-10 years,

Table 5
Characteristics of Mental Health Consultants

MHC Characteristics (<i>n</i> = 57)	Total		Urban		Rural		<i>t</i> test/ χ^2	<i>p</i>
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%		
Gender							1.39	.24
Female	41	71.9	25	78.1	16	64.0		
Male	16	28.1	7	21.9	9	36.0		
Race/ethnicity							6.59 ^{***}	.01
African-American	3	5.3	3	9.4	0	0.0		
Asian/Pacific-Islander	1	1.8	1	3.1	0	0.0		
Hispanic	5	8.8	4	12.5	1	4.0		
Native American	0	0.0	0.0	0.0	0	0.0		
Other or biracial	5	8.8	4	12.5	1	4.0		
White	43	75.4	20	62.5	23	92		
Education							.98 ^a	.32
4 year college degree	2	3.5	1	3.1	1	4.0		
Master's degree	34	59.6	21	65.6	13	52.0		
Doctoral degree	21	36.8	10	31.3	11	44.0		
Position description							1.52 ^a	.22
Therapist employed by Head Start	11	19.3	8	25	3	12.0		
Therapist employed by non-profit	14	24.6	7	21.9	7	28.0		
Therapist employed by government agency	4	7.0	2	6.3	2	8.0		
Therapist in private practice	15	26.3	6	18.8	9	36.0		
School-based therapist/counselor	3	5.3	2	6.3	1	4.0		
Other	10	17.5	7	21.9	3	12.0		
Years of experience in current position as MHC							7.67*	.02
Low: 0-3 years	23	40.4	18	56.3	5	20.0		
Medium: 4-10 years	24	42.1	10	31.3	14	56.0		
High: 11-37 years	10	17.5	4	12.5	6	24.0		
Years of experience with organization							3.99	.14
Low: 0-3 years	17	29.8	12	37.5	5	20.0		
Medium: 4-10 years	28	49.1	12	37.5	16	64.0		
High: 11-35 years	12	21.1	8	25.0	4	16.0		

Note:

^aDichotomous variables were created for the chi-square analyses.

p* < .05. *p* < .01

and 17.5% had 11-35 years of experience with the organization. The average number of years in their current position as a MHC did not differ among consultants in rural and urban programs ($M = 6.06$, $SD = 5.31$, range 0.25-25 years). However, urban MHCs (56.3%) were more likely to have low experience (0-3 years experience) in their current position as a MHC than rural MHCs (20.0%; $\chi^2(2) = 3.99$, $p < .01$).

Survey Instruments

Head Start direct service staff and mental health consultants completed the Head Start Mental Health Services Survey (HSMHSS), which was a survey developed by Green et al. (2006) that contained 146 Likert-type and open-ended questions. The HSMHSS was developed based on an in-depth qualitative study of mental health services in Head Start (Green, Simpson, et al., 2004). The HSMHSS staff version (see Appendix A) collected information regarding mental health services provided by the program, characteristics of mental health consultation services, and staff attitudes and opinions about the effectiveness of mental health consultation services.

Mental health consultants completed a complementary version of the HSMHSS. The consultant version (see Appendix B) collected information on consultant characteristics, frequency of consultation activities, MHC self-report of their knowledge and use of early childhood mental health best practices, and MHC opinions about the effectiveness of Head Start mental health services (Green, Everhart, et al., 2004). The consultant version also contained 146 Likert-type and open-ended questions.

In addition to the staff and MHC versions of the HSMHSS, program directors completed a director addendum to the HSMHSS. The addendum consisted of 27 questions regarding the characteristics of the Head Start program, such as number of children served, number of staff, and number of mental health consultants. Items from the HSMHSS staff version, consultant version, and director addendum were selected for inclusion in the analyses and are discussed below.

Program Characteristics

Program characteristics were included as covariates in the HLM analyses. This information was collected with the HSMHSS program director addendum (Green et al., 2006). The number of children served and the program location (urban/suburban vs. rural) were two items from the director addendum that were selected as potential covariates. The number of children served was considered an important covariate for inclusion, because the number of children served could be a factor that influences the quality of the relationship between the MHC and the Head Start staff. For example, it is possible that MHCs who work with very large Head Start programs have less opportunity to develop relationships with Head Start staff. Program location, whether the program was located in a rural or urban/suburban area, was included to determine if program location created an interaction with the independent variables.

Attributes of Mental Health Consultants

Using items from the HSMHSS consultant version, subscales were developed to measure six of the attributes of mental health consultants. The items included in

each subscale were chosen from the HSHMSS consultant version *a priori*, based on information gathered from the current literature on early childhood mental health consultation. Factor analysis was not used to develop the subscales, because factor analysis tends to create atheoretical scales that are driven by the data and to develop subscales that are highly correlated (Heppner, Kivlighan, & Wampold, 1999).

The six subscales that describe attributes of mental health consultants included: (a) knowledge and experience with Head Start and early childhood education; (b) relationships with Head Start parents; (c) relationships with Head Start staff; (d) consultant training, supervision, and support; (e) knowledge of early childhood mental health best practices; (f) and cultural sensitivity (see Table 6). The consultants responded to the items within each subscale using a 4-point Likert scale from 1 (strongly agree) to 4 (strongly disagree) and an option for “don’t know” (Green, Everhart, et al., 2004). All “don’t know” responses were treated as missing data and were excluded from analyses.

Reliability and construct validity were evaluated for each of the mental health consultant attributes. Construct validity, which evaluates whether each subscale is measuring the intended attribute (Cohen, Cohen, West, & Aiken, 2003), was explored using content validity, as well as convergent and discriminant validity. To determine content validity, the content of the items within each construct was compared to each construct’s operational definition as described in the literature review. Convergent and discriminant validity were determined using a correlation matrix of all of the items in each of the MHC attribute subscales (see Table 7). Convergence was confirmed

Table 6
MHC Attributes Subscale Reliability, $n = 57$

Attribute Subscale	Questionnaire Item	α	M	SD
Knowledge of and experience with HS	1. I have experience working with the HS population.	.57	3.8	.27
	2. I have experience working with young children. <i>**I provide services in a way consistent with the HS philosophy.</i>			
Relationships with Head Start families	1. I have a good relationship with HS program parents.	.74	2.9	.66
	2. I work closely with program parents to define services to meet children's needs.			
	3. Most of the parents in the program know me by name.			
	4. Parents of HS children with special needs know me by name.			
<i>**Cultural sensitivity</i>	<i>I have an awareness of my own cultural norms and expectations, and how these might differ from the cultural experiences of Head Start children and their families.</i> <i>I talk with staff about the ways in which understandings of mental health and related concepts (self-esteem, discipline, etc.) may differ for children based on culture.</i>	.19	3.6	.37
Relationships with Head Start staff	1. I have a good relationship with the HS program staff.	.63	3.6	.38
	2. I work as a partner with staff to meet children's MH needs.			
	3. Staff regularly come to me when they need help with particular children or families.			
	4. I talk with staff about the ways in which understandings of mental health and related concepts (self-esteem, discipline, etc.) may differ for children based on culture. <i>**I respect staff's perspectives on children's issues.</i> <i>**I am available when staff need me.</i>			
Consultant training, supervision, and support	1. I feel like I am "part of the team" trying to help HS families.	.72	3.3	.60
	2. I have a clear understanding of my role in supporting children's mental health in this program.			
	3. This program provides me with the training and professional support I need to do my job most effectively.			
	4. This program provides me with the emotional and personal support I need to do my job most effectively.			
Knowledge of early childhood mental health best practices	1. I have a good understanding of "best practices" in children's mental health.	.75	3.7	.38
	2. I consistently use best practices in children's mental health in my work.			
	3. I feel I do a good job in supporting children's mental health within this program context.			

***Items were deleted from the scales, because of low correlations with the other items.*

when the items within each of the subscales were significantly correlated ($p < .05$) with at least a medium effect size ($r > |.3|$; Rosenthal, 1996), and discriminant validity was confirmed when the items within the subscale were not significantly correlated ($p > .05$) with more than one item from the other mental health consultant attributes subscales.

1. *Knowledge and experience with Head Start and early childhood education.*

Three items were selected to measure the degree to which MHCs feel that they have knowledge of and experience with Head Start and early childhood education, but one item was dropped (“I provide services in a way consistent with the Head Start philosophy”) to improve the reliability from $\alpha = .56$ to $\alpha = .57$ ($M = 3.89$, $SD = 0.27$). Although the Cronbach’s alpha was low for this construct, it was acceptable for a two-item scale developed for preliminary research (Peterson, 1994).

The knowledge and experience with Head Start subscale demonstrated good convergent and divergent validity. The two items of the scale were correlated with each other, but they were not correlated with more than one item within each of the other subscales. With regard to content validity, the two items do reflect the operational definition of knowledge of Head Start, which emphasizes the MHCs’ knowledge and experience with early childhood education and early intervention systems.

2. *Relationships with Head Start families.* Four items were identified to measure the degree to which MHCs develop positive relationships with families. This construct contained items such as, “I have a good relationship with HS program

parents,” and “Most of the parents in the program know me by name.” All four items had good reliability and were retained in the subscale ($\alpha = .74$, $M = 2.91$, $SD = 0.66$).

The relationships with families subscale demonstrated good concurrent validity as the items were intercorrelated. Except for the item, “I have a good relationship with HS program parents,” which was highly correlated with items from the positive relationship with HS staff construct and the training, supervision, and support construct, the remaining three items showed good divergent validity. Those three items were not correlated with more than one item within each of the other subscales. The items of this subscale do support content validity, because they reflect the degree to which the MHC is able to develop positive relationships with Head Start parents.

3. *Cultural sensitivity.* The national survey of MHCs did not contain items that reliably measured cultural sensitivity. Three items in the survey were identified as reflecting cultural sensitivity. However, one item had to be dropped (“I am able to work effectively with non-English speaking families”), because it contained an option for “not applicable.” This led to missing data for this item, so it had to be dropped. The remaining two items on the subscale were not significantly correlated ($r = .12$, $p > .05$). Therefore, the subscale for cultural sensitivity was excluded from the HLM analyses due to low reliability ($\alpha = .12$, $M = 3.67$, $SD = 0.37$). Because detailed information regarding the cultural sensitivity could be gathered from the Phase II of the study, the decision was made to exclude this variable from Phase I.

4. *Relationships with Head Start staff.* Six items were originally identified as reflecting the concepts of mental health consultant relationship with Head Start staff.

However, two items were dropped from the positive relationships subscale, because they were not correlated with the other items. The remaining four items had acceptable reliability ($\alpha = .63$, $M = 3.65$, $SD = 0.38$).

The four items of the positive relationships with Head Start staff construct had good convergent validity, because they were intercorrelated. However, the four items in the positive relationship with Head Start staff did not exhibit strong divergent validity, because many of the items were highly correlated with items from the “relationship with parents” subscale and the “training, supervision, and support subscale.” Content validity was supported for these items as a construct of MHC relationship with HS staff, because they included the concepts of relationship and partnership.

5. *Consultant training, supervision, and support.* Four items were identified and retained as a measure of the training, supervision, and support that mental health consultants feel that they receive in their role. These four items had acceptable reliability ($\alpha = .72$, $M = 3.34$, $SD = 0.60$), and showed good convergent validity. However, because many of the items were highly correlated with items from the positive relationship with HS staff construct, this subscale did not demonstrate good discriminant validity. Content validity was supported in this subscale, because the four items addressed the concepts of understanding the MHC role, training, and support.

6. *Knowledge of early childhood mental health best practices.* Three items were identified and retained as a measure of MHC’s perceptions of their knowledge of

early childhood mental health best practices. This subscale includes items such as, “I consistently use best practices in children’s mental health in my work.” The three items in this scale had acceptable reliability ($\alpha = .75$, $M = 3.74$, $SD = 0.38$). This construct demonstrated good convergent and discriminant validity. The two items of the subscale were correlated with each other, but they were not correlated with more than one item from the four other subscales. Because the items in this subscale addressed the identified operational definition of best practices, which included MHC knowledge of best practices and the ability to implement best practices, the subscale achieved content validity.

Outcome Measures

1. *Effectiveness in helping child outcomes.* Three subscales were created from the HSMHSS staff version to measure Head Start staff reports of how helpful mental health consultation was in addressing the following child outcomes (see Table 8): reducing internalizing behavior; reducing externalizing behavior, and promoting positive social behavior (Green et al., 2006). The internalizing behavior subscale consisted of three items rating the helpfulness of consultation in reducing depression, withdrawal, and moodiness, and it had high reliability ($\alpha = .91$). The externalizing behavior subscale, which had five items, also had high reliability ($\alpha = .92$), and it measured the reduction in aggression towards adults and children, temper tantrums, and destructive behavior. Finally, four items measured positive social behaviors: positive social interactions, smooth transitions, age-appropriate emotional regulation, and non-violent problem solving. The positive social behaviors subscale also had high

Table 8
Level-1 Outcomes Subscale Reliability

Attribute	Questionnaire Item	α	M	SD
Reducing internalizing behavior	Withdrawn / overly shy behavior Extreme moodiness Child depression	.91	2.78	.81
Reducing externalizing behaviors	Aggression towards other children Aggression towards adults Self-destructive behavior Extreme temper tantrums	.92	2.88	.82
Increasing prosocial behaviors	Positive social interactions between children Smooth transitions between activities Prosocial behavior (e.g., helping, sharing) Age-appropriate emotional regulation Non-violent problem solving	.94	3.06	.80
Positive relationship with mental health consultant	I have a good relationship with the MHC(s). The MHC(s) works as a partner with staff to meet children's MH needs The MHC(s) seems like another member of the HS staff, not like an outsider. The MHC respects staff's perspectives on children's issues. The MHC(s) is "part of the team" trying to help families. The MHC(s) is available when I need him/her.	.89	3.33	.65

reliability ($\alpha = .94$). Although the three subscales were highly correlated, analyses suggested that predictors of the three subscales varied (Green et al., 2006). Therefore, the unique subscales were maintained.

2. *Quality of relationships between staff and mental health consultant.* Based on the previous work of Green et al. (2006), six items from the HSMHSS staff version were used to measure Head Start staff reports of the quality of the relationship between the consultant and the Head Start staff (see Table 8). The relationship subscale included items such as “I have a good relationship with the mental health consultant” and “the mental health consultant works as a partner with me to meet the children’s needs.” Head Start staff responded to these items on a 4-point scale ranging from 1 = Strongly Agree to 4 = Strongly Disagree. These six items had good reliability ($\alpha = .89$).

Covariates

Both level-1 and level-2 covariates were identified to be included in the model (Green et al., 2006). Because multi-level models become increasingly complex and difficult to interpret with large numbers of covariates, the decision was made to create parsimonious models by including only significant predictors as covariates. Level-1 covariates that were tested for inclusion were the Head Start staff respondents’ years of Head Start experience, race/ethnicity, gender, level of education, and Head Start position (management or direct service). To determine which Level-1 covariates were to be included in the model, each variable was entered as a Level-1 predictor of each of the four outcome variables (reducing internalizing behavior, reducing externalizing

behavior, promoting prosocial behavior, and quality of the relationship between staff and MHC). The variables that were significant predictors for at least two of the outcome variables were retained for inclusion in the model. As shown in Table 9, direct service staff race / ethnicity and years of experience were retained as level-1 covariates in the model. Years of Head Start experience was grand-mean centered.

The level-2 covariates that were tested for inclusion in the models were the MHCs' years of mental health experience, ethnicity (white versus person of color), gender, level of education, position description, and Head Start child enrollment size (see Table 9). Level-2 covariates to be retained for inclusion in the HLM models were determined by running each of these variables as predictors of the four outcome variables (reducing internalizing behavior, reducing externalizing behavior, promoting prosocial behavior, and quality of the relationship between staff and MHC), and the predictors that were significant for at least two outcome variables were retained for inclusion in the model. Head Start child enrollment is the only level-2 covariate that was retained for inclusion in the HLM models, although program location (rural vs. urban) was also included to test for interaction effects. Head Start enrollment was grand-mean centered, so that the intercept became the expected value of the outcome variable when the HS enrollment has the mean value (Hox, 2002).

Quantitative Analysis Methods

Hierarchical linear modeling (HLM) was used to address the two Phase 1 research questions: (1) What attributes of mental health consultants are most strongly associated with teacher reported effectiveness of mental health consultation for

Table 9
Standardized β s for Level 1 and Level 2 Covariates

Level 1 Covariates	Internalizing	Externalizing	Prosocial	Positive Relat.
HS Experience ^a	.01	.01	.01*	.01*
HS Race/ethnicity	.37**	.23**	.25**	.12
HS Gender	-.10	-.10	-.04	-.01
HS Education	-.23**	-.10	-.12	-.12
HS Position	.03	-.05	-.01	.02
Level 2 Covariates				
MHC Experience ^a	.01	.00	.00	.01
MHC Race/ethnicity	.10	.05	-.07	.09
MHC Gender	-.00	-.10	-.08	-.19
MHC Education	.04	.00	-.00	-.14
MHC Position Description	-.09	.08	-.01	-.10
HS Enrollment ^a	.00**	.00**	.00	.00
Rural or urban	.01	.06	-.05	-.01

Note.

* Significant at $p < 0.05$

**Significant at $p < 0.01$

^aGrand mean centered.

improving child outcomes for rural and urban Head Start programs; and (2) What attributes of mental health consultants are most strongly associated with teacher reports of the quality of mental health consultant and staff relationships for rural and urban Head Start programs?

Multilevel models were an appropriate analytic strategy, because the national survey of Head Start programs contains hierarchically structured data (Green et al., 2006; Kreft & de Leeuw, 2004). A hierarchy is present when lower levels, such as teachers, are nested within higher levels, such as mental health consultants and programs. Hierarchical linear models examine the level of variability within and between each level of nesting (Kreft & de Leeuw; Snijders & Bosker, 1999). This study examined whether there are “consultant” effects on teacher reports of consultation effectiveness and consultant-teacher relationships.

Multilevel analysis is often used in educational research, where research questions often contain independent variables that are measured at a higher level than the outcome variable (Garner & Raudenbush, 2006). For example, in educational research, HLM is useful for examining how teacher characteristics influence student learning over and above the influence of the students’ characteristics (Kreft & deLeeuw, 1998). Hierarchical linear models are also used to evaluate the influence of classroom level effects, such as social climate, on student educational outcomes (Ryan, Gheen, & Midgley, 1998). Such models can also examine school effects on child outcomes, such as the influence of school climate on student violent behavior (Brookmeyer, Fanti, & Henrich, 2006). Finally, hierarchical linear models can be

developed to model neighborhood effects on student educational outcomes (Garner & Raudenbush).

For the present study of mental health consultation in the Head Start early childhood educational setting, HLM was appropriate for determining the relationship between attributes of mental health consultants and child and staff outcomes of consultation. HLM was used successfully in a previous analysis of the national survey of Head Start programs and mental health consultants, which examined the characteristics and activities of mental health consultants that were associated with perceived effectiveness of mental health consultation (Green et al., 2006). In this study, Green et al. created multi-level models in which the Level 1 outcomes as reported by Head Start staff and managers were nested within program level characteristics, including mental health characteristics. The Level 2 program variables were created by aggregating information about staff member perceptions of the consultant. Separate hierarchical models were conducted to examine the influence of the Level-2 variables on the Level-1 outcome variables (Green et al.).

Although other data analysis techniques, such as structural equation modeling, could be used to address the Phase I research questions, there are three key advantages of utilizing multilevel modeling (Garner & Raudenbush, 2006). First, by clustering individuals within higher levels, there is not a violation of the assumption of independence of variance in error terms, which would occur if such models were tested using ordinary least squares regression. Second, multilevel models are able to estimate cross-level effects, which are defined as interactions between variables

measured at different levels, and which are presumed to not exist in Ordinary Least Squares-based estimation methods (Garner & Raudenbush; Kreft & deLeeuw, 1998;). For example, a cross-level effect may be present when there is an interaction between a student characteristic, such as degree of externalizing behaviors, and a teacher characteristic, such as level of teacher stress. Finally, with multilevel models it is possible to factor out the “true” variance from the sampling variance, which could not be accounted for when using other statistical models (Garner & Raudenbush). Because of these advantages, hierarchical linear modeling was thought to be an appropriate analysis strategy for this data set.

Hierarchical Linear Models

The multilevel analyses examined the degree to which variability within teacher responses to the four level-1 outcome variables were associated with the variability within consultant responses to the five level-2 predictor variables (see Figure 1). Thus, models were created in which the ($n = 407$) Head Start direct service staff (level-1) were nested within ($N = 57$) mental health consultants and their associated programs (level-2). Separate models were run for each of the four outcome variables.

Prior to developing the models, a one-way ANOVA with random effects model was run for each of the four variables, and intraclass correlation coefficients were produced to assess whether nesting was present. Four separate models were then run for each outcome variable paired with each of the level-2 predictor variables. In model one, only the level-1 variables were entered into the model, which is called the

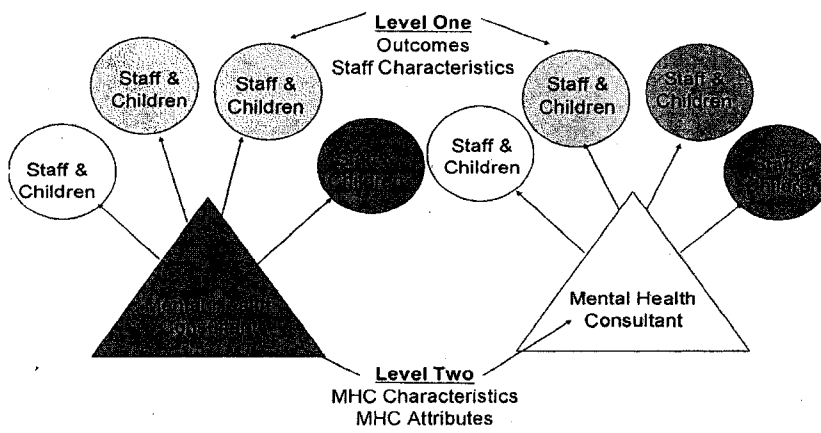


Figure 1. Analytic strategy: Hierarchical linear modeling was used to account for “nesting” of staff within mental health consultants.

random-coefficients regression model where the level-1 intercepts and slopes vary randomly over the level-2 groups (Raudenbush & Bryk, 2002). The second model included only the level-2 predictor variables and covariates, which is called the means-as-outcomes model. In the means-as-outcomes regression, the means from each of the MHCs were used as an outcome to be predicted by the level-2 MHC attributes (Raudenbush & Bryk, 2002). Model three, the intercepts and slopes as outcomes model, is a full model that included both the level-1 covariates and the level-2 predictor variables and covariates. Finally, model four built upon model three by including the rural or urban/suburban variable to test for an interaction. Because of differences in program size and Head Start staff characteristics between rural and urban/suburban programs, it was expected that the effects of MHC attributes might be moderated by rural versus urban/suburban program status. Only the results for models three and four will be presented, but the results of each of the models are included in Appendix G.

Integration of Phase I and Phase II Methods

The methods used in Phase II, the qualitative, telephone focus group study, were based on information gathered from the methods and results of Phase I, the quantitative, secondary analysis of a national survey of Head Start direct service staff and MHCs. Integration of the two methods was based on the assumption of complementarity: The quantitative, secondary analysis could provide limited information about the effective MHCs and their relationships with Head Start staff, but the qualitative, focus group study of MHCs' could supplement the quantitative data

(Erzberger & Kelle, 2003). The Phase I methods provided critical information for developing the focus group demographic questionnaire and the focus group questions, which are further described in the Phase II methods. Although Phase I and Phase II results are reported separately and integrated in the discussion, the results of Phase I influenced the methods for conducting the content analysis in Phase II, which is described in detail in the Phase II methods.

Phase II: Focus Groups

Focus groups are a qualitative research methodology that gathers information, thoughts, and feelings of four to eight participants through group interactions on an area of interest established by the researcher (Krueger, 1994; Morgan, 1996; Smithson, 2000). Focus groups are an ideal research method for examining complex topics that are not easily measured through quantitative methods, such as attitudes or opinions (Krueger, 1994). Through the focus group process, individuals within the group develop ideas collectively, which creates a rich discussion of the topic that would not be possible through individual interviews or other qualitative methods (Morgan, 1996; Smithson, 2000). An additional strength of focus groups is that participants often benefit from their interactions with other group members. For example, in this study of rural and urban Head Start mental health consultants, the consultants have benefitted from connecting with and speaking to other Head Start MHCs. Focus group interviews were chosen over individual interviews for this study, because of the potential networking and educational benefits of focus group participation for participants.

Although focus groups are typically held in a neutral location as face-to-face groups, telephone focus groups are becoming increasingly common for connecting participants who are extremely busy or who are geographically separated (Cooper, Jorgensen, & Merritt, 2003; Krueger, 1994). Cooper et al. conducted a review of published studies utilizing telephone focus groups that yielded 13 studies primarily conducted by health researchers. The research studies reported implementing telephone focus groups in order to include geographically remote participants (Cooper et al., 2003). Telephone focus groups build upon a common communication strategy for rural mental health personnel who use teleconference technology to connect with distant clients and supervisors (Schopler, Abell, & Galinsky, 1998; U.S. Department of Health and Human Services, 2004).

Telephone focus groups share the three key characteristics present in an inclusive definition of focus groups: (a) They are a qualitative method of data collection; (b) the group process is the central source of data; and (c) the researcher actively guides the focus group discussion based on predetermined topics (Morgan, 1996; Seal, Bogart, & Erhardt, 1998). However, telephone focus groups differ in that the researcher moderator and the participants communicate their ideas about the determined topic utilizing teleconference technology rather than through face-to-face meetings (Cooper et al., 2003). Using this inclusive definition encourages researchers to implement variations on traditional focus groups that utilize technology to match the needs of the participants or the research questions (Morgan; Seal et al.).

Participants

Mental health consultants working with Head Start programs in rural Alaska and rural and urban Oregon were identified for participation in the focus groups through both a convenience sample and a snowball sampling technique. The convenience sample was developed through a partnership with a Head Start program in Alaska, which provided the contact information for each of the mental health consultants who were working with the program during that program year.

Recruitment

To begin the snowball sampling technique, the Director of Oregon Head Start State Collaboration office agreed to post an announcement detailing the focus group study on the listserv that is sent to all Oregon Head Start directors. Five days after the announcement was posted on the listserv, the directors of each of the 29 Head Start programs in Oregon were contacted by email. Early Head Start, tribal, and Migrant Head Start programs were excluded, because they differ from the core Head Start programs. The email contained a brief summary of the project, and it asked the directors to consider forwarding the contact information (name, address, telephone number, and email address) for all of the mental health consultants who were working with their programs during the current year, so that the consultants could be invited to participate in the focus groups. The email also included an attached letter addressed to the Head Start director that explained the project in detail. All Head Start program directors who did not respond to the initial email received a follow-up email and a telephone call.

Of the 29 Oregon Head Start programs that were contacted, 14 directors provided the contact information for the mental health consultants who worked with their programs. Two of the directors initially declined to participate due to concerns regarding program time and financial limitations, but they agreed to provide consultant contact information once they were assured that the Head Start program would not be further involved in the project.

Because only six of the 29 Oregon Head Start centers are located in what might be considered urban and suburban areas, a snowball sampling technique was implemented to obtain the names and telephone numbers of additional MHCs working with suburban and urban Head Start programs in Oregon. The previously identified urban mental health consultants were contacted and asked if they could provide additional names and contact information for MHCs working with suburban and urban Head Start programs.

Through the convenience and snowball sampling, the names and contact information for 41 mental health consultants in Alaska and Oregon were obtained. Each of the mental health consultants were contacted by email and by telephone. During this initial contact, they received information about the focus groups, and they were asked if they would be interested in participating. Of the 41 MHCs contacted, six never responded to telephone calls and emails, and three declined because they were too busy. A total of 32 mental health consultants (78%) initially agreed to participate in the focus groups. Although 32 mental health consultants agreed to participate, six people were unable to participate. Two of the MHCs became ill after

agreeing to participate and were on a leave of absence from work, so it was not possible for them to attend a focus group. One MHC who was interested in participating was recently hired as the MHC and had not yet begun work, so he was ineligible for participation. One MHC was unable to attend the focus group, because the phone lines were down in the consultant's community on the day of the group. The remaining two consultants were interested in participating but were unable due to work conflicts. Therefore, a total of 26 mental health consultants returned informed consent forms and participated in the focus groups.

MHCs who agreed to participate in the focus group received a packet of information by mail, which included a letter of introduction, a consent form, a brief participant questionnaire, and a focus group schedule form. A self-addressed, postage-paid envelope was included for the return of the consent form, the questionnaire, and the focus group schedule form. During recruitment and in the letter of introduction, all participants were informed that they would receive a \$20.00 stipend for their participation in the focus group.

Telephone Focus Group Participant Characteristics

The consultants who participated in the focus groups worked with Head Start programs located in 16 counties in Oregon and four communities in Alaska. Approximately half of the focus group participants were MHCs who worked primarily with rural Head Start programs (53.8%), and half identified as working primarily with suburban (11.5%) or urban (34.6%) programs (see Table 10). Nineteen of the

Table 10
Characteristics of Focus Group Participants

MHC Characteristics	Total (n = 26)		Urban (n = 12)		Rural (n = 14)	
	n	%	n	%	n	%
Gender						
Female	19	79.2	8	72.7	11	84.6
Male	5	20.8	3	27.3	2	15.4
Race/ethnicity						
African-American	0	0	0	0	0	0
Asian/Pacific-Islander	0	0	0	0	0	0
Hispanic	2	7.7	0	0	2	14.3
Native American	0	0	0	0	0	0
White	21	80.8	12	100	9	64.3
Other or biracial	3	11.5	0	0	3	21.4
Education						
Master's degree	25	96.2	11	91.7	14	100
Doctoral degree	1	3.8	1	8.3	0	0
Primary training / professional affiliation						
Counselor	8	30.8	4	33.3	4	28.6
Psychologist	2	7.7	2	16.7	0	0
Psychiatrist	1	3.8	0	0	1	1
Social Worker	15	57.7	6	50.0	9	64.3
Position description						
Therapist employed by Head Start	4	15.4	3	25.0	1	7.1
Therapist employed by non-profit	8	30.8	4	33.3	4	28.6
Therapist employed by government agency	8	30.8	4	33.3	4	28.6
Therapist in private practice	4	15.4	0	0	4	28.6
School-based therapist/counselor	0	0	0	0	0	0
Other	2	7.7	1	8.3	1	7.1
Experience in children's mental health						
Low: 0-3 years	3	12	0	0	3	21.4
Medium: 4-10 years	12	48	6	54.5	6	42.9
High: 11-35 years	10	40	5	45.5	5	35.7
Experience with HS						
Low: 0-3 years	14	56	4	36.4	10	71.4
Medium: 4-10 years	6	24	3	27.3	3	21.4
High: 11-35 years	5	20	4	36.4	1	7.1

consultants were female (73%). Mental health consultants ranged in age from 31 to 63 years ($M = 48$, $SD = 9.56$).

Instruments

Informed Consent

Consultants who agree to participate in the focus groups signed an informed consent form, which detailed the potential risks of participation and the measures taken to protect against those risks. In addition, the informed consent procedure explained that all information shared within the focus group would remain confidential, and that information would not be linked to an individual or Head Start program or to characteristics that could identify an individual or Head Start program when results were reported.

MHC Brief Questionnaire

Prior to participating in the focus groups, mental health consultants completed a short demographic survey (see Appendix C), which was mailed to participants and returned to the researcher along with the informed consent. The brief survey was developed based on demographic questions used in the Head Start Mental Health Services Survey, which was the survey utilized in the secondary analysis in Phase I. The focus group member survey gathered demographic information, such as gender, age, ethnicity, highest education level attained, professional affiliation, level of licensure, number of years in current position, and number of years providing Head Start mental health consultation.

Focus Group Interview Guide

The focus groups were conducted using a standardized research protocol that utilized a predetermined set of questions and procedures (Morgan, 1996). The interview guide was semi-structured and contained open-ended questions with probes for further meaning (Krueger, 1994; Morgan). The interview protocol was designed to ensure that the focus group was 60 minutes in length, which is an ideal amount of time for a telephone focus group (Krueger, 2002). To ensure that respondents had the opportunity to fully respond to all questions, the final interview guide contained three questions that each had probes to encourage further discussion (Krueger, 2002). The focus group questions were designed to answer these research questions: (a) What are early childhood mental health consultants' perceptions of how to best develop relationships with staff in rural and Head Start programs? (b) What are MHCs perceptions of the skills, attributes, and supports needed to build positive relationships with Head Start staff and to produce positive consultation outcomes in rural Head Start programs? and (c) What are the challenges and barriers to providing mental health consultation in rural areas? The intent of the focus group questions was to encourage the mental health consultants to share their ideas and experiences regarding the attributes and skills that consultants need to develop relationships with Head Start staff and families. The questions explored their ideas around the skills, training, supervision, and support that they felt that MHCs need to be able to develop positive relationships with Head Start staff and families.

The focus group interview guide was developed based on the findings and the limitations of the secondary analysis. First, the secondary analysis of the national survey of mental health consultants revealed wide variation in MHC characteristics, Head Start program characteristics, and consultation models. Therefore, the focus group questions intentionally excluded questions about the MHCs' specific Head Start program consultation model that would be time consuming and would detract from the focus on attributes of effective consultants. Because the national survey showed that consultants differed in MHC experience levels, several of the focus group questions were written as hypothetical scenarios, rather than asking participants to share personal experiences, so that both inexperienced and experienced MHCs would feel confident in responding. Second, the focus group questions were tailored to elicit MHCs' ideas about providing consultation services specifically in rural or urban settings. This was necessary for explaining rural and urban interactions identified in Phase I and for uncovering differential issues in consultation for rural and urban MHCs. Third, the focus group questions and probes were developed using concepts from the MHC attributes subscales created in Phase I. This was important for exploring attributes that had null results, in the event that the attributes were clinically, if not statistically, significant. Fourth, the focus group questions explored MHCs' ideas about cultural sensitivity, because this was a consultant attribute that was excluded from the secondary analysis. Finally, the focus group questions were developed to allow MHCs to share their own ideas about the attributes of effective MHCs. The secondary analysis of attributes was limited to attributes identified in the

literature that could be reliably measured using the Head Start Mental Health Services Survey, so the focus group questions allowed MHCs to identify additional attributes.

After the focus group interview guide was developed, three experts in Head Start and early childhood mental health consultation independently reviewed the interview guide. The three experts reviewed the questions and discussed the relevance of the interview guide questions to the stated research questions. Based on the feedback from the three expert reviewers, improvements were made to the interview guide and it was field tested. The field test was a telephone focus group of four mental health consultants who worked with Head Start programs in rural Oregon. Based on the field test, two minor changes were made to the interview guide. First, an introductory, ice breaker question was excluded, because it was clear from the field test that MHCs did not need prompting to discuss their ideas and experiences as a MHC. Second, the fifth and final question, which was designed to be a back-up question, was also excluded. The field test confirmed that the three interview questions generated more than enough discussion to address the research questions within a one-hour telephone focus group.

The final interview guide consisted of a brief introduction and three interview questions, and the guide was tailored for focus groups with rural consultants (see Appendix D) and urban consultants (see Appendix E). The beginning of the focus group script consisted of an introduction to the focus group moderator and focus group assistant, a description of the project, and a review of the importance of confidentiality of the group. The first question stated,

For this question, I would like for you to think about the Head Start program that you worked with during the 2006-2007 Head Start school year, which was this past school year. Now I would like for you to think about when you first started working with this Head Start program as a mental health consultant.

What was helpful to you as you were just getting started with the program as their mental health consultant?

The associated probes (see Appendixes D and E) asked the consultant to reflect on what was difficult, and who they turned to for support.

The second question and probes asked consultants to consider the skills and attributes they would consider important if they were hiring a mental health consultant. The second question read,

Now I would like for you to imagine that you are in charge of hiring and training a mental health consultant to work with an urban / suburban (or rural) Head Start program, and you have an unlimited budget for salary, training, and supervision. First, imagine that you are interviewing people who are applying for this mental health consultation job. What skills does a successful applicant need in order to be an effective mental health consultant for an urban / suburban (or rural) Head Start program?

The final question and the associated probes asked the MHCs to share strategies they might use when working with a skilled and knowledgeable Head Start teacher who seems reluctant to work with the MHC, and this question stated:

Now I am going to describe a scenario. Imagine that you are the mental health consultant for an urban / suburban (or rural) Head Start program, and you are working with an excellent and experienced Head Start lead teacher.

Unfortunately, you get the feeling that this teacher is not interested in working with you, because she shares very little information with you. She says that everything in her classroom is fine, although during your observation of the classroom you noticed several children who had behaviors that concerned you. What are some ways that you might try to develop a partnership with this teacher?

Procedure

The focus groups were segmented based on three geographic locations: rural Alaska, rural Oregon, and urban / suburban Oregon. Segmentation refers to creating groups intentionally, so that the groups are homogeneous on a variable, such as gender, age, or geographic location (Morgan, 1996). Segmentation was necessary, because of differences in the mental health consultation service delivery in the three geographic regions. Because the focus groups included a small sample of mental health consultants, it would not have been practical to segment the groups on additional variables, such as years of experience.

Geographic segmentation produced two clusters of focus groups: rural Alaska and Oregon, and urban and suburban Oregon. Because these focus groups were held by teleconference, the focus groups were intentionally smaller than the traditional 7 to 10 participants (Krueger, 1994, 2002). A smaller group size of 4 to 6 people was more

appropriate for a telephone focus group (Hurworth, 2004; Krueger, 2002). However, due to participant attrition, several of the groups had fewer than four participants. In the rural Alaska and Oregon cluster, a total of five telephone focus groups were conducted with 14 MHCs. Two focus groups were held with MHCs from rural Alaska, and each group included two participants for a total of four MHCs. Three focus groups were held with MHCs from rural Oregon, and two of the groups had three participants and one had four participants for a total of ten rural Oregon MHCs. In the urban and suburban Oregon cluster of three focus groups, one group had five participants, one had four participants, and one had three participants for a total of 12 MHCs in the urban and suburban Oregon cluster.

Using information from the focus group schedule form, focus groups were scheduled within each cluster at times convenient for participants. When assigning MHCs to focus groups, efforts were made to develop groups that included participants working for different Head Start programs, so that participants would not enter the groups with existing group dynamics (Krueger, 1994; Freeman, 2006). However, this was not always possible, for many preexisting relationships between consultants were unknown. Before finalizing a focus group date and time, the date and time was confirmed with each participant.

Several focus group date and time reminders were implemented to avoid participant attrition. Once the focus group date and time was confirmed with all participants in the group, each participant received a scheduling letter by mail or email that stated the date and time of the focus group, instructions for dialing into the call,

and the list of interview questions. One week prior to the call, participants received a reminder postcard by mail that detailed the date and time of the call and instructions for joining the teleconference. On the day of the telephone focus group, participants were reminded by telephone or by email at least one hour prior to the call.

Each telephone focus group was conducted using a teleconference company, so that the calls were free of charge to participants. To access the call, participants dialed a 1-800 number and entered a conference identification number, which gave them access to the private teleconference. Participants were informed in both the consent form and the focus group introduction that the focus groups would be audio-recorded and transcribed. The teleconference company audio-recorded the teleconference and burned the recorded focus groups onto CD-Rom, which the company mailed. A professional transcriber with knowledge and experience in children's mental health research transcribed the focus groups.

Each telephone focus group was one hour in length and was semi-structured using the pre-determined focus group interview guide. The same three questions and associated probes were asked of all eight focus groups, although the questions were tailored for rural and urban / suburban focus groups. The principal investigator was the moderator for all eight focus groups, and a focus group assistant supported the moderator for all of the groups. Prior to helping with the call, the assistant received a 15-minute training and signed a confidentiality statement. The role of the assistant was to track the amount of time being dedicated to each question and to track when participants responded to each question. The moderator took a relatively active role in

ensuring that the groups spent equal time on each question and that each member of the focus groups had an opportunity to share ideas. At the close of each focus group, participants had an opportunity to share additional ideas or information that they felt was important and was not covered, and they were thanked for their participation. Within a week after the telephone focus group, each participant received a thank you note and a \$20.00 check as compensation for their time.

Several strategies were implemented to increase the integrity and quality of the telephone focus groups and to overcome the shortcomings of this focus group technique. To begin, all participants received the questions in advance of the focus groups, so that they could read the questions as well as listen to the questions. At the beginning of the focus group, the moderator requested that each person state his or her name before speaking, so that the participants, the moderator, and the transcriber could identify each speaker (Hurworth, 2004). The questions were open for participants to answer, and participants were encouraged to share. Throughout the focus group, the moderator encouraged participation by all group members and acknowledged participation through verbal comments, such as "That's interesting," because it was impossible to show interest through non-verbal cues (Hurworth). When the focus group assistant noted that some participants were sharing more than others, the focus group moderator encouraged participation with prompts, such as, "Now let's hear from members we haven't heard from," and "are there other ideas that have not been discussed?" Because the telephone focus groups contained no more than five participants, ensuring participation from all group members was manageable.

Qualitative Analysis Methods

The telephone focus group data were analyzed using content analysis to answer the following qualitative research questions: (a) What are early childhood mental health consultants' perceptions of how to best develop relationships with staff in rural and urban Head Start programs? (b) What are MHCs' perceptions of the professional skills, attributes, and supports needed to build positive relationships with Head Start staff and to produce positive consultation outcomes? and (c) What are the challenges and barriers to providing mental health consultation in rural areas? Using content analysis as an analytic strategy made it possible to develop systematic inferences from the data about mental health consultants' perceptions and to identify key ideas or categories that made meaning of the data (Berg, 2004). Content analysis was conducted using six codes that described attributes of effective Head Start mental health consultants that were developed *a priori* for the quantitative analysis in Phase I, and one code for rural issues or challenges. The seven codes were: (a) knowledge and experience with Head Start and early childhood education; (b) relationship with Head Start families, (c) cultural sensitivity; (d) relationship with Head Start staff; (e) MHC training, supervision, and support; (f) knowledge of early childhood mental health best practices; and (g) rural issues. The code for rural issues was developed to capture the experiences, issues, or challenges that rural focus group participants identified as specific to providing mental health consultation services in rural communities.

The focus group analyses were developed and implemented by the principal investigator, who was a social work doctoral student with knowledge and experience

in early childhood mental health and in working with Head Start programs. The principal investigator also had knowledge and experience in qualitative research methods and data analysis. To ensure that the coding was reliable, a research assistant participated in coding each of the eight telephone focus group transcripts. The research assistant was a social work doctoral student with practice experience in children's mental health. As a doctoral student, the research assistant had taken a course in qualitative research methods. In addition, the research assistant received two hours of training on the research project, the *a priori* codes, and open coding. The research assistant also received support and supervision from an experienced mixed methods researcher.

Content analysis of the eight telephone focus groups was conducted over several phases. In the first phase, the principal investigator read each of the transcripts and inserted methodological and theoretical notes to begin actively documenting the research process, which occurred throughout the coding process (Berg, 2004). In the second phase of the content analysis, the principal investigator and the research assistant independently open coded each of the focus groups using a guide that described each of the seven codes (see Appendix F). Focus group coding began with the five rural focus groups and concluded with the three urban focus groups. The descriptions of the codes contained in the focus group guide were developed based on the concepts from the associated Head Start Mental Health Services Survey MHC attribute subscales. After open coding each of the focus groups, the research assistant and the principal investigator compared the coding and discussed discrepancies in the

coding until a common code was agreed upon. This process continued until 100% inter-coder reliability was achieved. The process of independently coding and reviewing the coding for each rural and urban focus group was repeated until 100% agreement for each of the eight focus groups was attained. Throughout open coding, the principal investigator and the research assistant continually referred to the research questions and the description of codes to guide the coding (Berg). Both coders also noted and discussed emergent codes or concepts that were distinctive from the *a priori* codes.

During the process of open coding the five rural focus groups and the three urban focus groups, tentative concepts and categories began to emerge from the data. The final phase of the content analysis was developing a coding frame (see Appendix F). The coding frame organized the ideas and concepts identified through the open coding process into a visual representation of the data (Berg; Woods, Priest, & Roberts, 2002). To develop the coding frame, the principal investigator read and analyzed the quotations for each code within each focus group. Themes were identified for each code within each focus group. The themes were compared across focus groups, and quotations identified for each theme from each focus group. A coding frame was developed for each of the codes to organize the themes and quotations. The findings were presented based on the organization of the coding frame.

Ensuring the trustworthiness and authenticity of the findings was central to the analysis of the telephone focus groups. Trustworthiness of the findings was ensured

by implementing the values of dependability, credibility, and confirmability.

Dependability of the findings was attained by developing and following a focus group interview protocol, by audio recording the focus groups, by dual coding each focus group, by keeping records of all data collected, and by maintaining a journal of research activities (Berg, 2004). Second, credibility, which refers to the degree to which stakeholders view the results and data analysis as accurate, was addressed by engaging the focus group members in member checks and by working with peer reviewers (Rodwell, 1989). Focus group members were mailed a summary of the focus group findings and a feedback form, which allowed them to review the interpretation of the findings to ensure accuracy. Six focus group participants returned the feedback form, and their responses were addressed in the results. Finally, confirmability, which examines whether the reported results are related to the context of the focus group discussions (Rodwell), was created by working closely with two peer reviewers, who reviewed the accuracy of the results. Both peer reviewers are staff members of large Head Start programs and have knowledge and experience in Head Start, early childhood mental health, and cultural sensitivity. The peer reviewers were mailed the interpretations of the findings within their area of expertise, as well as the associated coded transcripts. The peer reviewers had the opportunity through teleconference to ask the principal investigator challenging questions regarding the interpretations of the focus group data (Rodwell). The peer reviewers also provided written feedback by completing a feedback form. Through the questions and the

feedback form, the researcher received feedback regarding the accuracy of the interpretations of the data.

CHAPTER 5: RESULTS

Phase I: Secondary Analysis

Level-1 Outcome Variable Descriptives

The hierarchical linear models included four level-1 outcome variables, which were based on Head Start direct service staff self-reports (see Table 11). The first three measures asked direct service staff to report the degree to which the program's mental health services helped the following child behaviors: internalizing behaviors ($M = 2.77$, $SD = .81$), externalizing behaviors ($M = 2.87$, $SD = .82$), and prosocial behaviors ($M = 3.06$, $SD = .80$). Each of these measures ranged from 1 ("hasn't helped") to 4 ("helped a lot"). In the fourth outcome variable, direct service staff reported on the quality of their relationship with the mental health consultant ($M = 3.33$, $SD = .65$), which ranged from 1 ("strongly disagree") to 4 ("strongly agree"). There were no mean differences on the four outcome variables between rural and urban / suburban Head Start direct services staff (see Table 11).

Level-2 Predictor Variable Descriptives

The hierarchical linear models included five measures of MHC attributes, which were included in the analyses as level-2 independent variables (see Table 11). All five measures were MHC self-report, and the possible responses ranged from 1 ("strongly disagree") to 4 ("strongly agree"). These five independent level-2 variables were: knowledge of Head Start and early childhood education ($M = 3.89$, $SD = .27$); relationships with families ($M = 2.91$, $SD = .66$); relationships with Head Start staff ($M = 3.64$, $SD = .38$); level of training, supervision, and support ($M = 3.34$, $SD = .60$);

Table 11
Level 1 Outcome Variables and Level 2 Predictor Variables Descriptives

	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t</i> test	<i>p</i>
Level 1 Outcome Variables	Total (<i>n</i> = 407)		Urban (<i>n</i> = 212)		Rural (<i>n</i> = 195)			
Reducing internalizing behaviors	2.77	.81	2.79	.83	2.76	.78	-.32	.75
Reducing externalizing behaviors	2.87	.82	2.91	.79	2.85	.85	-.82	.41
Increasing prosocial behaviors	3.06	.80	3.04	.78	3.08	.83	.51	.61
Relationships with MHC	3.33	.65	3.34	.63	3.33	.67	-.14	.89
Level 2 Predictor Variables	Total (<i>n</i> = 57)		Urban (<i>n</i> = 32)		Rural (<i>n</i> = 25)			
Knowledge of and experience with HS	3.89	.27	3.86	.29	3.92	.24	0.85	.40
Relationships with Head Start families	2.91	.66	3.05	.71	2.73	.56	-1.82	.08
Relationships with Head Start staff	3.64	.38	3.73	.28	3.53	.46	-2.09*	.04
Consultant training, supervision, and support	3.34	.60	3.34	.56	3.34	.67	-.03	.98
Knowledge of early childhood mental health best practices	3.74	.38	3.72	.39	3.76	.38	.40	.69

Note.

**p* < .05

and knowledge of early childhood mental health best practices ($M = 3.74$, $SD = .38$). MHC relationships with staff was the only variable with mean differences between rural and urban / suburban MHCs (see Table 11). Urban MHCs rated their relationships with HS direct service staff ($M = 3.73$, $SD = .28$) more positively than rural MHCs ($M = 3.53$, $SD = .46$; $t = -2.09$, $p < .05$). In each of the HLM models, the five predictor variables were grand mean centered. Therefore, the intercept became the expected value of the outcome variable when the predictor variables had the mean value (Hox, 2002).

Multi-level Analyses

Research Question #1: What attributes of mental health consultants are most strongly associated with teacher-reported effectiveness of mental health consultation for improving child outcomes for rural and urban Head Start programs? Separate hierarchical linear models were run to determine the influence of each of the five level-2 mental health consultant attributes [(a) knowledge of Head Start and early childhood education; (b) relationships with families; (c) relationships with Head Start staff; (d) training, supervision, and support; (e) and knowledge of early childhood mental health best practices] on the three measures of staff-reported effectiveness of mental health consultation in improving child outcomes (reducing internalizing behavior, reducing externalizing behavior, and promoting positive social behavior). An interaction between rural and urban Head Start program location on MHC attributes was also tested to determine if any of these attributes were particularly important for rural or urban programs.

For example, the first model examined the relationship between MHCs' knowledge of Head Start and perceived helpfulness in reducing internalizing behavior. The level-1 covariates (HS staff race/ethnicity and HS staff experience) and the level-2 covariates (HS enrollment) were included in the model. For this model, the equations were:

Level-1

$$Y_{ij} = \beta_{0j} + \beta_{1j}HSEXP + \beta_{2j}HSRACE + r_{ij}$$

Where Y_{ij} is the mean score on "perceived helpfulness in reducing internalizing behavior" for staff person i working with consultant j . β_{1j} is the level-1 covariate "Head Start staff years of experience with the organization," and β_{2j} is the level-1 covariate "Head Start staff ethnicity." r_{ij} is a random error term.

Level-2

$$\beta_{0j} = \gamma_{00} + \gamma_{01}TOTKIDS + \gamma_{02}RURURB + \gamma_{03}KNOWHS + \gamma_{04}INTKNO + u_{0i}$$

$$\beta_{1j} = \gamma_{10} + u_{1j}$$

$$\beta_{2j} = \gamma_{20} + u_{2j}$$

where γ_{01} is the level-2 covariate "total number of children enrolled," γ_{02} is the "rural / urban" covariate, γ_{03} is the level-2 dependent variable "MHC knowledge of Head Start," and γ_{04} is the interaction term for knowledge of Head Start and being rural or urban. β_{0j} , the adjusted mean for "perceived helpfulness in reducing internalizing behavior" for MHC j , varies as a function of the mental health consultant's knowledge of Head Start. γ_{00} is the adjusted mean level of "MHC reduces internalizing behaviors" across all mental health consultants.

In analyzing the results, the variance of the intercepts was examined, which determined if perceived helpfulness in reducing internalizing behavior varied significantly across programs when controlling for MHC knowledge of Head Start. The variance of the slopes were also examined, which determined whether knowledge of Head Start is significantly related to perceived helpfulness in reducing internalizing behavior, and if this association varied significantly across programs. In addition, urban and rural status were included in the model to determine whether a program was urban vs. rural moderated the effect of MHC knowledge of Head Start on perceived helpfulness in reducing internalizing behavior.

Internalizing Behavior

The first analysis was a test of the fully unconditional model with reducing internalizing behavior as the outcome variable. The results indicated that the grand mean of reducing internalizing behaviors was 2.77 on a 1-4 point scale with higher scores indicating that the MHC “helped a lot” to reduce internalizing behaviors ($\gamma_{00} = 2.77, SE = 0.05, p < .001$). Teachers’ reports of the helpfulness of consultation in reducing internalizing behaviors varied significantly between mental health consultants ($\tau_{00} = 0.09, SD = 0.29, p < .001$), although the variation of teacher reports of internalizing behavior was greater within mental health consultants ($\sigma^2 = 0.57, SD = 0.75$) than between mental health consultants. The intraclass correlation coefficient, which is the proportion of variance in the outcome that is between groups (Raudenbush & Bryk, 2002), for internalizing behaviors was $\rho = 0.14$, such that MHCs accounted for 14% of the variability among teacher reports of internalizing

behavior. Therefore, the responses of teachers who worked with a particular consultant were on average more similar than the responses of teachers who worked with other consultants (Hays, 1973). Because the intraclass correlation coefficient was greater than zero, it was clear that some of the variability in the teacher responses on internalizing behavior could be accounted for by non-independence due to the nesting within consultants (Hays).

As shown in Table 12, the results of Model 3 for the outcome variable reduced internalizing behaviors, in which all level-1 and level-2 variables and covariates were entered into the model, revealed that none of the five mental health consultant attributes were significant predictors of Head Start direct service staff reports that mental health services help to reduce internalizing behaviors. In addition, there was not a significant rural/urban interaction effect.

Externalizing Behavior

The first analysis was a test of the fully unconditional model with reducing externalizing behavior as the outcome variable. The results indicated that the grand mean of reducing externalizing behaviors was 2.87 ($\gamma_{00} = 2.87$, $SE = 0.06$, $p < .001$). Teacher reports of the helpfulness of consultation in reduced externalizing behaviors varied significantly between mental health consultants ($\tau_{00} = .09$, $SD = 0.30$, $p < .001$), although the variation of teacher reports of externalizing behavior was greater within mental health consultants ($\sigma^2 = 0.58$, $SD = 0.76$) than between mental health consultants. The intraclass correlation coefficient for externalizing behaviors was $\rho = 0.14$, such that MHCs accounted for 14% of the variability among teacher reports of

Table 12
Full HLM Models

Dependent variable	Independent variable	Full model (standardized β)	SE	<i>p</i>
Reducing internalizing behaviors	MHC knowledge of HS	-.16	.23	.19
	MHC relationship with families	.06	.07	.42
	MHC relationship with HS staff	-.03	.11	.78
	MHC training, supervision, & support	.11	.10	.26
	MHC knowledge of children's mental health	.18	.12	.15
Reducing externalizing behaviors	MHC knowledge of HS	-.03	.15	.83
	MHC relationship with families	.06	.08	.46
	MHC relationship with HS staff	.07	.12	.57
	MHC training, supervision, & support	.13	.10	.21
	MHC knowledge of children's mental health	.21	.15	.16
Increasing prosocial behaviors	MHC knowledge of HS	.01	.19	.97
	MHC relationship with families	.05	.08	.52
	MHC relationship with HS staff	.15	.13	.23
	MHC training, supervision, & support	.18*	.10	.07
	MHC knowledge of children's mental health	.26*	.15	.08
HS staff relationship with MHC	MHC knowledge of HS	.00	.00	.98
	MHC relationship with families	.15*** ^a	.07	.04
	MHC relationship with HS staff	.21**	.09	.02
	MHC training, supervision, & support	.19*	.10	.06
	MHC knowledge of children's mental health	.00	.19	.97

Note. All models controlled for Level-1 covariates: HS staff experience (grand mean centered) and HS staff race; and controlled for Level-2 covariates: Program enrollment (grand mean centered).

^aDenotes significant rural/urban interaction.

* $p < .10$, ** $p < .05$.

externalizing behavior. Therefore, the responses of teachers who worked with a particular consultant were on average more similar than the responses of teachers who worked with other consultants (Hays, 1973). Because the intraclass correlation coefficient was greater than zero, it was clear that some of the variability in the teacher responses on externalizing behavior could be accounted for by non-independence due to the nesting within consultants (Hays).

Results of the full HLM model (model 3), in which all level-1 and level-2 variables and covariates were entered into the model, revealed that none of the five mental health consultant attributes were significant predictors of Head Start staff reports of reduced externalizing behaviors (see Table 12). Entering the rural / urban variable did not produce any significant interaction effects.

Prosocial Behavior

The first analysis was a test of the fully unconditional model with increasing prosocial behavior as the outcome variable. The results indicated that the grand mean of prosocial behaviors was 3.05, which corresponds to teacher reports that mental health services “somewhat helped” to improve prosocial behaviors ($\gamma_{00} = 3.05$, $SE = 0.06$, $p < .001$). Promotion of prosocial behaviors varied significantly between mental health consultants ($\tau_{00} = 0.10$, $SD = 0.319$, $p < .001$), although the variation of teacher reports of prosocial behavior was greater within mental health consultants ($\sigma^2 = 0.55$, $SD = 0.75$) than between mental health consultants. The intraclass correlation coefficient for prosocial behaviors was $\rho = 0.15$, such that MHCs accounted for 15% of the variability among teacher reports of improved prosocial behavior. Therefore,

the responses of teachers who worked with a particular consultant were on average more similar than the responses of teachers who worked with other consultants (Hays, 1973). Because the intraclass correlation coefficient was greater than zero, it was clear that some of the variability in the teacher responses on prosocial behavior was accounted for by non-independence due to the nesting within consultants (Hays).

Although none of the MHC attributes were significant predictors of increasing prosocial behavior, MHC training, supervision, and support and MHC knowledge of mental health best practices were significant at the level of a trend (see Table 12). These results revealed that Head Start direct service staff were more likely to report that consultation led to an increase in prosocial behaviors, if they worked with MHCs who reported that they received training, supervision, and support ($\gamma_{02} = .18, p < .10$) and who reported higher levels of knowledge of children's mental health best practices ($\gamma_{02} = .26, p < .10$). Entering the rural / urban variable did not produce any significant interaction effects.

Research Question #2: What attributes of mental health consultants are most strongly associated with teacher reports of the quality of mental health consultants and staff relationships for rural and urban Head Start programs? Separate hierarchical linear models were run to determine the influence of each of the level-2 mental health consultant attributes (knowledge of Head Start and early childhood education, comfort working with families, positive relationships with Head Start staff, level of training, supervision, and support, and knowledge of early childhood mental

health best practices) on the HS direct service staff-reported quality of their relationship with the mental health consultant.

HS staff relationship with MHC

The first analysis was a test of the fully unconditional model with HS staff reports of relationship with the MHC as the outcome variable. The results indicated that the grand mean of relationship with MHC was 3.32 on a 1-4 point scale with higher scores indicating that staff reported a more positive relationship with the MHC ($\gamma_{00} = 3.32, SE = 0.05, p < .001$). Teacher reports of their relationship with MHC varied significantly between mental health consultants ($\tau_{00} = 0.09, SD = 0.30, p < .001$), although there was greater teacher variation within MHCs on teacher reports of positive relationships with MHCs ($\sigma^2 = 0.58, SD = 0.76$). The intraclass correlation coefficient for HS staff relationship with the MHC was $\rho = 0.13$, such that MHCs accounted for 13% of the variability among teacher reports of HS staff-MHC relationship. Therefore, the responses of teachers who worked with a particular consultant were on average more similar than the responses of teachers who work with other consultants (Hays, 1973). Because the intraclass correlation coefficient was greater than zero, it was clear that some of the variability in the teacher responses on relationship with MHC can be accounted for by non-independence due to the nesting within consultants (Hays).

Several of the MHC attributes were found to be significant predictors of the HS direct service staff reports of their relationship with the MHC when controlling for both level-1 and level-2 covariates (see Table 12). HS direct service staff were more

likely to report a positive relationship with the mental health consultant when working with a MHC who reported a more positive relationship with the HS staff ($\gamma_{02} = .21, p < .05$). In addition, direct service staff were more likely to report a positive relationship when they worked with a mental health consultant who received higher levels of training, supervision, and support, which was significant at the level of a trend ($\gamma_{02} = .19, p < .10$). Finally, direct service staff were more likely to report a positive relationship with the MHC when they worked with a MHC who reported more positive relationships with families ($\gamma_{02} = .15, p < .05$). MHC knowledge of HS and children's mental health were not significant predictors of HS direct service staff reported quality of relationship.

Entering rural/urban did have a significant interaction effect for the impact of MHC relationships with parents on the HS direct service staff reports of the relationship with the MHC, but not for the other four MHC attributes. Bivariate analysis of rural and urban differences revealed that urban MHCs reported more positive relationships with families ($M = 3.05, SD = .71$) than rural MHCs ($M = 2.73, SD = .56$), although this difference was not statistically significant. As shown in Figure 2, the effect of the MHCs' relationship with parents on the HS staff report of their relationship with the MHC is greater in urban programs than rural programs ($\gamma_{04} = .32, p < .05$). Urban MHC reports of strong relationships with families are associated with urban Head Start direct service staff who report having a more positive relationship with the MHC, while urban MHCs who have a lower level of comfort working with families are associated with urban Head Start staff reporting a less

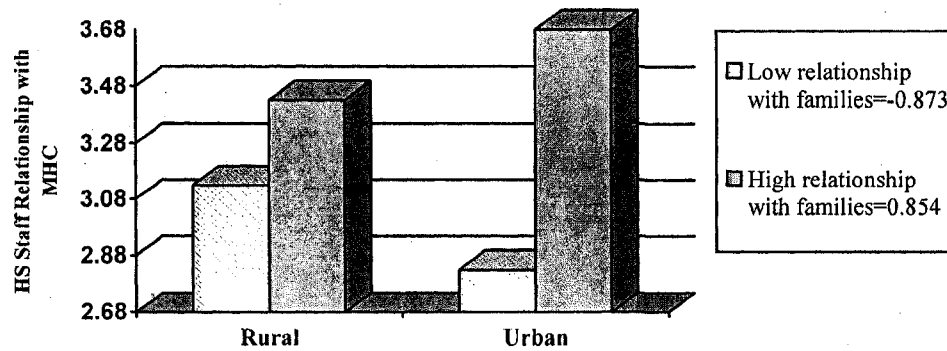


Figure 2. Rural/urban interaction for the effect of MHC comfort working with parents on HS direct service staff relationship with the MHC. $\gamma_{04} = .32, p < .05$

positive relationship with the MHC. Among rural MHCs, the association between rural MHCs relationships with families and their relationships with Head Start staff was not as strong.

Integration of Phase I and Phase II Results

Although results from Phase I and Phase II were analyzed and reported separately, the results from Phase I influenced the content analysis of Phase II. The concepts from the MHC attribute subscales of the Head Start Mental Health Services that were developed for Phase I were used to inform the coding guide for Phase II. In addition, rural and urban focus groups were coded and analyzed separately, but common themes for each code were identified across rural and urban groups, which reflects findings from Phase I. Differences in rural MHCs experience of providing consultation services were identified by analyzing and identifying themes for a separate code for rural issues. The results of the rural MHC experience are reported in research question three.

Phase II: Focus Groups

Research Question 1

The first research question for the qualitative focus groups was: *What are early childhood mental health consultants' perceptions of how to best develop relationships with staff in rural and urban Head Start programs?* When responding to the focus group questions, the mental health consultants described several strategies that they had used when developing relationships with the Head Start programs. Discussions within the focus groups about building relationships with Head Start staff

reflected several major themes: building relationships takes time; MHCs need opportunities to formally meet Head Start staff; Head Start administrators are key; MHCs must gain credibility with Head Start staff; MHCs need strong listening skills; and there are barriers to developing relationships.

Building Relationships Takes Time

Mental health consultants participating in focus groups discussed that building a relationship with Head Start staff takes time. A common strategy identified by MHCs in the focus groups was taking time to get to know the Head Start staff by spending time in the classroom and in the Head Start center. They explained that their relationships with Head Start staff developed over time, and this relationship was necessary to establish by meeting and spending time with staff, before beginning consultation work. Therefore, MHCs should “...*just to take time to get to know the people they are working with and visit the classrooms and spend time and not feel an urgency to start diving right in right away.*” Therefore, they recommended that MHCs begin building relationships early and advised that the relationship will improve with time. For example, this MHC explained, “*I had to do a lot of work really around who I am and what I do, and it took two years for the staff to accept me.*” Acceptance by the Head Start indicates that the MHC is developing a relationship with the staff.

Despite the need to take time to develop a relationship with staff, a MHC who responded to the focus group member check clarified that MHCs must create a connection with staff in a timely manner. This focus group member explained that, “*If change doesn't begin quickly, then teachers will give up on the MHC as a resource.*”

MHCs who are unable to develop a working relationship with staff members within a few visits may risk losing the staff members' confidence.

MHCs also explained that often the best time to develop relationships with Head Start staff was during unscheduled and unstructured time, which provided an opportunity for the MHCs and the staff to get to know each other. An urban MHC described this unstructured time by saying,

Things happen that don't happen when you have a scheduled time to talk with someone. The number of times that I was just in the hallway going from one classroom to the bathroom to another classroom and would be caught by a teacher or an advocate who would want to chat about something that they might not have remembered it if it had had to wait until the next scheduled meeting. When we had that kind of unofficial informal time, relationships blossomed more fully than I think they have been able to since then.

However, the MHCs recognized that having enough time with staff was challenging. The MHCs in the focus groups varied in the amount of time that they were able to spend with the Head Start program, and mental health consultants who worked with rural and suburban / urban differed significantly in the number of hours of consultation that they provided to the Head Start program per month ($t = -4.19, p < .01$). Rural MHCs reported providing an average of 20 hours of consultation per month ($M = 19.75, SD = 44.68$), which is approximately 5 hours per week. In contrast, MHCs who worked with urban or suburban Head Start programs reported providing an average of 98 hours of consultation per month ($M = 97.58, SD = 46.24$), which is approximately 24 hours per week. Yet both rural and urban MHCs discussed the need for more time to work with Head Start staff. For example, this urban MHC stated,

Another big barrier I think is just time, enough time to spend in a classroom or to spend when the teacher is able to sit down for lunch for a break or whenever it is, to have that time to talk about the classroom, to talk about life in general, just that basic time. Everybody is in a system of scarcity. It is hard to have enough time to really do that.

Opportunities to Formally Meet Head Start Staff

Focus group participants reported that it was essential to be introduced to the Head Start staff and to learn about each others' roles within the program. According to participants, when a Head Start administrator or mental health consultant who was familiar with the program provided early and formal introductions to the Head Start staff, the MHC and the staff immediately began building that trusting relationship by sharing their skills and strengths with each other. Through the formal introductions to Head Start staff, the MHCs had an opportunity to explain their ideas and their approach to providing mental health consultation services. As the following comments illustrated, MHCs needed an opportunity to meet the staff and to introduce themselves to staff,

I wish that I would have been more properly introduced to all the staff so that they knew who I was and that I knew who they were, so when I stepped into that system I knew who they were, what role they played in the students' and in the staffs' lives and what they expected of me.

MHCs also maintained that connecting with key Head Start staff members helped them learn about the program and connect with teachers. They said that the Head Start staff were a great resource for gathering information about the program. The key staff members identified by the focus group participants included education coordinators, family advocates, and administrative assistants. For example, this focus group member said, *"I would say family advocates and education coordinators*

probably are two key people and health, too, because you are working on the mental health aspect of it and that integrates so finely with the physical health."

Head Start Administrators and Management are Key

MHC reported that Head Start administrators played an important role in their relationships with Head Start staff. First, Head Start program administrators were essential for setting the tone for positive collaboration between the MHC and the staff by developing a clear vision of mental health services and conveying the importance of children's mental health.

I think what was really helpful to us is that ... the [management] had social work backgrounds, so they really understood what mental health was about and welcomed it, and were supportive about it... That was kind of our entrée, having people who were so supportive and introducing us in such a positive way and us really sitting down and spending time together in the first couple of months with sharing ideas about how to really infuse the system with mental health and how to mostly begin by making relationships with teachers and to try to help make their lives easier. I'd say that is where we really started building some trust.

MHCs described how it was important for them to work with Head Start program administrators to establish boundaries around the roles of the MHC. They explained that to maintain trusting relationships with Head Start staff, they had to work with the Head Start administrators to ensure that their role would not be seen as punitive by the teachers. The MHCs explained to the administrators that mental health classroom observations and consultations should not be used to evaluate teacher performance. If teachers believed that the observations and other consultation activities conducted by the MHC would be used for performance evaluation purposes, then they may not be open about the challenges that they faced in the classroom. As illustrated by the

following statement, MHCs established boundaries that clarified that they did not have a supervisory role over Head Start staff,

I told the director and the mental health and disabilities coordinator when I first came on that I just wanted to be really clear that teachers shouldn't hear about problems that they have in the classroom because of my observations. I saw that as really important because I could offer the program a lot of support if the teachers didn't have any reason to fear my coming into the classroom. So I would do everything I could to set the teacher's mind at ease but I also needed the program to understand that when I go in [to the classroom] that I meet with teachers and my goal there is to support them, not to call attention to all the things that they could be doing that they are not doing.

According to the MHCs, an important aspect of developing a positive relationship with Head Start staff was being seen as a support person, rather than a supervisor or an adversary.

Gain Credibility with Head Start Staff

According to focus group participants, gaining credibility with Head Start staff was an important means of developing relationships. They explained that Head Start staff became more comfortable with MHCs when they understood their approach, their style, and their skills. To gain credibility with staff, they had to demonstrate their ability to work with preschool age children, which is illustrated in this statement, "*You can have all of the clinical expertise in the world, but if you look like a deer in the headlights when you go into the classroom, you lose credibility.*" The MHCs who attended the focus groups identified several means of sharing their skills with Head Start staff and gaining credibility with teachers, such as conducting staff and parent trainings, being competent in their interactions with children, spending time in the classroom or on the playground, or leading a children's group during circle time.

It helps a lot for me when I do training for the staff and training for the parents, because they get to know me. So when we have the conversations, the feedback and stuff, it is on a different level. It is another kind of relationship.

Use Strengths-Based Approach

A strengths-based approach was reported by these MHCs to be an important means of developing relationships with Head Start staff. According to the focus group participants, a strengths-based approach in providing observation feedback or discussing classroom challenges with staff helped the staff to feel that the MHC understood their challenges and set the stage for discussing children and families. MHCs stated that praising staff and having a positive approach when discussing children, families, or classroom and program challenges was important to building relationships. These ideas were reflected in the following statement,

Try to be positive. Hopefully, if you are consistently present there in her classroom, you are helping out, and you are being positive, then she will eventually come to you and talk with you about specific children that she is concerned about. Just put some faith in the building of that relationship.

Listen to Staff

Focus group participants stated that listening to staff and soliciting staff input, ideas, and feedback helped to build relationships with Head Start staff. Rather than immediately offering suggestions for change, the MHCs described that it was more effective to elicit staffs' ideas about how to respond or intervene. By listening to staff, MHCs gained a better understanding of how and why Head Start staff do things. It also gave MHCs an opportunity to learn about the challenges that Head Start staff were experiencing. Listening to staff helped to equalize the power differential by

placing the teacher, rather than the MHC, in the role of the expert. This statement illustrates the power of listening,

I just solicit her opinions about the kids that I see without actually saying I think they have behavior problems. I just ask her opinions about those kids, what she thinks about them and what she has done with them, just to let her have a chance to speak before I would venture to saying anything about them. I hope that maybe she might say something that I can concur with that would lead into a discussion of further intervention.

Barriers

During the telephone focus groups, MHCs identified several barriers to developing relationships with Head Start staff. Both rural and urban MHCs identified the program's relationship with the previous MHC as a potential barrier to developing a relationship. When Head Start staff had a negative experience with the previous consultant, MHCs found it difficult to begin building relationships with the staff, which was revealed by this comment,

Prior to my being in this program they had had a different mental health person every year for several years. The first year they were just waiting to see if I was going to actually come back the second year or not.

The stigmatization of mental health challenges is another potential barrier that may affect the relationship between the MHC and Head Start staff, according to the focus group participants. The following statement reflects the challenge of overcoming the stigmatization of mental health providers that MHCs may face:

I think people have a lot of perceptions or misperceptions about mental health and what a mental health provider may know. I think there is just some reticence on the part of some staff folks and families. It is kind of like we are interested, but we don't know if we want you in our business.

According to the focus groups, many Head Start staff and families may have had negative past experiences with mental health professionals. These past experiences may contribute to their reluctance to refer children to the mental health consultant or their comfort in developing relationships with the MHC.

In summary, the rural and urban MHCs who participated in the focus groups described a very active process of developing relationships with Head Start staff. They discussed the importance of having a variety of opportunities to meet and to be introduced to Head Start staff, as well as having the time to develop relationships. In developing relationships, MHCs explained that while it is important to gain credibility with the Head Start staff, MHCs must also approach staff with a strengths-based approach and an open ear that places the staff in the role of the expert. Despite strategies for developing relationships with Head Start staff, MHCs stated that the stigmatization of mental health services and staff members' previous experience with MHCs or other mental health professionals may be present challenges in developing positive relationships.

Research Question 2

The second qualitative research question was: *What are MHCs perceptions of the skills, attributes, and supports needed to build positive relationships with Head Start staff and to produce positive consultation outcomes in rural and urban Head Start programs?*

MHC Role Clarification

Understanding the role of the MHC was not initially identified as an *a priori* attribute, but while reading and coding the transcripts, it emerged as a strong and consistent theme throughout the rural and urban focus groups. Both rural and urban mental health consultants discussed that they and the Head Start staff that they worked with needed a better understanding of the roles and responsibilities of a mental health consultant. Focus group participants described feeling confused about their role as a mental health consultant, which affected their ability to develop relationships with Head Start staff and to provide effective services. In addition, the Head Start staff were often unfamiliar with the roles and responsibilities of the MHC, which limited their ability to effectively use the services of the consultant. As illustrated by this focus group participant, MHCs often entered their work with the Head Start program without a clear understanding of their role,

One thing that was difficult is I was unclear of my own role. I didn't really know what was the expectation and what it was that I could provide. I feel like Head Start kind of expected me to be helpful therapeutically, yet my role was as a consultant. I think they also were confused about what is it that a consultant does. Perhaps I still have some confusion about that, actually.

To address the lack of clarity around the mental health consultant role within Head Start programs, consultants in the focus groups believed that MHCs should work closely with the Head Start program to determine the roles and responsibilities of the MHC and to establish a program-wide vision of mental health services. Focus group participants disclosed that it was helpful when they worked with the program to

determine the focus areas of the consultation, which included children and classrooms, families, staff, or the program. For example, a rural MHC said,

I kind of went in thinking, at first, that kids who were significant problems would be where the consultation lies. It ended up to be much more global than that, kind of like the systems theory of a little Head Start. Management of the group in general ended up being where my focus lies.

However, the consultants in the focus groups acknowledged that their role as a MHC changed over time, particularly as the staff and program became more familiar with their skills and began to develop a relationship with the consultant. For example, early in the relationship, the program may only want the MHC to do classroom observations, but by the end of the year the staff may be asking the MHC to observe individual children or provide parent trainings in addition to conducting classroom observations.

Both rural and urban mental health consultants identified establishing boundaries as an important aspect of clarifying and defining the role of the MHC within the Head Start program. Once their role was established and agreed upon by the MHC and the program, the participants explained that they had to continually draw boundaries around what they could and could not do as a mental health consultant. They explained that the children, families, and staff within Head Start programs that they worked with often faced challenges that exceeded the scope of their mental health consultant role. In addition, they felt that the communities did not have the adult or child mental health services to meet the needs of children and families. Consequently, they felt that the Head Start staff often hoped that they could do more than they were actually able to do, which is reflected in this statement by a focus group member,

I think it is important for the consultant to understand what the limits are, and to be able to convey them, because there is a lot more that needs to be done, and I agree there is a tendency to at least want to help in all areas, but to recognize that that is just not possible. The consultant would need to be able to set the limits and consistently keep them, because people forget and try again [to get services not agreed upon].

Focus group participants also pointed out that many Head Start programs do not have the resources to provide staff with the level of social and emotional support that they need to continue to effectively provide for and educate young children with social and emotional challenges. Consequently, Head Start staff and programs often turn to the MHC as a resource for a range of needs that are beyond the scope of the services that they agreed to provide. By establishing boundaries, the MHCs explained that they avoid taking on too many roles within the program, so that they can more effectively provide the consultation services that they agreed to provide.

Finally, rural and urban MHCs who participated in the focus groups discussed the importance of continually educating Head Start teachers, family advocates, and other direct service staff about the role of the mental health consultant within their Head Start program. The focus group participants expressed the idea that Head Start direct service staff often do not have knowledge of the role of the consultant, even if the Head Start administrators and the program have a clear vision of the role of the consultant within the program. Therefore, the MHCs in the focus groups stated that it is necessary to personally inform Head Start staff about the role of the mental health consultant and to provide staff with detailed information, such as who you are, when you will be at the center or in their classroom, and what you will do while you are there. For example, this urban MHC explained, *“It certainly helps at the beginning of*

the school year to talk to the team about what my style is or what I am going to be doing and looking for and when I will be coming.” The focus group members identified this part of role clarification as an important aspect of developing trust relationships with the Head Start staff.

Relationship with Head Start Families

The rural and urban mental health consultants who participated in the focus groups identified their work with families as an important aspect of their role as a mental health consultant, because they believed that many families were eager for information about and support for their child’s social and emotional health. The focus group participants disclosed that supporting the needs of families required them to develop working relationships with families. Developing relationships with families, according to the MHCs in the focus groups, was dependent on MHCs having opportunities to connect with families, maintaining a family centered approach with families, and being culturally sensitive.

Mental health consultants who participated in the focus groups discussed the need for opportunities to connect with families as an important aspect of developing relationships with and providing services to families. Focus group participants identified home visits and parent trainings as an important means of connecting and developing relationships with parents. Parent meetings and parent trainings were identified as opportunities to introduce themselves to parents and to discuss their background, knowledge, and skills. They were a way for MHCs to connect with

parents in a manner that was non-threatening, as illustrated by this rural mental health consultant,

If I could be more involved with some of the activities that the Head Start centers have for parents, that is just another way for them to get to know me, and maybe not feel the stigma or shyness or whatever it is about asking questions about child development, just asking general questions, see what is happening at home, what could I do. I would like to be more involved with the families.

The focus group participants disclosed that Head Start programs can support MHCs in developing relationships with families by inviting MHCs to join them on a home visit or to participate in parent trainings or parent committee meetings. For example, an urban MHC stated that when establishing relationships with parents, she relied on her relationship with the staff and built upon their relationship with the family,

A lot of what we did was piggyback onto the teacher's trust relationships with the families and kind of come in the door along with our relationships with the teachers, so that they felt safer and could be more open.

Although the focus group participants felt that having opportunities to meet with parents was important, many mentioned that they would have liked more opportunities to connect with parents, which is reflected in this statement by a rural MHC, "...if I would have been more included with the introduction to the parents, working with the parents and operating from what their needs and where they are coming from, I think it would have been very helpful and everything there." The consultants in the focus groups emphasized that, regardless of the means of connecting with parents, they needed to remain flexible and willing to be available at times that were convenient for family members.

MHCs who participated in the focus groups discussed using a family-centered and strengths-based approach when working with families, as illustrated by this MHC who works with rural Head Start programs, *“I also think that being a person who is more family-centered in their thinking and looks at the situation from a strengths-based perspective is real important.”* Using a family-centered and strengths-based approach was considered by consultants to be supportive of the Head Start philosophy that the parent is the child’s first teacher. MHCs asserted that it was important to recognize that the parents were the experts on their children, so they sought to learn from the parent. The focus group participants described the importance of meeting families where they were and recognizing that families may have had a range of experiences, including negative experiences, with mental health providers or educators, which may have limited their ability to address their child’s emotional and behavioral challenges. For example, this consultant stated,

The other thing is also understanding and going at the pace of the parents and not pushing too far, but letting them have a good experience with a mental health person. A lot of these folks have really had a negative experience with systems, with mental health people, schools, and [I am] just trying to turn that into a positive experience for them.

Maintaining a family-centered and strengths-based approach, according to information provided by rural and urban focus group participants, allowed them to develop positive working relationships with diverse Head Start families.

Finally, cultural sensitivity was a key component of focus group participants’ ability to develop relationships with Head Start families. Understanding the culture of the family and the community was essential for working with families, and several

stated that bilingualism is an important skill or attribute of a MHC. They explained that MHCs should understand the impact of the stigmatization of mental illness within cultures and within communities on families' willingness or ability to seek mental health consultation services. The cultural stigma surrounding mental health may present a barrier for developing relationships, which is articulated by this urban MHC,

I think it is vital is they really, absolutely have to understand cultural differences and the implications for families when their child has been referred to a mental health consultant, even just coming to observe that child in the classroom. I think it is so threatening for some families and so intimidating.

MHCs within the focus groups also identified the challenges that low-income families face as an important aspect of culturally sensitive work with families of children enrolled in Head Start. According to the participants, MHCs who work with Head Start programs should have experience working with low-income families. Prior experience will help MHCs to be sensitive to the possibility that low income families may face challenges that affect their ability to utilize and implement the supports and services provided by the mental health consultant and the Head Start program.

Knowledge and Experience with Head Start and Early Childhood Education

The mental health consultants who participated in the focus groups varied in the depth of experience that they had working with Head Start programs. Some of the consultants were in their first year of work with the Head Start program, while others had worked with the program for up to 25 years. On average, the participants had worked with the current Head Start program for approximately 6 years ($M = 5.99$, $SD = 6.31$), and there were no significant differences between rural and urban consultants ($t(15.21) = -1.93$, $p > .05$ (equal variances not assumed)). Several of the consultants had

previous experience as employees in Head Start or early childhood education programs in capacities other than as the mental health consultant. Positions they previously held included preschool or Head Start teacher, nutritionist, family advocate, and Head Start parent. Experienced and inexperienced focus group participants alike expressed the view that MHCs should have knowledge and experience in the philosophy and structure of Head Start programs as well as in early childhood education and child development.

Head Start mental health consultants who participated in the focus groups discussed the importance of understanding the Head Start philosophy and Head Start culture. The consultants maintained that it is especially important for contracted MHCs, compared to MHCs employed by the Head Start program, to understand the philosophy and value system of Head Start, which was illustrated by this rural MHC,

Head Start has its own kind of philosophy and value system. Unless it is very, very clear to the person who is coming, particularly if it is a mental health consultant that is coming in from a different agency or is a contracted person or an independent contractor such as myself, it is hard to know, unless you keep constantly on that, what is the value system. Are we speaking the same language? When you are coming from being within that organization, it is a given that you are speaking the same language. When you are being hired out or as a contracted position, it is not a given.

Focus group participants also believed that MHCs should understand the Head Start value system that emphasizes child development and kindergarten readiness and places the parent as the child's first teacher. In addition to familiarity with the Head Start philosophy and values, focus group mental health consultants expounded on the need for MHCs to be familiar with the Head Start program structure.

Mental health consultants who worked with rural and urban programs expressed the importance of understanding the structure of the Head Start program. Across focus groups, consultants viewed the Head Start program as a complex system with many intricate layers. According to the participants, they needed to learn about the Head Start system from the federal level down to the local level, and how those layers of the system have an impact on the mental health consultation services that they provided to Head Start children, families, staff, and programs. A rural MHC said,

I felt real fortunate because... I was a parent and policy council chairperson, and I have had many experiences with Head Start. I have a good understanding of how it works, but I know that many people come into it without that background and it really is important to have that opportunity to learn about just the program itself, from the federal level on down.

At the federal level, they said that it was helpful to be familiar with the Head Start Performance Standards, which are the federal guidelines that all Head Start programs are required to implement. The Head Start Performance Standards mandate the mental health consultation services that MHCs provide, so they should have a working knowledge of these standards. For example, this MHC stated,

I think when I started, the idea of the Head Start Performance Standards was new to me. I don't think I ever got an overview of the performance standards, what they are and what types of things they cover. That type of thing probably would be helpful, and certainly just being made aware that they exist [is important].

In addition to the structure of the Head Start program at the federal level, MHC focus group participants discussed the need for an orientation to the Head Start structure at the program level. MHCs explained that it was helpful for them to be familiar with the program-level policies and procedures that are based on the

Performance Standards. In particular, it was advantageous for the MHCs to have access to policies specific to children's mental health, such as the procedure for conducting mental health screenings, "*The Head Start programs all have to do some sort of behavior screening ..., and [you need to know] how the Head Start has policies set up for identifying those kids.*" MHC focus group participants explained that reviewing the program policies provided them with insight into how the Head Start program worked. In addition, they found it useful to become familiar with the ages and number of children that the program serves, the hours of operation, and the staff work schedules. For example, this rural MHC said, "*...the migrant Head Start program is very, very short here. It was like four months in a year. It is really hard to get organized and everything running.*" According to focus group participants, knowledge of the details of the Head Start program structure helped them to better coordinate with teachers and other staff and to establish effective consultation services.

Another aspect of the Head Start structure that MHC focus group participants identified as important was the roles and responsibilities of each of the Head Start staff members, including management, coordinators, teachers, assistant teachers, and family advocates. They explained that it was helpful to be oriented to the role of each of the staff members, and to the way the roles of staff members interface with the roles and responsibilities of the MHC.

I think one of the pieces is an understanding of roles. If it is a multidisciplinary team, what is the role of this person or that person? I certainly had to participate in conversations about the teacher is going to cover this in their role as teacher. The family worker is going to cover this,

because their role is slightly different. So understanding how each person is functioning in their role contributes to an overall understanding that then allows the consultation to be more effective.

According to focus group participants, the MHC should also become aware of how staff members interact with each other, how management supports the staff, and how the MHC might work to support each of those roles.

Finally, focus group members asserted that in addition to understanding the Head Start program, to be effective MHCs must have experience in early childhood education, knowledge of child development, and an understanding of the challenges teachers face educating young children. Participants explained that early childhood education is quite different from K-12 education, so to be effective MHCs should be familiar with the language and approach used in early childhood settings. For example, this urban consultant explained that,

...they talk in terms of defining gross motor skills, expressive and receptive language and these different developmental concepts – adaptive skills, social emotional development. [It is important to know] how the different screenings are done in each developmental area, because you have got to look at the child from a total developmental perspective and get all the information on that child's development.

According to focus group participants, knowledge of early childhood development is essential to providing mental health consultation services in Head Start.

Conversation within the focus groups highlighted the need for MHCs to understand the challenges of teaching a classroom of preschool age children. MHCs with prior experience in early childhood settings explained that those experiences allowed them to understand and to empathize with teachers. Both rural and urban consultants believed that teaching young children in Head Start programs, especially

young children with social and emotional challenges, is difficult and stressful work. According to these consultants, to be effective, a MHC should have empathy for the challenges that teachers face in the classroom and understand that often teachers are doing the best they can. When discussing why a teacher may be unwilling to discuss challenges that children are facing in the classroom, this MHC said,

They don't really want to share that kind of information with you because they hold themselves to such a high standard that if there are behavioral issues in there, that somehow it is their personal failure, that they are just not keeping it all together. That somehow it is a reflection of them not doing their job well.

MHCs also explained that understanding the early childhood classroom environment will help the MHC understand the time constraints teachers encounter that may conflict with opportunities to observe or to consult with teachers in the classroom.

Cultural Sensitivity

All of the focus group participants who worked with urban and suburban Head Start programs identified as Caucasian ($n = 12$), while of the 14 rural mental health consultants, 2 identified as Hispanic and 3 identified as biracial. Despite the relative homogeneity of the focus group participants, cultural sensitivity was a consistent theme across rural and urban focus groups. The rural and urban mental health consultants who participated in the focus groups consistently described the need to integrate culturally sensitive practices into their work with Head Start programs.

Both rural and urban focus group participants described how self-awareness is an important skill for working with culturally diverse children, families, and staff in Head Start programs. According to MHCs in the focus groups, cultural sensitivity

begins with an understanding of one's personal culture, history, and assumptions, which is illustrated by this rural MHC who explained,

So from the very beginning really... recognition of one's own self, one's own values, one's own belief system, one's own culture, to really know yourself in a certain way so that ...you can be open and helpful and not condescending and not off-putting to the people that you are working with. So...the first piece is knowing yourself and then having great insight...into your own self and your own culture.

MHCs described bringing a sense of curiosity to their work with children, families, and staff of different cultures. The consultants explained that through this curiosity, they were able to admit when they did not have knowledge and or experience with the culture of a particular child and family and ask the teacher or parent to educate them.

An urban MHC illustrated this by saying,

It is pretty obvious I am a white male...When I've been called to consult and the teacher is either of another culture or the kid we are talking about is of another culture, I just ask the teacher to educate me... Give me as much information that will help me understand the complexity of this kid's cultural environment as is possible, and calling upon the teacher to be the expert rather than the person in need of consultation.

In addition to self-awareness and curiosity, focus group participants said that working with children, families, and staff of different cultures required them to see and understand differences, to be non-judgmental, and to be willing to learn.

The mental health consultants who participated in the focus groups discussed overcoming language barriers as an important skill. Both bilingual and English-only speakers within the rural and urban focus groups expressed the belief that Head Start MHCs should be bilingual to meet the needs of Head Start children, families, and staff. This urban MHC asserted,

[MHCs] should be bilingual. I am not, and the person that I supervise is not. It is a big issue. It means that when I was doing some of the mental health consultation and I had a Spanish speaking family that I needed to consult with, I went with a teacher or I went with somebody who was bilingual. We found a way to work around it, but we shouldn't have to do that. Bilingual is, I think, crucial.

MHCs who were not bilingual stated that it was essential that to have had experience working through an interpreter. They often used the skills of bilingual Head Start program staff to assist with translation.

When discussing the importance of cultural sensitivity, focus group participants also described the importance of learning about and understanding the community where the Head Start program was located. They explained that several cultural groups may reside within one community, and that they needed to become familiar with each of them. This focus group participant said,

I think especially if it is a person new to the area, just kind of understanding the culture of the community is important. For example, where I live it is an agriculture-based community. We have a fairly substantial American Indian population that we work with as well as a fairly substantial Hispanic population. There just are certain things about each one of those groups of people that are just important to know and would be helpful, I think, for a mental health consultant to have some kind of insight into.

Therefore, the MHC must become familiar with the community and the culture of the children and families within the community.

Throughout the discussion of culturally sensitive practices, MHCs described the need to understand the impact of poverty on Head Start children and families. They explained that because the majority of children and families participating in Head Start meet the federal poverty income guidelines, they share a common experience of poverty. Working with low-income families required participants to

remain non-judgmental and to recognize that factors related to poverty may affect a family's ability or readiness to engage in the mental health consultation process. As described by this urban MHC,

I think a background with some experience working with people who have very little money and someone who gets the notion of a parent needing to figure out that they have either enough gas to come to parent night or enough gas to go to the grocery store the next day. That is not a reflection on somebody's investment in being a parent. I think it is easy for people to get judgmental about parents who don't come to things or who don't keep appointments.

MHC Training, Supervision, and Support

All of the mental health consultants who participated in the focus groups had at least a Master's degree, and one MHC had a doctoral degree. The consultants represented a variety of professions including 8 counselors, 2 psychologists, 1 psychiatrist, and 15 social workers. MHCs were employed by Head Start programs (15%), community non-profits (31%), government agencies or Native health corporations (31%), or they were therapists in private practice (15%). Throughout the focus groups, the participants discussed their ideas about the level of education, the skills, and the experience that they believed professionals need to provide consultation services to Head Start programs. Most believed that a MHC should have a Master's degree, and many believed that licensure was important. While at least one MHC believed that a Master's degree was not necessary, participants across rural and urban focus groups discussed the importance of experience in children's mental health, early childhood education, working with low income families, child development, and classroom behavior management. This idea is summarized by an urban MHC who said,

I think there is a difference between education and training and licensure, and the individual skills and temperament that meet with the job, because it requires a lot of different knowledge... about child development and Head Start standards and mental health and attachment theory and throw in just general classroom behavior management, but also being able to think on your feet with a teacher.

Regardless of the educational or professional background of MHCs, participants believed that to be effective, MHCs need training, which should include a program and community orientation and training in mental health consultation, which is illustrated by this urban consultant,

I think it has been part of our orientation that really kind of explains that systems approach to consultation, kind of treating the whole system as your client. I think that that is really helpful. I think knowing what the community resources are is really important and networking with other people and having a lot of support to do it, as well as, I think, staying current on all the different trainings there are – the trainings on brain development and attachment, and new models of parent training, and all of that.

According to the focus groups, MHCs should receive training that orients them to the Head Start program and to the community. The Head Start program orientation should provide the MHC with an introduction to the Head Start staff, an overview of the Head Start structure, and a discussion about the role of the mental health consultant within the program. The orientation to the community should provide the MHC with information about community resources and how they interact with the Head Start program. In addition to the Head Start and community orientation, focus group participants discussed the need for specific training on early childhood mental health and providing early childhood mental health consultation services. The consultants mentioned a variety of training resources, including *Mental Health*

Consultation in Early Childhood (Donahue, Falk, & Provet, 2000) and *Early Childhood Mental Health Consultation* (Cohen & Kaufmann, 2005).

The mental health consultants discussed seeking and receiving support in their work as central to providing effective consultation services to Head Start programs, because mental health consultation “*is incredibly intense and demanding work, and we have to interact with so many people about so many complex issues.*” Within the focus groups, the participants said they often turned to Head Start staff, such as education coordinators, family advocates, and teachers, for support. However, they described providing mental health consultation services as very isolating work, and that they needed support from other mental health consultants. However, many stated that they had never had the opportunity to meet with other MHCs, as illustrated by a rural MHC who said,

I would love to meet with others and maybe have little workshops together about strategies and considerations, kind of a training of sorts. There hasn't been anything like that offered to me, and I don't think it has existed here in Oregon. So that is one idea that I have that would be helpful to me.

The MHCs in the focus groups who did receive support from other mental health consultants believed that it provided them with opportunities to gather new ideas, problem solve, vent frustration, and discuss challenges.

Finally, MHCs discussed the importance of supervision in their work. When discussing their own experience with supervision, MHCs revealed a variety of levels of supervision, including supervision by a Head Start supervisor, a mental health supervisor, and a clinical supervisor. Throughout rural and urban focus groups, clinical supervision was declared as the most desirable form of supervision. A rural

mental health consultant described her experience with Head Start supervision versus clinical supervision,

My supervisor at Head Start doesn't have nearly the experience that I do..., and I think she doesn't feel really comfortable always as a supervisor for me. She is not so helpful in that respect, but my LCSW [clinical] supervisor is very helpful, so that really has been good for me. I'm almost finished now and I was just thinking about what am I going to do when I don't have my [clinical] supervisor to talk to anymore. I may continue just on an individual or private basis from time to time, because it really has been useful for me.

Although clinical supervision may be useful, as it was for this MHC, other focus group participants and a peer reviewer suggested that to be effective clinical supervisors must have knowledge and experience in early childhood mental health consultation with Head Start programs.

Regardless of the form of supervision, focus group participants maintained that the supervisor should have knowledge, training, and experience in children's mental health and early childhood mental health consultation with Head Start programs to be effective, which is illustrated by this urban MHC who stated, "*I am 'supervised' by the person that hired me from the mental health agency, but that person is sort of distanced from Head Start, so it hasn't been very helpful.*" The MHCs described that the purpose of the supervision is to ensure that the MHC is meeting the needs of the Head Start program, to answer questions, and to support the MHC. Without strong knowledge and experience in Head Start and in early childhood mental health, care, and education, both task and clinical supervisors may be unable to provide effective and informative supervision to Head Start MHCs.

Knowledge of Early Childhood Mental Health Best Practices

The mental health consultants who participated in the telephone focus groups were typically very experienced in children's mental health, and the average number of years of experience was approximately 11.5 years ($M = 11.54$, $SD = 8.93$). Only 3 of the participants had less than 3 years of experience in early childhood mental health, 46% had 4 to 10 years of experience, and 39% had 10 to 35 years of experience. In the discussion of early childhood mental health best practices, the focus group participants described the importance of avoiding the stigma against mental health, which they believed alienated Head Start staff and families, by focusing on child behavior and by referring to themselves as a behavioral specialist rather than a mental health consultant. A rural MHC described this reframing by saying,

I guess I did kind of pass myself off as a behavioral specialist. "What are the behaviors in the classroom that you have the most trouble with?" They were, of course, willing and very eager to talk about that, from that standpoint. Then I could bring in some of those other more specific mental health issues.

The consultants felt that by focusing on child behavior they could begin to develop relationships with staff and families, so that they might establish the trust needed to approach topics of social and emotional health. When working with Head Start staff and families to address the mental health needs of young children, it was crucial to utilize a strengths-based approach, which was described by this urban MHC who stated, *"As you have started by really acknowledging all those strengths, then you could start just intervening in a non-threatening, not a big way, but just kind of helping out with some of those challenging behaviors."*

In addition to approaching their work with children, families, and staff from a strengths-based perspective, the MHCs in the focus groups identified several additional skills that are essential for implementing early childhood best practices in the Head Start setting. First, they described the need for MHCs to have good observation skills. Based on information provided in the focus groups, classroom observations are a key means of gathering information about the social and emotional environment in the classroom and providing feedback to Head Start teachers. Second, the participants believed that MHCs should have knowledge of early childhood screening and assessment tools. Third, MHCs should have knowledge and experience with the DSM-IV and early childhood mental health diagnosis. Fourth, MHCs should have strong communication and therapeutic skills to help them develop relationships and connect with children, families, and Head Start staff. Finally, they explained that knowledge of early childhood development, including physical and emotional development, is essential for providing effective early childhood mental health consultation services.

Research Question 3

What are the challenges and barriers to providing mental health consultation in rural areas?

Five of the 8 focus groups included mental health consultants who worked with rural Head Start programs. Three of the rural focus groups included mental health consultants from rural Oregon, and two of the groups included mental health consultants from Alaska. A total of 14 mental health consultants who worked with

primarily rural programs participated in the telephone focus groups (see Table 10). Of these rural participants, 85% were female. Two of the rural mental health consultants identified as Hispanic, 3 as biracial or other, and 6 as White. All of the rural participants had a master's degree; 29% self-identified as counselors, and 64% self-identified as social workers. Eight of the rural MHCs worked for a non-profit or government agency, 4 were in private practice, and 1 was employed by a Head Start program. Although the mental health consultants who worked with rural Head Start programs were experienced in children's mental health (78.6% had four or more years of experience in children's mental health), many of them were not very experienced in working with Head Start programs, as 71% had three years or less experience working with Head Start.

In order to identify the challenges and themes that were unique to rural MHCs, themes from the five rural focus groups were identified from the quotations that were associated with the code "rural issues." Three themes were identified regarding the challenges of providing early childhood mental health consultation services to rural Head Start programs. First, mental health consultants who participated in the telephone focus groups discussed feeling isolated in their work. Second, they revealed the importance of relationships in rural communities, and that mental health consultants working with rural Head Start programs must take extra care to respect the importance of relationships within rural communities. Finally, the telephone focus group participants said that it is essential to understand and respect the rural community and the rural lifestyle.

Isolation

Rural mental health consultants in the focus groups discussed isolation as a challenge of providing early childhood mental health consultation services to Head Start programs. The MHC participants explained that they are not only isolated from other mental health professionals in general, but also that they are isolated from others who are providing early childhood mental health consultation services. Mental health consultants working with rural Head Start programs may have never met another Head Start MHC:

I would love for there to be some kind of statewide meeting of mental health consultants so I could meet others that are doing my job, because I feel so isolated. I guess that is one piece of being rural. I feel very isolated and I've never met hardly anybody else who does my job. I feel like in many ways I am groping in the dark.

Many of the rural MHCs described traveling great distances to visit the Head Start program. For those mental health consultants traveling to remote Head Start programs as contracted mental health consultants, they felt isolated because not only are they outsiders because they are the only mental health professional, but also because they are not part of the Head Start organization. For example this consultant stated, "You know what I mean, there is that isolation of not living in the community and then being a contract employee and being the only behavioral specialist."

MHCs discussed that geographic isolation affected the services they felt that they could provide to children, families, and Head Start programs. The cost and time associated with travel between geographically distant Head Start programs often limited the amount of consultation hours that the consultant could provide for

programs. In fact, the rural MHCs provided significantly fewer hours of consultation services (approximately 20 hours per month) than urban MHCs, who provided an average of 98 hours per month ($t(20) = 4.08, df = 20, p < .01$).

Finally, MHC participants discussed how isolated rural communities often experienced a lack of mental health services for young children, which influenced their work as MHCs. Isolation from early childhood mental health professionals provided an additional burden for mental health consultants working with Head Start programs, because they were often the only resource for early childhood mental health services. Consequently, MHCs at times felt overwhelmed by the need for services that they were unable to provide.

I think being in the rural area, it is challenging because of the lack of resources and knowing how and where to refer kids on to when they need more extensive evaluation or therapy or services than what we can provide in Head Start. That is challenging.

Relationships in Rural Communities

Focus group participants who worked with rural Head Start programs discussed the importance of relationships within rural communities and how those relationships affected their work with Head Start programs, children, and families. Mental health consultants who worked in rural Head Start programs discussed the challenges that they had in maintaining dual roles within small, rural communities. For mental health consultants in rural areas, they described being easily recognized as the mental health provider by members of the community, which they identified as both a strength and a challenge. For this MHC, familiarity with families was an

advantage in approaching them about the difficult subject of their child's mental health,

Because I know some of [the families] anyway, I could kind of be, maybe a little bit not informal, but I could interact with them in a way to say, "I know it is kind of intimidating what I do, but let me just tell you about what I know and let me see if this is something you guys are interested in hearing more about."

At other times the dual role made it challenging to separate from being the mental health provider outside of work hours. As a result, maintaining client confidentiality was considered critical by rural MHCs. This rural MHC discussed the challenges of the dual role by saying, *"When you go to the grocery store it is hard to wear the hat of being a friend or a neighbor as opposed to being a mental health consultant or a psychologist."*

Rural focus group participants also said that rural MHCs should understand that dual roles also apply to rural Head Start teachers. As explained by this rural focus group participant, Head Start teachers may not feel comfortable discussing concerns about a child who may be their neighbor, friend, or family member,

It is a very small place in a rural community, and if you are a member of the community, such as a teacher, and you are saying to the mental health consultant you really need to look at this kid because there is something goofy going on, and you live next door to that family or they are the next ranch over, it is way more personalized in a rural community. It could also, in a rural community, make it really tough, because it is hard to separate [the roles].

Understand the Rural Community Lifestyle

Mental health consultants who worked with rural Head Start programs discussed the importance of understanding and respecting the rural lifestyle and rural communities. They stated that they needed knowledge about not only the history of

the community, but also current events that had an impact on the Head Start, children and families. They felt that learning about challenges within the community was essential for working with individual children and families within the Head Start program.

Really take each case as individual and work the case and keep it really individual to that child and family and match what has been going on in the community and be really sensitive to the community at large. Like I said earlier, there are so many connections in terms of those small towns.

MHCs also mentioned that when working with Head Start programs in rural communities, it is essential to have a love and appreciation for the rural lifestyle. MHCs in the rural focus groups mentioned experiences specific to working with rural Head Start programs, such as rounding up loose cows during a parent training or sleeping in the Head Start center during visits. The focus group participants disclosed that feeling comfortable in a rural community and appreciating the strengths of the community were important for developing relationships with children, families, and staff. For example, a MHC stated, *“Also, if you can express a real love for a rural lifestyle, that seems to be embraced by people, at least where I work. You have to really appreciate everything about the place where you work, including the climate.”*

While the rural mental health consultants shared many of the experiences of their colleagues working with Head Start programs in urban settings, they also discussed attributes and challenges that are unique to providing consultation services to rural programs. Rural mental health consultants experienced significant isolation in their work providing mental health services to Head Start programs. Mental health consultants who work with rural Head Start programs must have a shared love and

understanding of the rural lifestyle, and they need to recognize the essential role of relationships among residents, mental health professionals, and early childhood staff within rural communities.

CHAPTER 6: DISCUSSION AND CONCLUSION

Together the results from the quantitative and qualitative phases of this mixed methods study provided useful information about the attributes of early childhood mental health consultants who work with rural and urban Head Start programs. Current research in early childhood mental health consultation has focused on the effectiveness of mental health consultation for improving child, family, staff, and program outcomes for early childhood programs, but little is known about the attributes of mental health consultants that contribute to positive consultation outcomes (Brennan et al., in press). Seven attributes of rural and urban mental health consultants were examined: MHC training, supervision, and support; MHC understanding of consultant role; MHC relationship with Head Start staff; relationships with Head Start families; MHC knowledge of and experience with HS; MHC knowledge of early childhood best practices; and MHC cultural sensitivity. The quantitative findings from a secondary analysis of a national survey of rural and urban Head Start staff and mental health consultants (Green et al., 2006) yielded information about the MHC attributes that were and were not associated with Head Start staff reports of improved child outcomes and of positive relationships with Head Start staff. More specific information about the nature of MHC attributes and the challenges of rural consultation was identified through the qualitative results of telephone focus groups of rural and urban Head Start MHCs. The information gathered from the quantitative and the qualitative phases of the study was more meaningful and

interpretable than the information that either method would have provided alone (Erzberger & Kelle, 2003; Greene et al., 1989; Morgan, 1998).

MHC Training, Supervision, and Support

Results of the secondary analysis revealed that MHC training, supervision, and support were not significantly associated with decreasing internalizing or externalizing behaviors. However, MHC training, supervision, and support was associated at the level of a trend with staff reports of consultation increasing child prosocial behaviors and of positive relationships with the MHC. MHCs who feel that they have received training, supervision, and support are more likely to be associated with Head Start staff who feel that they have a positive relationship with the MHC and that the consultation services improve children's prosocial behaviors. While these findings are only statistically significant at the level of a trend, they suggest that the construct of MHC training, supervision, and support may have clinical significance.

The focus groups provided valuable information regarding the clinical relevance of training, supervision, and support for MHCs. Many MHCs expressed a desire for more training in mental health consultation, as well as ongoing training in topics related to children's mental health. While participants felt that they received valuable support from key Head Start staff, such as education coordinators and family advocates, they also believed that it was important to receive quality supervision with someone knowledgeable about children's mental health, early childhood education, and mental health consultation in Head Start. Those consultants who received clinical supervision described it as being essential, and those who had never received it felt

that it would improve the quality of services that they provided. Research in early childhood mental health consultation has not examined the importance of MHC training, supervision, and support (Brennan et al., in press), but experts in consultation have identified it as an important component of consultant effectiveness (Donahue et al., 2000; Johnston & Brinamen, 2006).

Understanding of the MHC Role

One aspect of training, supervision, and support, as measured by the *a priori* construct for the quantitative analyses, was the degree to which MHCs agreed to the statement, "I have a clear understanding of my role in supporting children's mental health in this program." While this was just one item within the construct for the secondary analyses, it was so consistently discussed in both rural and urban focus groups as being important for developing relationships with Head Start staff that it was given a separate and distinct code in the qualitative analyses. These qualitative findings suggest that the degree to which the MHCs understand their role as the MHC within the program may be a key attribute that contributes to positive relationships with Head Start staff and to providing effective consultation services.

Focus group participants stated that when the MHC and the program staff, including direct service staff, work together to define the role of the MHC, they develop stronger relationships with each other. By defining the role of the consultant together, the MHC and the staff develop a mutual understanding of the program's goals in supporting children's social and emotional wellness. In addition, MHCs and Head Start staff have opportunities to work together and to understand each others'

roles within the program. When MHCs and program staff have the opportunity to develop a strong relationship, mutual trust, and an understanding of the programs' goals for social and emotional wellness, they work together more effectively to meet the needs of children, families, and the program.

MHCs' detailed focus on the importance of MHCs and Head Start staff having a mutual understanding of the MHC role within the classroom and the organization is similar to the concepts described in the organizational and therapeutic alliance literature. MHCs' description of the importance of shared goals between the MHC and the Head Start program staff reflects concepts of both principal-agent theory and the therapeutic alliance. According to principal-agent theory, conflict and poor outcomes may result when the principal (Head Start staff) and the agent (the MHC) do not share common goals or ideas about how to achieve those goals (Peterson & Hartz, 1998). A strong therapeutic alliance is characterized by the consultant and the staff having common goals that they are working toward as well as a shared understanding and responsibility for performing tasks required for meeting those goals (Bordin, 1979). Based on this analysis, it appears that the degree to which the MHC and the staff have a shared understanding of the role of the consultant may influence the MHC – staff relationship as well as the outcomes of the consultation. Further research should address this.

MHC Relationships with Head Start Staff

Results of the secondary analysis revealed that MHC perceptions of their relationship with Head Start staff was not significantly associated with teacher reports

of decreased internalizing or externalizing behaviors or improved prosocial behaviors in children. The lack of significant results is striking, because a previous study conducted with this survey data set found significant, positive associations between staff reports of positive relationships and improved child outcomes (Green et al., 2006). A possible explanation for the lack of significant association with child outcomes is that the Green et al. study examined perceptions of the consultation relationships within Head Start staff, while the present study examined the perceptions of the relationship across MHCs. The differences in the measurement of staff perceptions of the relationship with MHCs may have contributed to the absence of significant outcomes in the present study.

However, the MHC perceptions of their relationship with Head Start staff were positively associated with Head Start staff reports of a positive relationship with the MHC. When MHCs feel that they have a positive relationship with staff, staff are also more likely to feel a positive connection with the MHC. These findings build upon a previous study of the national Head Start Mental Health Services Survey, which found that Head Start staff who felt that they had positive relationships with the MHC were more likely to report that the mental health services were effective and that the program supported them (Green et al., 2006). Together, these findings provide preliminary evidence that when MHCs feel that they have a positive relationship with staff, the staff will feel positive about the consultation relationship and will more likely to find the consultation services to be effective and supportive.

The secondary analysis established the importance of MHC perceptions of the relationship with Head Start staff, but the focus groups provided detailed information about how MHCs build those positive relationships. The themes identified in the focus groups also provided preliminary support for the concepts in Johnston and Brinamen's (2006) description of the consultative stance. Focus group participants identified personal skills, such as being a good listener and using a strengths-based approach, as necessary for developing positive relationships with Head Start staff. These skills reflect the consultative stance elements of "mutuality of endeavor, wondering instead of knowing, using subjective experience, and parallel process" (Johnston & Brinamen, p. 14). MHCs also discussed the importance of gaining credibility with Head Start staff, while allowing the staff to feel that they are the expert within their classroom, which reflects the consultative stance elements of "avoiding the position of expert, considering levels of influence, and centrality of relationships" (Johnston & Brinamen, p. 14). MHCs also described actions that Head Start programs can take to support positive relationships between consultants and staff. They shared that Head Start administrators could model enthusiasm and support for promoting the social and emotional wellness of children within the program. Focus groups participants stated that Head Start programs could also facilitate positive relationships by creating time and opportunities for MHCs and staff to meet and to work together, such as inviting the MHC to attend a pre-service training or asking the MHC to conduct staff trainings.

MHC Relationships with Head Start Families

The quantitative secondary analysis results suggested that Head Start staff were more likely to report positive relationships with consultants when the mental health consultants believed that they had established positive relationships with families. In addition, an interaction between rural and urban/suburban programs with relationships with families revealed that MHCs' relationship with families was more strongly associated with staff reports of positive relationships with the MHCs for urban programs than for rural programs. Urban MHCs who reported less positive relationships with parents were associated with Head Start staff who reported less positive relationships with the MHC, and urban MHCs who reported positive relationships with families were strongly associated with staff who reported positive relationships with the MHC. Differences in the rural and urban MHCs' perceptions of developing positive relationships with families are illustrated by information provided by the focus group participants.

Both rural and urban MHCs discussed the importance of having opportunities to meet with families and of maintaining a family-centered, culturally-sensitive approach to develop positive relationships with families. However, rural and urban MHCs discussed the nature of their relationships with families somewhat differently. An urban MHC stated that she relied on her positive relationships with Head Start staff and their relationships with families to help her "get in the door" with families. In contrast, rural MHCs, who shared that they often have pre-existing relationships with Head Start families, discussed the challenge of managing dual relationships with

family members: MHCs are often simultaneously the mental health professional and the families' friend, neighbor, or relative. It is possible that because many MHCs in rural areas often already know family members, they do not have to rely on staff members to develop those relationships.

These findings on MHCs' relationships with families reflect the importance given to this topic in the literature on early childhood mental health consultation. Consultation services for families, such as parent training (Lehman et al., 2005; Reid, Webster-Stratton, & Baydar, 2004; Sanford & Illback, 2004) and direct consultation services for parents (Alkon et al., 2003; Bleecker & Sherwood, 2004; Green, Everhart, et al., 2004; Shelton et al., 2002), are a component of many models of early childhood mental health consultation that have been evaluated and reported (Brennan et al., in press). Three quasi-experimental studies provided preliminary evidence that mental health consultation services improved parenting skills (Bleecker & Sherwood, 2004; Hennigan et al., 2004), but provided mixed outcomes in whether or not consultation decreased parenting stress (Hennigan et al.; Lehman et al., 2005). In addition, experts in the field advocate for programs to hire MHCs who have knowledge of family systems and experience working with families (Cohen & Kaufmann, 2000; Collins et al., 2003; Johnston & Brinamen, 2006).

Knowledge of and Experience with Head Start and Early Childhood Education

MHC knowledge of and experience with Head Start and early childhood education were not found to be significantly associated with Head Start staff reports of improved child outcomes or with positive relationships with the MHC, based on

results of the secondary analysis. Despite the lack of statistically significant findings in Phase I, rural and urban MHCs in the focus groups discussed the importance of MHCs understanding the Head Start philosophy and culture. According to focus group participants, knowledge of the Head Start program structure and culture may be particularly important for contracted MHCs who may be coming from a mental health organization with a different value base. In addition, the focus group members identified knowledge and experience in early childhood education as important for helping MHCs to empathize with the challenges that early childhood teachers experience in the classroom. These findings are supported by experts in early childhood mental health consultation who have identified knowledge and experience in early childhood education as necessary for MHCs to be able to relate to teachers' challenges and to understand their strengths, thereby avoiding acting as an expert (Cohen & Kaufmann, 2005; Johnston & Brinamen, 2006; Piotrkowski et al., 1994). However, the degree to which MHC knowledge of Head Start and early childhood education influences consultation outcomes has not been evaluated (Brennan et al., in press; Perry et al., 2006).

Knowledge of Early Childhood Mental Health Best Practices

Results from Phase I of the study provided limited information about the association between MHC knowledge of children's mental health best practices with teacher reports of improved child internalizing or externalizing behavior or of positive relationships with the MHC. The results did suggest a relationship at the level of a trend between MHC knowledge of best practices and staff ratings of improved

prosocial behaviors. Despite the lack of statistically significant associations between knowledge of mental health best practices and child internalizing and externalizing behaviors and staff relationships with the MHC, the focus groups provided valuable information about MHCs' perceptions of the importance of a strong foundation in early childhood mental health best practices.

Focus group participants described several skills that they considered necessary for effective consultation, and these skills reflect the definition of early childhood mental health best practices (Simpson et al., 2001). In the focus groups, participants stated that MHCs should have a strengths-based, family-centered approach. They discussed consultants' need for knowledge of early childhood development, developmentally appropriate practices, and early childhood community resources. They need to be familiar with screening and assessment tools. Finally, MHCs should have strong communication and therapeutic skills that support them in implementing preventive consultation services. Although the research base on MHC has not thoroughly examined the role of MHC knowledge of children's mental health best practices in consultation outcomes, it is considered by consultation experts to be a critical skill for early childhood mental health consultants (Cohen & Kaufman, 2005; Johnston & Brinamen, 2006).

Cultural Sensitivity

Because of challenges with developing a reliable measure of cultural sensitivity with the items in the consultant version of the Head Start Mental Health Services Survey, it was not possible to use secondary analysis to examine the

influence of mental health consultant cultural sensitivity on staff reports of child outcomes and the relationship with the MHC. Nonetheless, this national sample of Head Start staff and MHCs revealed demographic differences between Head Start staff and MHCs. Of the direct service staff, 45% ($n = 185$) identified as persons of color, while 25% ($n = 14$) of the MHCs identified as persons of color (see Table 10). Within rural areas, 36% of the Head Start staff identified as persons of color, and 8% of the mental health consultants identified as persons of color. While the literature base on early childhood mental health consultation has not examined the relationship of consultant ethnicity to consultation outcomes (Brennan et al., in press; Perry et al., 2006), the focus groups provided preliminary information about MHCs' views of the role of cultural sensitivity in mental health consultation.

MHCs across rural and urban focus groups shared that an essential skill of an effective consultant is understanding and respecting the cultural, geographic, and economic diversity of Head Start children, families, and staff. Only a handful of MHCs in the focus groups shared that they were bilingual and bicultural, yet many advocated for hiring and training bilingual and bicultural mental health consultants. They stated that to be effective, MHCs should be able to communicate with children, families, and staff in their primary language, and they should be knowledgeable of the culture and history of the community. In a discussion of ethics and evidence in consultation, Wesley and Buysse (2006) suggest that consultants in early childhood settings have an ethical responsibility to provide services that are sensitive to client and consultee worldviews and that recognize the danger of applying a single-culture

perspective to their consultation with early childhood programs. Research studies designed to better understand the role of cultural factors in consultation have been identified as an important area of future inquiry (Perry et al., 2006).

Challenges of Rural MHC

The final major contribution of this study to the field of mental health consultation is the knowledge gained regarding the provision of consultation services to Head Start programs in rural areas. First, MHCs shared that to develop positive relationships with rural Head Start staff, it is essential that the consultant understand, appreciate, and embrace the rural lifestyle. When mental health providers are unfamiliar with the rural lifestyle, there is often a gap in provider knowledge about the concerns, needs, and challenges that the rural residents experience. This gap in perspective has been described as a barrier for rural children and families seeking mental health services (U.S. Department of Health and Human Services, 2004).

Second, MHCs practicing in rural areas often feel isolated from other mental health professionals in general and other MHCs in particular. In fact, it was not uncommon for rural MHCs in the focus groups to have never met another mental health professional who was providing consultation services to Head Start programs. Isolation is a common experience of rural mental health providers, and it has been identified as a major barrier to recruiting and retaining rural mental health providers (Huang et al., 2004). To address this isolation, the focus group participants advocated for a statewide meeting or training for Head Start mental health consultants.

Finally, rural MHCs often have very few contact hours with the Head Start programs, which may be due to the time and expense of traveling great distances to provide services to the Head Start programs. Geographic distance between children and families and mental health providers has been identified as a significant barrier to children receiving mental health services (U.S. Department of Health and Human Services). Consequently, rural Head Start programs may need to build more creative opportunities for staff and MHCs to connect that do not require travel, such as teleconference calls and technology-assisted consultation.

Limitations

Phase I: Secondary Analysis

The secondary analysis of the national survey of Head Start programs and mental health consultants is limited because it is an exploratory study using a cross-sectional, non-experimental research design. Consequently, it is not possible to attribute causal direction to the findings (Green et al., 2006). In addition, the results of the study have limited internal validity, meaning that the outcomes may have been influenced by variables other than the predictor variables. For example, staff responses to the outcome variables could have been influenced by participation in training in early childhood mental health or by a new social and emotional curriculum adopted by the program. The mental health consultants' responses to the survey could have been influenced if they had recently participated in a continuing education course or had attended a national children's mental health conference presentation on mental

health consultation. Because these variables were not measured in the survey, it was not possible to control for them in the analyses.

In addition, measurement of the outcome variable may be biased due to construct validity of the effect, meaning that staff and consultant responses to the survey may have varied due to social desirability of positive responses or other external influences, rather than as a function of the attributes of mental health consultants. Staff and consultant responses could not be validated, because the survey relied solely on self-report (Green et al., 1996). No observational data of child outcomes, teacher and consultant relationships, or MHC attributes were included in the analyses.

The findings of this exploratory secondary analysis are also limited by the reliability and the validity of the predictor and outcome variables. The survey items included in the Head Start Mental Health Services Survey were developed from the findings of a previous qualitative study on mental health consultation services in Head Start (Green et al., 2006). Because the survey did not include additional items from validated scales, it was difficult to establish convergent validity for the predictor and outcome variables. In addition, the constructs that measured the mental health consultant attributes (the predictor variables) were developed using *a priori* operational definitions that were based on theoretical descriptions of MHC characteristics culled from the literature on mental health consultation. The conceptual definitions of the predictor variables were then developed by matching existing items in the consultant version of the survey to the theoretical constructs in

the operational definition. As a result, there is risk of low construct validity with the mental health consultant attributes, and it is possible that the mental health consultant attributes constructs were not accurate measures.

The exclusion of the cultural sensitivity construct was an example of the challenges of developing reliable and valid constructs for the identified mental health consultant attributes. The decision was made to exclude the cultural sensitivity construct from the secondary analyses due to concerns with validity and reliability of the construct. Because the construct could be examined in the focus group study, this decision seemed to be a reasonable choice. However, excluding the cultural sensitivity variable leaves a gap in the findings of the secondary analyses.

Phase II: Focus Groups

Despite the advantages of telephone focus groups for geographically diverse and busy professional participants, conducting the focus groups by telephone introduced potential challenges and shortcomings in the qualitative phase of the study, including sampling bias and decreased social presence. Utilizing teleconference technology for the focus groups may have resulted in sampling bias, because those focus group participants who were not accustomed to the use of teleconference as a common communication strategy may have been less likely to participate in the focus group (Tolhurst & Dean, 2004). In the present study, this may have been especially true for the non-rural participants. Urban and suburban mental health consultants may not be as familiar with the use of teleconference technology as rural mental health consultants, who are more likely to use teleconferencing for training and for

communicating with clients and supervisors (Schopler, Abell, & Galinsky, 1998; U.S. Department of Health and Human Services, 2004). However, teleconferencing is becoming an increasingly popular means of providing national trainings, which consultants from both rural and urban mental health consultants may utilize.

A second disadvantage of telephone focus groups was the inability of the participants to exchange nonverbal cues, such as head nodding, eye contact, smiles, or frowns (Krueger, 2002; Schneider et al., 2002; Schopler et al., 1998). In face-to-face focus groups, positive social cues that convey interest may encourage participants to provide additional information or detail (Schneider et al.). In addition, the moderator may be better able to determine when it is necessary to engage participants who are not paying attention. The lack of non-verbal social cues and social presence of others in these telephone focus groups might have limited the development of group relationships and group dynamics among the mental health consultants within the groups (Schopler et al.).

However, people may seek to develop social presence in a variety of technological mediums, such as online chat sessions or teleconferences (Schneider et al., 2002). Telephone focus groups do allow participants to develop social presence through paraverbal cues, such as voice inflections, emphases, interjections, and laughter (Schneider et al.). For these telephone focus groups, the moderator tracked the engagement of each mental health consultant to ensure that all participants had the opportunity to share ideas. Finally, the anonymity afforded by telephone focus groups may free some participants to share their ideas more openly (Schopler et al., 1998).

A third limitation of the telephone focus groups is the limited generalizability of the findings. The focus groups consisted only of MHCs from urban and rural Oregon and rural Alaska. It is possible that the concerns of those MHCs may be specific to the Pacific Northwest region and that the generalizability to other regions of the United States may be limited. In addition, the sample of mental health consultants was culturally biased, as only 5 of the 26 participants identified as people of color. Because the focus groups were segmented by geographic location, the participants who identified as persons of color each participated in separate groups. It is possible that as the minority voice within their group, they may have agreed with socially acceptable opinions, rather than disagreeing with the majority. However, it should be noted that because participants could not see each other, it may have been less likely that participants made assumptions about cultural backgrounds of other participants, unless the participants self-disclosed.

Despite the challenges associated with telephone focus groups, they were a useful qualitative methodology for the present study. Because the focus groups were conducted by teleconference, the study was able to gather information and ideas from mental health consultants working with Head Start programs in geographically distant communities in rural Alaska and Oregon who would have been excluded in face-to-face focus groups due to the time and expense of bringing them together (Hurworth, 2004; Krueger, 2002; Tolhurst & Dean, 2004). The study not only benefited from learning of their unique perspectives, but the consultants may have also benefited from the opportunity to learn from and network with other rural-based Head Start mental

health consultants (Fahey et al., 2003; Tolhurst & Dean, 2004; Morgan, 1996).

Conducting the focus groups by telephone may have increased the participation rate of mental health consultants. The convenience of participating in focus groups by telephone from home or office may have made it possible for busy mental health professionals to participate, especially since the focus groups were held during the summer when most Head Start programs were not in session (Tolhurst & Dean).

Based on the needs of the participants and the research questions, telephone focus groups were selected as the methodology for identifying the ideas and experiences of mental health consultants in rural Alaska and Oregon and urban / suburban Oregon.

Implications for Future Research

Knowledge of the attributes of rural and urban mental health consultants that contribute to positive relationships with Head Start staff and to positive consultation outcomes has significant implications for future research. First, the results of both the quantitative and the qualitative phases of the study provide useful information for developing a scale of early childhood mental health consultant attributes, which could be used in outcome research to measure the influence of consultant attributes on consultation outcomes. Understanding how and why MHCs are effective in promoting positive child, family, staff, and program outcomes is essential for developing and evaluating consultation services (Knoff & Hines, 1995). Additional information about MHCs' perceptions of effective consultation practice is needed to develop MHC training, effective consultation services, and informative evaluations (Knoff & Hines, 1995).

The quantitative and qualitative findings of this study provide preliminary evidence that the training, supervision, and support that MHCs receive may be associated with consultation outcomes. However, the relationship between different levels and types of MHC training, support, and supervision and child, family, staff and program outcomes needs to be examined. Evaluations of different types and levels of consultation supports should also be conducted in order to develop efficient and effective systems for training, supporting, and supervising MHCs.

The present study brought to light the need to further examine the degree to which MHCs and Head Start staff have a mutual understanding of the role of the consultant within the program. Future research should examine the theoretical link, based on principal-agent theory and research on the therapeutic relationship, between role clarity and the quality of relationships between the Head Start staff and the MHC. In addition, research might examine the possibility that the degree of role clarification has a moderating effect on the relationship between the consultant and the staff and on the child, family, staff, and program outcomes. For example, when MHCs and staff both have a clear understanding of the tasks and responsibilities of the MHC, then the effect of the MHC-staff relationship on staff and child outcomes may become non-significant. Future research on MHC, staff, and program perceptions of the role of the MHC within early childhood programs may provide an additional benefit of delineating the role of the MHC within the literature base. Unclear definitions of the components of MHC have been identified as a barrier to evaluating early childhood mental health consultation program and to comparing the results of evaluations

(Hepburn et al., 2007). Future research should examine the effect of the various components of the MHC role on child, family, staff, and program level outcomes. This line of research should evaluate the content of mental health consultation, which could be identified through direct observation of MHCs.

The findings of this project suggest that future research should continue to examine the relationship between the MHC and the early childhood program staff, including direct service staff and management. The present study examined only the relationship between MHCs and early childhood direct service staff, but future studies might examine how relationships with the MHC differ between direct service staff and managers, and how the relationship with the MHC is conceptualized differently by direct service staff and by managers. Although the relationship between the MHC and the early childhood staff has been identified as a central component in early childhood mental health consultation services by experts in mental health consultation (Cohen & Kaufmann, 2005; Johnston & Brinamen, 2006), this variable has been omitted from consultation evaluations (Brennan et al., in press). The hypothesized path between MHC relationships with staff and child outcomes needs to be further examined. In addition, future research should evaluate how the relationships between MHCs and early childhood staff affect the relationship between MHCs and families. A better understanding of the nature of the relationship between MHCs and Head Start families will provide useful information about how early childhood mental health consultation supports and promotes positive outcomes for Head Start families.

The role of cultural sensitivity in early childhood mental health consultation deserves significant more attention in consultation research. While the focus groups revealed that MHCs believe that cultural sensitivity is necessary for developing positive relationships with Head Start Studies, future research should clarify the nature of that association. It would be important to examine the degree to which MHC cultural sensitivity affects child, family, staff, and program level outcomes. In addition to cultural sensitivity, future research might identify any relationships between the match in race or ethnicity of the MHC and the children, staff, or families, and the effect of that match or mismatch on consultation outcomes.

An area in need of additional research is the characteristics of institutional environments that promote effective ECMHC. According to ecological systems perspective, it is necessary to examine overall structural patterns at macro-system level (Bronfenbrenner, 1979). The structure of the early childhood program, such as program size, management styles, and program organization, may influence the effectiveness of consultation. The institutional environment may affect a variety of consultation variables, including the relationship of the MHC with the early staff and families, the number of consultation hours, and the types of services the consultant provides. Further research is needed to identify institutional strategies that might promote positive ECMHC outcomes.

Finally, future research should begin to unpack the differential experiences and outcomes of early childhood mental health consultation for rural and urban programs. While the focus group analyses revealed many shared attributes of rural and urban

MHCs, there are also differences. For example, future research on the effect of MHC relationships with early childhood staff and families on child, family, staff, and program outcomes should take into consideration the unique needs and challenges of rural consultants, which include need for a deep understanding of the rural community, potential dual relationships within rural communities, and the influence of isolation on the provision of rural consultation services. This study also provided support for the use of telephone focus groups for conducting research with busy, professional participants who reside in diverse geographic locations.

Implications for Theory

The complexity of early childhood mental health consultation creates a challenge for identifying a single theoretical approach to guide ECMHC practice and evaluation (Brennan et al., in press; Gallesich, 1985). The findings of the present research suggested that a mix of theoretical approaches may provide valuable information about the pathways through which consultation affects child, family, staff, and program outcomes. The theory of change hypothesized that mental health consultants provide indirect services to early childhood staff through a collaborative relationship, which results in changes in teachers' attitudes, skills, and behaviors. Within the focus group study, MHCs supported this concept by discussing the importance of supporting early childhood staff by listening, understanding staff challenges, and having a strengths-based approach. The staff level changes increase their ability to address children's social and emotional needs within the classroom and families' need for support. Through the ecological systems perspective, consultation

services are examined at the micro-, meso-, exo-, and macrosystem levels. At the microsystem level, MHCs may seek to influence child outcomes using a variety of theoretical approaches, including behavioral and social learning theories. At the mesosystem level, MHCs may apply the principles of social learning theory, psychoanalytic theory, and ecological systems theory to develop relationships with early childhood staff and parents. The results from the secondary analysis and the focus groups both point to the importance of MHCs having the ability to develop positive relationships with Head Start staff. Finally, consultation may influence change at the exo- and macrosystem levels, so organizational theories, such as principal-agent theory, provide information about how MHCs and early childhood organizations work together to produce consultation outcomes. At the macrosystem level, the focus group study highlighted the need for both MHCs and early childhood programs to have a mutual understanding of the role of the MHC and for managers to support and encourage a mental health perspective.

Combining multiple theories to explain consultation outcomes is a unique approach to understanding mental health consultation. Rather than seeking to explain change at one level of consultation, such as microsystem level child outcomes, the multiple theory approach allows the MHC, program developer, and the researcher to examine the scope of child, family, staff, and program level interventions and outcomes. This theory of change moves the field away from focusing on a single level of consultation practice and outcomes and toward focusing on the multiple paths

through which effective consultation practices influence child, family, staff, and program level outcomes.

Implications for Practice and Policy

Early childhood mental health consultation is an intervention and prevention strategy being implemented across the United States (Hepburn et al., 2007), and this study provides valuable information about how states, programs, and consultants can implement more effective mental health consultation services. Based on the findings, efforts to improve mental health consultation services should be implemented at both the practice and the policy levels.

At the practice level, the findings of this study suggest that in order for MHCs to provide effective mental health consultation services both the MHC and the program must have a clear understanding of the role of the MHC. Although the relationship remains unclear, theory and research point to a connection between a mutual understanding of the roles of the MHC and the quality of the relationship between the MHC and the early childhood staff. When Head Start programs hire or contract with a mental health consultant, the MHC and the program staff should have the opportunity to work together to develop and to define the role of the mental health consultant within the program. The MHC's role should integrate the strengths and skills of the identified MHC with the needs of the Head Start children, staff, and program. Working together to develop the role of the MHC may strengthen the relationship between the MHC and the staff by establishing mutual goals, shared tasks, and a respectful and trusting bond. In addition, the process of developing the role of

the MHC within the program will guide programs in developing a theory of change and logic model, which are important tools for conducting an evaluation of the programs' mental health consultation services (Hepburn et al., 2007).

When developing the role of the MHC, program-supported strategies should be identified for the MHC to develop relationships and to work with Head Start staff and families. Because mental health funding is scarce and the mental health needs of children and families are many, programs may feel the need to structure MHC service time in an effort to get the most out of their time with the MHC. However, mutually trusting and respectful relationships between MHCs and Head Start staff and families may be best developed through unstructured gatherings, meetings, and interactions.

Head Start programs view the mental health consultant as an expert in children's mental health who needs little guidance in addressing the children's mental health needs within their program, but the training, support, and supervision of MHCs are critical components of early childhood mental health consultation that are typically overlooked. Mental health professionals who provide services as MHCs should receive an introductory training about the policies and procedures of the early childhood program and ongoing training in mental health consultation content, such as culturally sensitive practice, screening and assessment, and early childhood mental health best practices. In addition to training, MHCs, especially those practicing in rural areas, need opportunities to connect, network, and share ideas with other MHCs. Support from other MHCs may help to increase recruitment and retention of early childhood mental health consultants, especially in rural areas (U.S. Department of

Health and Human Services, 2004). Finally, MHCs need opportunities for quality supervision from a qualified professional with knowledge and experience in early childhood mental health, development, and education. While clinical supervision may be the gold standard in supervision, MHC supervision should, at a minimum, integrate issues related to early childhood mental health consultation, child development, and early childhood education in a Head Start setting.

The findings of this study also have important implications for policies guiding the development, implementation, and evaluation of early childhood mental health consultation practices. First, funding of mental health consultation services should cover not only the mental health services provided by the MHC, but also the training, support, and supervision of the early childhood mental health consultants. Second, the findings of this study suggest the need for state and federal policies that support training programs to develop a qualified workforce to provide culturally sensitive and developmentally appropriate early childhood mental health consultation services. Training programs should specifically recruit and educate bilingual and bicultural professionals who are interested in providing early childhood mental health services, as well as those who are interested in working in rural areas. Third, mental health consultation policies, such as the Head Start Mental Health Performance Standards, should emphasize the necessity of MHCs and programs working together to identify the roles and responsibilities of the MHC and the staff in the consultation process. The process of mutually defining the role of the MHC may help to develop positive

relationships between the consultant, the staff, and parents, and may improve the likelihood that the consultation will achieve the desired outcomes.

Conclusion

This mixed methods study of rural and urban Head Start MHCs revealed that mental health consultation with Head Start programs is a dynamic position that requires mental health professionals to have a variety of skills and knowledge to be effective. But more importantly, this study highlighted the strengths of effective MHCs, the challenges that rural and urban mental health professionals experience, and the need for MHCs to receive training, supervision, and support. Although mental health professionals typically enter the consultation relationship with Head Start programs with knowledge of mental health, they look to the Head Start programs for considerable guidance about the goals of the consultation process and the strengths and needs of the children, the families, the staff, and the early childhood program. Regardless of the skills and knowledge that MHCs possess, without a strong partnership and relationship with the program staff they are likely to have limited success in identifying and meeting the needs of the children, families, and staff.

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Appendix A: Direct Services Staff Version Head Start Mental Health Services Survey

Green, B. L., Everhart, M. C., Gettman, M. G., Gordon, L., & Friesen, B. (2004). *Mental health consultation in Head Start: Selected national findings*. Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.

Head Start Mental Health Services Survey

Please answer the following questions about yourself.

1. What is your job title? _____
2. Which of the following best describes your position?

<input type="checkbox"/> Teacher ₁	<input type="checkbox"/> Program director/executive
director/assistant director ₄	
<input type="checkbox"/> Teacher's assistant ₂	<input type="checkbox"/> Family advocate/case
manager/family services specialist ₅	
<input type="checkbox"/> Manager or coordinator ₃	<input type="checkbox"/> Other staff. Please specify: _____
_____ ₆	
3. How long have you worked for this organization? _____
4. How long have you held your current position? _____
5. What is the highest education level you have obtained?

<input type="checkbox"/> High school diploma ₁	<input type="checkbox"/> 4 year college degree ₄
<input type="checkbox"/> 2 year degree/certificate ₂	<input type="checkbox"/> Master's degree ₅
<input type="checkbox"/> Child Dev. Assoc. Certificate ₃	<input type="checkbox"/> Doctoral degree (Ph.D., etc.) ₆
6. How would you describe your race/ethnicity? (Check all that apply.)

<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic/Latino(a)
<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Native American
<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Other. Please specify: _____

7. What is your gender? Male ₁ Female ₀

Please answer the following questions about your program's approach to children's mental health promotion.

8. Please rank the following educational objectives for children according to their importance in your program during the next year. Put a "1" by the most important, a "2" by the next most important, and so on until you get to "6" for the least important. Each objective must have only *one* number next to it.

In our program, it is important...

- ___ to help children develop language and problem-solving skills.
 ___ to help children build strong friendships and learn to share.
 ___ to help children master concepts needed for reading and arithmetic.
 ___ to help children develop skill and independence in caring for themselves.
 ___ to help children develop physical coordination.
 ___ to help children develop a healthy self-esteem and positive self-concept.

9. Does your program have a *written* philosophy or approach (beyond the performance standards) about how to provide children's mental health services? This could include a policy or vision statement, set of "guiding principles" or other written documentation about how to approach children's mental health issues.

Yes ₁ No ₀

10. Does your program have an *unwritten*, but commonly understood, philosophy or approach about how to best provide children's mental health services.

Yes ₁ No ₀

IMPORTANT!

If you answered "No" to BOTH questions 9 and 10, GO TO question 28.

If you answered "Yes," to either 9 or 10, continue with question 11.

11. Which of the following led to the development of your program's mental health approach? Check all that apply.

- Management team developed the approach. All staff helped to develop the approach.
 The MHC(s) developed the approach. I don't know how the approach was developed.

Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
I learned about this approach:					
12.	By reading about it in a training manual.	1	2	3	4

13.	Because it was part of my initial training when I was hired.	1	2	3	4
14.	Through informal conversations or meetings with staff.	1	2	3	4
15.	Through our program's regular pre-service/in-service training.	1	2	3	4
16.	Through informal conversations or meetings with the mental health consultant.	1	2	3	4
17.	By observing or watching other staff.	1	2	3	4
18.	Just by being part of the program.	1	2	3	4
19.	I understood this approach before I started working with this program.	1	2	3	4
The following groups understand and share the program's approach to mental health services:					
20.	Administrators/managers/coordinators/management team	1	2	3	4
21.	Classroom teachers	1	2	3	4
22.	Assistant teachers	1	2	3	4
23.	Family advocates/family services staff	1	2	3	4
24.	Support staff (secretaries, bus drivers, cooks, etc.)	1	2	3	4
25.	Head Start parents	1	2	3	4
26.	Mental health consultants	1	2	3	4

Questions 28–63 ask about your program's mental health consultant(s) (MHC). If you work with more than one consultant, please think about their overall characteristics and how the consultants, on average, work with you and your program. (See next page.)

Instructions: Please indicate the frequency with which your mental health consultant(s) engage in each of the following activities, <i>to the best of your knowledge</i> . If you work with more than one MHC, think about what they do, overall, in general.		Rarely or Never	1–2 Times per Year	Every other Month	Monthly	Weekly or More
28.	The MHC(s) conducts group (classroom) screenings and observations.	1	2	3	4	5
29.	The MHC(s) conducts individual screenings of children.	1	2	3	4	5
30.	The MHC(s) conducts more in-depth assessments of children after they have been screened.	1	2	3	4	5
31.	The MHC(s) does planning for children with special needs (e.g., IEPs).	1	2	3	4	5
32.	The MHC(s) makes referrals for children or families to community services.	1	2	3	4	5

33.	The MHC(s) attends management team meetings.	1	2	3	4	5
34.	The MHC(s) meets with staff teams to discuss children or families.	1	2	3	4	5
35.	The MHC(s) provides direct therapeutic/counseling service to families and children.	1	2	3	4	5
36.	The MHC(s) provides formal training to teachers.	1	2	3	4	5
37.	The MHC(s) talks and meets with parents.	1	2	3	4	5
38.	The MHC(s) provides support to staff for their own well-being.	1	2	3	4	5
	Other activities of the MHC(s). Please specify:					
39.	a.	1	2	3	4	5
40.	b.	1	2	3	4	5
41.	c.	1	2	3	4	5

Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. If you work with more than one MHC, think about what they do, overall, in general. Answer these questions to the best of your knowledge.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
42.	The MHC(s) has experience working with the HS population.	1	2	3	4
43.	I have a good relationship with the MHC(s).	1	2	3	4
44.	The MHC(s) works as a partner with staff to meet children's MH needs.	1	2	3	4
45.	The MHC(s) seems like another member of the HS staff, not like an outsider.	1	2	3	4
46.	The MHC(s) understands how mental health can be addressed through all program components.	1	2	3	4
47.	The MHC(s) has good relationships with parents.	1	2	3	4
48.	The MHC(s) works closely with parents to define services to meet children's needs.	1	2	3	4
49.	Most of the parents in the program know the MHC(s) by name.	1	2	3	4
50.	Staff regularly go to the MHC(s) when they need help with particular children or families.	1	2	3	4
51.	The MHC(s) expresses an awareness of his or her own cultural norms and expectations, and how these might differ from the cultural experiences of Head Start children and their families.	1	2	3	4
52.	The MHC(s) is able to work effectively with non-English speaking families.	1	2	3	4
53.	The MHC(s) is an essential part of our program.	1	2	3	4

Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. If you work with more than one MHC, think about what they do, overall, in general. Answer these questions to the best of your knowledge.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
54.	The MHC(s) has experience working with young children.	1	2	3	4
55.	The MHC(s) respects staff's perspectives on children's issues.	1	2	3	4
56.	The MHC(s) is "part of the team" trying to help families.	1	2	3	4
57.	The MHC(s) provides services in a way consistent with the HS philosophy.	1	2	3	4
58.	Parents trust the MHC(s).	1	2	3	4
59.	Parents of children with special needs know the MHC(s) by name.	1	2	3	4
60.	The MHC(s) is available when I need him/her.	1	2	3	4
61.	The MHC(s) talks with staff about the ways in which understandings of mental health and related concepts (self-esteem, discipline, etc.) may differ for children based on culture.	1	2	3	4
62.	When talking with families about their children, the MHC (s) demonstrates an awareness of each family's unique cultural characteristics and preferences.	1	2	3	4
63.	Dollars spent on mental health consultation would be better spent on other areas of the program.	1	2	3	4

Please answer the following questions about your program's mental health activities.

Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. Although different staff may think or behave differently, consider how program staff overall, in general, behave. Think about the program staff that you know.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
64.	Program leadership has a clear vision of how children's mental health issues are related to all program components.	1	2	3	4
65.	Program leadership (e.g., managers, directors, coordinators) supports staff to learn more about children's mental health needs and how to address them.	1	2	3	4
66.	Program leadership advocates and tries to obtain more resources for children's mental health services.	1	2	3	4
67.	Staff in our program disagree on what mental health services should be provided to which children.	1	2	3	4

68.	Our mental health services and approach are well-integrated into all program components.	1	2	3	4
69.	Staff would like to see therapeutic classrooms for all children with behavioral health challenges.	1	2	3	4
70.	Our program's mental health services focus more on children with special needs than on preventing mental health problems.	1	2	3	4
71.	Families in our program who need therapeutic/counseling services have problems accessing these through community-based programs.	1	2	3	4
72.	Staff believe that the best way to meet children's mental health needs is to identify what is "right" with the child, not what is "wrong."	1	2	3	4
73.	Parents of children with special needs regularly attend staffings or service planning meetings.	1	2	3	4
74.	This Head Start program has effective ways of involving parents in the management of problem behaviors.	1	2	3	4
	Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. Although different staff may think or behave differently, consider how program staff overall, in general, behave. Think about the program staff that you know.	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
75.	When a child has a mental health issue, staff actively involve the child's family in meeting this child's needs.	1	2	3	4
76.	Staff work actively to identify and facilitate services for adult mental health issues.	1	2	3	4
77.	When talking with families about children's mental health issues, staff demonstrate an awareness of each family's unique cultural characteristics and preferences.	1	2	3	4
78.	Our Head Start program uses curricula that provide images of and attention to children and families from a variety of cultural backgrounds.	1	2	3	4
79.	Our Head Start program offers effective trainings on racial/ethnic, social/economic, religious and other cultural differences among children and families.	1	2	3	4
80.	Our program's approach to mental health focuses extensively on classroom curriculum.	1	2	3	4
81.	Staff in this program see mental health as part of everything they do.	1	2	3	4
82.	Staff believe that children with significant behavioral challenges are best served by programs other than Head Start.	1	2	3	4
83.	When a few children have significant behavioral challenges, staff find it difficult to spend time with any of the other children in the classroom.	1	2	3	4
84.	Our program has a strong partnership with at least one community-based mental health provider.	1	2	3	4
85.	Staff are able to build on family and child strengths even	1	2	3	4

	when the family is facing significant challenges (e.g., substance abuse, mental illness, homelessness, etc.).				
86.	Parents of children with special needs are invited to attend staffings or service planning meetings.	1	2	3	4
87.	Staff feel comfortable talking with parents about their children's mental health needs or issues.	1	2	3	4
88.	This HS program has a mechanism for communicating positive behaviors or events to parents.	1	2	3	4
89.	Staff believe that family participation is essential to improving a child's well-being.	1	2	3	4
90.	Staff have an awareness of how their own cultural norms and expectations may differ from the cultural experiences of Head Start children and their families.	1	2	3	4
91.	Our program has staff who feel comfortable talking to non-English speaking families about mental health issues in their own language.	1	2	3	4
92.	In their interactions with children and families, staff regularly demonstrate an appreciation for cultural norms and expectations different from their own.	1	2	3	4
93.	Our program's approach to mental health includes a strong focus on staff wellness.	1	2	3	4
94.	Our program's approach to mental health focuses exclusively on how to manage children's behavior in the classroom.	1	2	3	4
95.	I have a good understanding of "best practices" in children's mental health.	1	2	3	4
96.	I have a clear understanding of my role in supporting children's mental health in our program.	1	2	3	4
97.	Our program provides me with the training and professional support I need to do my job most effectively.	1	2	3	4
98.	This program recognizes the good work that I do on behalf of children and families.	1	2	3	4
99.	Transitions are smoother in my classroom (or classrooms I know about) because of our mental health services.	1	2	3	4
100.	Our mental health services help all children in our program.	1	2	3	4
101.	Staff have a hard time knowing what to do to help children with challenging behaviors.	1	2	3	4
102.	Classroom staff do their jobs better because of our mental health consultant.	1	2	3	4

	Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. Although different staff may think or behave differently, consider how program staff overall, in general, behave. Think about the program staff that you know.	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
103.	Our program's mental health services and approach are sufficient to meet the needs of children and families.	1	2	3	4
104.	This HS program has a plan for dealing with children who may have a situational crisis.	1	2	3	4

105.	I consistently use best practices in children's mental health in my work.	1	2	3	4
106.	I feel I do a good job in supporting children's mental health within our program context.	1	2	3	4
107.	Our program provides me with the emotional and personal support I need to do my job most effectively.	1	2	3	4
108.	Our program's mental health services have improved the quality of our classroom environments.	1	2	3	4
109.	Our mental health services help children with challenging behaviors.	1	2	3	4
110.	Our mental health services help families know how to cope with children's challenging behaviors.	1	2	3	4
111.	Our mental health services and approach help staff to feel less stress.	1	2	3	4
112.	Our mental health services and approach are in need of improvement.	1	2	3	4

113. How many children are there in your classroom or caseload? _____

114. How many children in your classroom or caseload received a group (classroom) screening? _____

115. How many children in your classroom or caseload received an individual assessment? _____

116. How many children in your classroom or caseload have been identified as needing mental health services? _____

Of those children who were identified as *needing* mental health services, how many have received the following

(provided by either Head Start or by another service):

117. Individual therapeutic services (counseling, play therapy, etc.) _____

118. Family therapeutic services (counseling, etc.) _____

119. Medication only _____

120. Medication plus therapeutic services _____

121. Other mental health services _____

Please describe: _____

122. How many adult family members of children in your classroom, or on your caseload, have been identified as needing mental health services? _____

Of those adults who were identified as *needing* mental health services, how many have received the following

(provided by either Head Start or by another service):

123. Individual therapeutic services (counseling, individual treatment, etc.) _____

124. Group counseling/group therapy (support groups, etc.) _____

125. Family therapeutic services (counseling, parent education, etc.) _____

126. Medication only _____

127. Medication plus therapeutic services _____

128. Other services _____ Please describe: _____

Instructions: To what extent do you think your mental health services, including prevention and classroom activities, as well as direct mental health services, have helped each of the following? Circle 1 if it has helped a lot, 2 if it has helped somewhat, 3 if it has helped a little, and 4 if it hasn't helped.		Helped a lot	Helped somewhat	Helped a little	Hasn't Helped
129.	Aggression towards other children	1	2	3	4
130.	Aggression towards adults	1	2	3	4
131.	Self-destructive behavior	1	2	3	4
132.	Extreme temper tantrums	1	2	3	4
133.	Withdrawn/overly shy behavior	1	2	3	4
134.	Extreme moodiness	1	2	3	4
135.	Child depression	1	2	3	4
136.	Speech/language problems	1	2	3	4
137.	Problems concentrating	1	2	3	4
138.	Positive social interactions between children	1	2	3	4
139.	Smooth transitions between activities	1	2	3	4
140.	Prosocial behavior (e.g., helping, sharing)	1	3	4	4
141.	Age-appropriate emotional regulation	1	2	3	4
142.	Non-violent problem solving	1	3	3	4

143. At this Head Start, if a teacher requested mental health services for a child, how long would the child have to wait for an evaluation if it is not a crisis?

- 1 week ₁ 1-2 wks ₂ 2-4 wks ₃ 1-2 months ₄ More than 2 months ₅

144. Sometimes Head Start is unable to meet the needs of children with particular issues or problems. In your program, what *issues most frequently* lead to children being referred to another program or service instead of Head Start? That is, what issues or problems do children have who cannot be served in the Head Start classroom?

145. What do you believe is the *most outstanding* part of your mental health services? That is, what makes your mental health services most effective?

146. What do you believe is the *most unsatisfactory* part of your mental health services? That is, what *prevents* your mental health services from being as effective as they could be?

Thank you very much for your valuable time. Now just fold, tape and place this survey in outgoing mail. You will be entered in the cash drawing, and we look forward to sending your program's report.

Appendix B: Consultant Version Head Start Mental Health Services Survey

Green, B. L., Everhart, M. C., Gettman, M. G., Gordon, L., & Friesen, B. (2004). *Mental health consultation in Head Start: Selected national findings*. Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.

Head Start Mental Health Services Survey

Please answer the following questions about yourself.

1. What is your job title? _____
2. Which of the following best describes your position?
 - Therapist or counselor employed directly by the Head Start program ⁷
 - Therapist or counselor employed by a community nonprofit ⁸
 - Therapist or counselor employed by a government agency (e.g., county health department) ⁹
 - Therapist or counselor in private practice ¹⁰
 - School-based therapist/counselor ¹¹
 - Other, please describe: _____ ¹²
3. How long have you worked for this organization? _____
4. How long have you held your current position? _____
5. What is the highest education level you have obtained?

<input type="checkbox"/> High school diploma ¹	<input type="checkbox"/> 4 year college degree ⁴	<input type="checkbox"/>
<input type="checkbox"/> 2 year degree/certificate ²	<input type="checkbox"/> Master's degree ⁵	
<input type="checkbox"/> Child Dev. Assoc. Certificate ³	<input type="checkbox"/> Doctoral degree (Ph.D., etc.) ⁶	
6. How would you describe your race/ethnicity? (Check all that apply.)

<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic/Latino(a)
<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Native American
<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Other. Please specify: _____
7. What is your gender? Male ¹ Female ⁰

Please answer the following questions about this program's approach to children's mental health promotion.

9. Does this program have a *written* philosophy or approach (beyond the performance standards) about how to provide children's mental health services? This could include a policy or vision statement, set of "guiding principles" or other written documentation about how to approach children's mental health issues.

Yes ₁ No ₀ Don't Know ₉

10. Does this program have an *unwritten*, but commonly understood, philosophy or approach about how to best provide children's mental health services.

Yes ₁ No ₀ Don't Know ₉

IMPORTANT!

If you answered "No" to BOTH questions 9 and 10, GO TO question 27.

If you answered "Yes," to either 9 or 10, continue with question 11. (See next page).

11. Which of the following led to the development of this program's mental health approach? Check all that apply.

- Management team developed the approach. ₁ The MHC(s) developed the approach. ₂
- All staff helped to develop the approach. ₃ I don't know how the approach was developed. ₄

Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
		1	2	3	4
I learned about this approach:					
12.	By reading about it in a training manual.	1	2	3	4
13.	Because it was part of my initial training when I was hired/contracted with.	1	2	3	4
14.	Through informal conversations or meetings with staff.	1	2	3	4
15.	Through this program's regular pre-service/in-service training.	1	2	3	4
16.	Through informal conversations or meetings with other mental health consultants.	1	2	3	4
17.	By observing or watching other staff.	1	2	3	4
18.	Just by being part of the program.	1	2	3	4
19.	I understood this approach before I started working with this program.	1	2	3	4

The following groups understand and share the program's approach to mental health services:					
20.	Administrators/managers/coordinators/management team	1	2	3	4
21.	Classroom teachers	1	2	3	4
22.	Assistant teachers	1	2	3	4
23.	Family advocates/family services staff	1	2	3	4
24.	Support staff (secretaries, bus drivers, cooks, etc.)	1	2	3	4
25.	Head Start parents	1	2	3	4
26.	Mental health consultants	1	2	3	4

Questions 27–61 ask about the work that you do with this program as the mental health consultant or specialist.

27. Of the total hours spent with this program, what percentage of your time do you spend providing feedback or consultation at the **program level** (e.g., not working with or providing feedback about specific children)? This could include: training staff, developing strategies for improving transitions in classrooms, providing support to staff, helping the program improve the quality of services provided to children with special needs, etc.

- 0% (never do this.) ₁
 51–75% ₅
 Less than 10% ₂
 76–95% ₆
 10–25% ₃
 Over 95% ₇
 26–50% ₄

Instructions: Please indicate the frequency with which you do the following:		Rarely or Never	1–2 Times per Year	Every other Mth	Monthly	Weekly or More
28.	Conduct group (classroom) screenings and observations.	1	2	3	4	5
29.	Conduct individual screenings of children.	1	2	3	4	5
30.	Conduct more in-depth assessments of children after they have been screened.	1	2	3	4	5
31.	Do planning for children with special needs (e.g., IEPs).	1	2	3	4	5
32.	Make referrals for children or families to community services.	1	2	3	4	5
33.	Attend management team meetings.	1	2	3	4	5
34.	Meet with staff teams to discuss children or families.	1	2	3	4	5

35.	Provide direct therapeutic/counseling service to families and children.	1	2	3	4	5
36.	Provide formal training to teachers.	1	2	3	4	5
37.	Talk and meet with parents.	1	2	3	4	5
38.	Provide support to staff for their own well-being.	1	2	3	4	5
	Below list any <i>other</i> major activities that you do for the program that were not listed above:					
39.	a.	1	2	3	4	5
40.	b.	1	2	3	4	5
41.	c.	1	2	3	4	5

	Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement.	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
42.	<i>I have experience working with the HS population.</i>	1	2	3	4
43.	<i>I have a good relationship with the HS program staff.</i>	1	2	3	4
44.	<i>I work as a partner with staff to meet children's MH needs.</i>	1	2	3	4
47.	<i>I have a good relationships with HS program parents.</i>	1	2	3	4
48.	<i>I work closely with program parents to define services to meet children's needs.</i>	1	2	3	4
49.	<i>Most of the parents in the program know me by name.</i>	1	2	3	4
50.	<i>Staff regularly come to me when they need help with particular children or families.</i>	1	2	3	4
51.	<i>I have an awareness of my own cultural norms and expectations, and how these might differ from the cultural experiences of Head Start children and their families.</i>	1	2	3	4
52.	<i>I am able to work effectively with non-English speaking families. 0 Not Applicable</i>	1	2	3	4
54.	<i>I have experience working with young children.</i>	1	2	3	4
55.	<i>I respect staff's perspectives on children's issues.</i>	1	2	3	4
56.	<i>I feel like I am "part of the team" trying to help HS families.</i>	1	2	3	4
57.	<i>I provide services in a way consistent with the HS philosophy.</i>	1	2	3	4
	Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement.	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
59.	<i>Parents of HS children with special needs know me by</i>	1	2	3	4

	<i>name.</i>				
60.	<i>I am available when staff need me.</i>	1	2	3	4
61.	<i>I talk with staff about the ways in which understandings of mental health and related concepts (self-esteem, discipline, etc.) may differ for children based on culture.</i>	1	2	3	4

Please answer the following questions about this program's mental health activities.

	Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. If you <i>don't know</i> , please circle "DK." Think about how program staff, overall, in general, behave.	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Don't Know
64.	Program leadership has a clear vision of how children's mental health issues are related to all program components.	1	2	3	4	DK
65.	Program leadership (e.g., managers, directors, coordinators) supports staff to learn more about children's mental health needs and how to address them.	1	2	3	4	DK
66.	Program leadership advocates and tries to obtain more resources for children's mental health services.	1	2	3	4	DK
67.	Staff in this program disagree on what mental health services should be provided to which children.	1	2	3	4	DK
68.	This program's mental health services and approach are well-integrated into all program components.	1	2	3	4	DK
69.	Staff would like to see therapeutic classrooms for all children with behavioral health challenges.	1	2	3	4	DK
70.	This program's mental health services focus more on children with special needs than on preventing mental health problems.	1	2	3	4	DK
71.	Families in this program who need therapeutic/counseling services have problems accessing these through community-based programs.	1	2	3	4	DK
72.	Staff believe that the best way to meet children's mental health needs is to identify what is "right" with the child, not what is "wrong."	1	2	3	4	DK
73.	Parents of children with special needs regularly attend staffings or service planning meetings.	1	2	3	4	DK
74.	This HS program has effective ways of involving parents in the management of problem behaviors.	1	2	3	4	DK
75.	When a child has a mental health issue, staff actively involve the child's family in meeting this child's needs.	1	2	3	4	DK
76.	Staff work actively to identify and facilitate services for adult mental health issues.	1	2	3	4	DK
77.	When talking with families about children's mental health issues, staff demonstrate an awareness of each family's unique cultural characteristics and preferences.	1	2	3	4	DK

78.	This Head Start program uses curricula that provide images of and attention to children and families from a variety of cultural backgrounds.	1	2	3	4	DK
79.	This Head Start program offers effective trainings on racial/ethnic, social/economic, religious and other cultural differences among children and families.	1	2	3	4	DK
80.	This program's approach to mental health focuses extensively on classroom curriculum.	1	2	3	4	DK
	Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. If you <i>don't know</i> , please circle "DK." Think about how program staff, overall, in general, behave.	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Don't Know
81.	Staff in this program see mental health as part of everything they do.	1	2	3	4	DK
82.	Staff believe that children with significant behavioral challenges are best served by programs other than Head Start.	1	2	3	4	DK
83.	When a few children have significant behavioral challenges, staff find it difficult to spend time with any of the other children in the classroom.	1	2	3	4	DK
84.	This program has a strong partnership with at least one community-based mental health provider.	1	2	3	4	DK
85.	Staff are able to build on family and child strengths even when the family is facing significant challenges (e.g., substance abuse, mental illness, homelessness, etc.).	1	2	3	4	DK
86.	Parents of children with special needs are invited to attend staffings or service planning meetings.	1	2	3	4	DK
87.	Staff feel comfortable talking with parents about their children's mental health needs or issues.	1	2	3	4	DK
88.	This HS program has a mechanism for communicating positive behaviors or events to parents.	1	2	3	4	DK
89.	Staff believe that family participation is essential to improving a child's well-being.	1	2	3	4	DK
90.	Staff have an awareness of how their own cultural norms and expectations may differ from the cultural experiences of Head Start children and their families.	1	2	3	4	DK
91.	This program has staff who feel comfortable talking to non-English speaking families about mental health issues in their own language.	1	2	3	4	DK
92.	In their interactions with children and families, staff regularly demonstrate an appreciation for cultural norms and expectations different from their own.	1	2	3	4	DK
93.	This program's approach to mental health includes a strong focus on staff wellness.	1	2	3	4	DK
94.	This program's approach to mental health focuses exclusively on how to manage children's behavior in the classroom.	1	2	3	4	DK

95.	<i>I have a good understanding of "best practices" in children's mental health.</i>	1	2	3	4	DK
96.	<i>I have a clear understanding of my role in supporting children's mental health in this program.</i>	1	2	3	4	DK
97.	<i>This program provides me with the training and professional support I need to do my job most effectively.</i>	1	2	3	4	DK
99.	Transitions are smoother in classrooms because of the program's mental health services.	1	2	3	4	DK
100.	This program's mental health services help all children in this program.	1	2	3	4	DK
101.	Staff have a hard time knowing what to do to help children with challenging behaviors.	1	2	3	4	DK
103.	This program's mental health services and approach are sufficient to meet the needs of children and families.	1	2	3	4	DK
104.	This HS program has a plan for dealing with children who may have a situational crisis.	1	2	3	4	DK
105.	<i>I consistently use best practices in children's mental health in my work.</i>	1	2	3	4	DK
106.	<i>I feel I do a good job in supporting children's mental health within this program context.</i>	1	2	3	4	DK
107.	<i>This program provides me with the emotional and personal support I need to do my job most effectively.</i>	1	2	3	4	DK

	Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. If you <i>don't know</i> , please circle "DK."	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Don't Know
108.	This program's mental health services have improved the quality of the classroom environments.	1	2	3	4	DK
109.	Our mental health services help children with challenging behaviors.	1	2	3	4	DK
110.	Our mental health services help families know how to cope with children's challenging behaviors.	1	2	3	4	DK
111.	Our mental health services and approach help staff to feel less stress.	1	2	3	4	DK
112.	Our mental health services and approach are in need of improvement.	1	2	3	4	DK

Instructions: Please circle the <i>approximate</i> percentage appropriate to each question.		Less than 5%	6-25%	26-50%	51-75%	76-95%	Over 95%
In the past year:							
114.	What percentage of children in this program received a group (classroom) screening?	1	2	3	4	5	6
115.	What percentage of children received an individual assessment?	1	2	3	4	5	6
116.	What percentage of children were identified as needing mental health services?	1	2	3	4	5	6
122.	What percentage of families or adults are identified as needing mental health services?	1	2	3	4	5	6
Thinking <u>only</u> of those children who were identified as <i>needing</i> mental health services, what percentage of <i>those children</i> received the following (provided by either Head Start or by another service)?		Less than 5%	6-25%	26-50%	51-75%	76-95%	Over 95%
117.	Individual therapeutic services (counseling, play therapy, etc.)	1	2	3	4	5	6
118.	Family therapeutic services (counseling, etc.)	1	2	3	4	5	6
119.	Medication only	1	2	3	4	5	6
120.	Medication plus therapeutic services	1	2	3	4	5	6
121.	Other services. Please describe:	1	2	3	4	5	6
Thinking <u>only</u> of those family adults who were identified as <i>needing</i> mental health services, what percentage of <i>those adults</i> received the following (provided by either Head Start or by another service)?		Less than 5%	6-25%	26-50%	51-75%	76-95%	Over 95%
123.	Individual therapeutic services (counseling, individual treatment, etc.)	1	2	3	4	5	6
124.	Group counseling/ group therapy (support groups, etc.)	1	2	3	4	5	6
125.	Family therapeutic services (family counseling, parent education, etc.)	1	2	3	4	5	6
126.	Medication only	1	2	3	4	5	6
127.	Medication plus therapeutic services	1	2	3	4	5	6
128.	Other services. Please describe:	1	2	3	4	5	6

Instructions: To what extent do you think your mental health services, including prevention and classroom activities, as well as direct mental health services, have helped each of the following? Circle 1 if it has helped a lot, 2 if it has helped somewhat, 3 if it has helped a little, and 4 if it hasn't helped.		Helped a lot	Helped somewhat	Helped a little	Hasn't Helped
129.	Aggression towards other children	1	2	3	4
130.	Aggression towards adults	1	2	3	4
131.	Self-destructive behavior	1	2	3	4
132.	Extreme temper tantrums	1	2	3	4
133.	Withdrawn/overly shy behavior	1	2	3	4
134.	Extreme moodiness	1	2	3	4
135.	Child depression	1	2	3	4
136.	Speech/language problems	1	2	3	4
137.	Problems concentrating	1	2	3	4
138.	Positive social interactions between children	1	2	3	4
139.	Smooth transitions between activities	1	2	3	4
140.	Prosocial behavior (e.g., helping, sharing)	1	3	4	4
141.	Age-appropriate emotional regulation	1	2	3	4
142.	Non-violent problem solving	1	3	3	4

143. At this Head Start, if a teacher requested mental health services for a child, how long would the child have to wait for an evaluation if it is not a crisis?

- 1 week ₁ 1-2 wks ₂ 2-4 wks ₃ 1-2 months ₄ More than 2 months ₅

144. Sometimes Head Start is unable to meet the needs of children with particular issues or problems. In this program, what *issues most frequently* lead to children being referred to another program or service instead of Head Start? That is, what issues or problems do children have who cannot be served in the Head Start classroom?

145. What do you believe is the *most outstanding* part of this program's mental health services? That is, what makes your mental health services most effective?

146. What do you believe is the *most unsatisfactory* part of this program's mental health services? That is, what *prevents* your mental health services from being as effective as they could be?

Thank you very much for your valuable time. Now just fold, tape, and place this survey in outgoing mail. You will be entered in the cash drawing, and we look forward to sending your program's report.

Appendix C: Focus Group Participant Questionnaire

Focus Group Participant Questionnaire
Mental Health Consultant Project

1. **Date:** _____ 2. **Date of Birth** _____
3. **What is your gender?** ___ M ___ F
4. **What is your job title?** _____
5. **Which of the following best describes your position? (Check one)**
- Therapist or counselor employed directly by the Head Start program
- Therapist or counselor employed by a community nonprofit
- Therapist or counselor employed by a government agency (e.g., public health department) or Native Health Corporation
- Therapist or counselor in private practice
- School-based therapist/counselor
- Other, please describe:

6. **How many months/years have you worked for this organization?**
_____ mths/ _____ years
7. **How many months/years have you held your current position?**
_____ mths/ _____ years

8. Which of the following best describes the Head Start program in which you work the most?

- Primarily rural (small town)
- Primarily suburban (serving the outlying areas of a moderate or large city)
- Primarily urban (serving persons within a moderate or large city)

9. How many months/years have you worked with the current Head Start program? _____ mths/_____ years

10. How many hours a week do you work with the current Head Start program?
_____ hours/week

11. How many hours a month do you work with the current Head Start program? _____ hours/month

12. How many months/years have you worked in early childhood mental health?
_____ mths/_____ years

13. What is the highest education level you have obtained? (Please provide year obtained)

- | | |
|---|-----------------------------|
| _____ High School | _____ 4-year college degree |
| _____ Associate Degree | _____ Master's Degree |
| _____ Child Dev. Assoc. Certificate (CDA) | _____ Doctoral degree |

14. What is your primary training or professional affiliation?

- Counselor
- Licensed Marriage and Family Therapist
- Physical Therapist
- Social Worker
- Speech Pathologist
- Psychologist
- Psychiatrist
- Public Health Nurse/ Nurse
- Other _____

15. How do you describe your race/ethnicity? (Check all that apply)

- Asian/Pacific Islander
- Alaska Native / American Indian
- Black/African-American
- Caucasian
- Hispanic/Latino(a)
- Other:

Please return this form to:

Mary Dallas Allen
Regional Research Institute for Human Services
Portland State University
P.O. Box 751, Portland, OR 97207
Phone: (503) 725-4113
Fax: (503) 725-4180

Appendix D: Focus Group Interview Guide - Rural

Focus Group ID:

Focus Group Date:

Focus Group Time Start: _____

Focus Group Time End: _____

Focus Group Participants:**Mental Health Consultant Focus Group Script****(8 minutes) Introduction:** Start _____ Stop _____

Now that we have everyone on the call, I would like to get started. First, I want to make sure that everyone received the focus group questions that I sent. {If not, we will fax}.

Let's begin with introductions, so that we all know who is on the call. Please share your name and where you are calling from.

Again my name is Mary Dallas Allen, and I am a graduate student in the School of Social Work at Portland State University. Before returning to graduate school, I worked for a Head Start program as a family services coordinator, which is where I became interested in mental health consultation. I would also like to introduce _____, who will be helping me on this call. {_____ 's introduction}.

The purpose of this focus group is to learn more about how mental health consultants develop strong working relationships with Head Start staff. We have asked you to participate because we would like for you to share your experience as a mental health consultant working with Head Start staff in rural communities. We will be asking you about your ideas and your experiences.

Thank you so much for returning your consent to participate forms and the questionnaires. I would like to remind you that your participation in this telephone focus group is entirely voluntary. Although the group is scheduled for one hour, you may leave the group at any time. You may also choose to not answer any questions. This teleconference will be audio-recorded and typed into a transcript. If for some reason you get disconnected from the call, you can simply rejoin by dialing the number and entering the conference room number.

I would like to remind everyone that the confidentiality of all participants is very important. You can help maintain the confidentiality of other focus group members by keeping all information that is shared during this call within the focus group. The research team will maintain the confidentiality of all members by storing all information in a locked file cabinet and password protected computer files. In addition, results of the study will be reported anonymously so that it will not be possible to identify you, your place of employment, your community, or the Head Start program that you work with.

We would like to thank you for participating in this focus group. The \$20.00 stipend mentioned in the recruiting information will be mailed next week.

Because this is a telephone conference group, I would like to ask everyone to state your first name prior to speaking. Stating your name will help all of us to know who is speaking, and it will also help to identify each speaker when the tape is transcribed. Thank you.

Are there any questions?

At this time, we would like to begin our focus group. We will have about fifty-five minutes to discuss the questions regarding your experiences as a mental health consultant that I sent to you by email or by fax. Did everyone receive those questions? I would like to encourage everyone to share their ideas, and I want to be sure that I am not leaving anyone out of the conversation. If you have an idea that has not been expressed, then I encourage you to share it. Please remember to state your name before you begin speaking.

****Start recording!!!**

Question One: 15 minutes (3:10-3:25) Start _____ Stop _____

1. For this question, I would like for you to think about the Head Start program that you worked with during the 2006-2007 Head Start school year, which was this past school year. Now I would like for you to think about when you first started working with this Head Start program as a mental health consultant. What was helpful to you as you were just getting started with the program as their mental health consultant?

Probes:

- What was difficult when you were first getting started?
- What helped you to overcome those challenges?
- Who did you turn to for information and support?
- Were there any challenges that you think are specific to providing mental health consultation with a rural Head Start program?

Question Two: 20 minutes (3:25-3:45) Start _____ Stop _____

2. Now I would like for you to imagine that you are in charge of hiring and training a mental health consultant to work with a rural Head Start program, and you have an unlimited budget for salary, training, and supervision.

- First, imagine that you are interviewing people who are applying for this mental health consultation job. What skills does a successful applicant need in order to be an effective mental health consultant for a rural Head Start program? **(10 minutes)**

Probes:

- What interpersonal skills does a successful applicant need to have in order to be an effective mental health consultant to a Head Start program?
- What skills does an applicant need to successfully work with Head Start families?
- What types of work experience does a successful applicant need to have had in the past?
- What type of education or training does a successful applicant need in order to be an effective mental health consultant for a rural program?
- What level of education does a successful applicant need in order to be an effective mental health consultant for a rural Head Start program (AA degree, Bachelors, Masters, PhD)?
- Now imagine that you have hired a person to be a mental health consultant. What information about mental health consultation in rural communities do

you think is important to share with this recently hired mental health consultant? **(10 minutes)**

Probes:

- What information about Head Start do you think is important to share with this recently hired mental health consultant?
- What information about working with Head Start families in rural communities do you think is important to share with this recently hired mental health consultant?
- What type of supervision do you think that a new mental health consultant in a rural Head Start program should receive?
- What type of support do you think that a new mental health consultant in a rural Head Start program should receive?

Question Three: 15 minutes (3:45-4:00) Start _____ Stop _____

3. Now I am going to describe a scenario. Imagine that you are the mental health consultant for a rural Head Start program, and you are working with an excellent and experienced Head Start lead teacher. Unfortunately, you get the feeling that this teacher is not interested in working with you, because she shares very little information with you. She says that everything in her classroom is fine, although during your observation of the classroom you noticed several children who had behaviors that concerned you. What are some ways that you might try to develop a partnership with this teacher?

Probes:

- Is there anything else you can think of that you would do to develop a positive relationship with this Head Start teacher?
- What do you think are some of the barriers between mental health consultants and Head Start teachers?
- How would you overcome those barriers?
- How might you work to develop your relationship if the teacher has a different background than you? (cultural, racial, socioeconomic, education, experience)
- What are some things that you think this Head Start program could do to help you and this teacher to build a positive relationship?

Conclusion: 2 minutes End time _____

That concludes our focus group questions. Thank you so much for participating. During this group I learned a great deal, such as

_____.

This was one of several focus groups that we will be holding. What advice do you have for us as we listen to others? Is there anything else about your experience as a mental health consultant that you would like to share?

Thank you so much for participating in this focus group. We will mail your \$20.00 compensation check to you early next week. You have each provided valuable information that will make a significant contribution to our knowledge of early childhood mental health consultation with Head Start programs. If you have any questions or concerns about this focus group, please feel free to contact me at

503.725.4113 or you may contact the PSU Human Subjects Research Review

Committee at 503.725.4288 or toll free at 1.877.480. 4400. Goodbye.

Appendix E: Focus Group Interview Guide – Urban

Focus Group ID:

Focus Group Date:

Focus Group Time Start: _____

Focus Group Time End: _____

Focus Group Participants:**Mental Health Consultant Focus Group Script****(8 minutes) Introduction:** Start _____ Stop _____

Now that we have everyone on the call, I would like to get started. First, I want to make sure that everyone received the focus group questions that I sent. {If not, we will fax}.

Let's begin with introductions, so that we all know who is on the call. Please share your name and where you are calling from.

Again my name is Mary Dallas Allen, and I am a graduate student in the School of Social Work at Portland State University. Before returning to graduate school, I worked for a Head Start program as a family services coordinator, which is where I became interested in mental health consultation. I would also like to introduce _____, who will be helping me on this call. {_____ 's introduction}.

The purpose of this focus group is to learn more about how mental health consultants develop strong working relationships with Head Start staff. We have asked you to participate because we would like for you to share your experience as a

mental health consultant working with Head Start staff in urban / suburban communities. We will be asking you about your ideas and your experiences.

Thank you so much for returning your consent to participate forms and the questionnaires. I would like to remind you that your participation in this telephone focus group is entirely voluntary. Although the group is scheduled for one hour, you may leave the group at any time. You may also choose to not answer any questions. This teleconference will be audio-recorded and typed into a transcript. If for some reason you get disconnected from the call, you can simply rejoin by dialing the number and entering the conference room number.

I would like to remind everyone that the confidentiality of all participants is very important. You can help maintain the confidentiality of other focus group members by keeping all information that is shared during this call within the focus group. The research team will maintain the confidentiality of all members by storing all information in a locked file cabinet and password protected computer files. In addition, results of the study will be reported anonymously so that it will not be possible to identify you, your place of employment, your community, or the Head Start program that you work with.

We would like to thank you for participating in this focus group. The \$20.00 stipend mentioned in the recruiting information will be mailed next week.

Because this is a telephone conference group, I would like to ask everyone to state your first name prior to speaking. Stating your name will help all of us to know

who is speaking, and it will also help to identify each speaker when the tape is transcribed. Thank you.

Are there any questions?

At this time, we would like to begin our focus group. We will have about fifty-five minutes to discuss the questions regarding your experiences as a mental health consultant that I sent to you by email or by fax. Did everyone receive those questions? I would like to encourage everyone to share their ideas, and I want to be sure that I am not leaving anyone out of the conversation. If you have an idea that has not been expressed, then I encourage you to share it. Please remember to state your name before you begin speaking.

****Start recording!!!!**

Question One: 15 minutes (3:10-3:25) Start _____ Stop _____

4. For this question, I would like for you to think about the Head Start program that you worked with during the 2006-2007 Head Start school year, which was this past school year. Now I would like for you to think about when you first started working with this Head Start program as a mental health consultant. What was helpful to you as you were just getting started with the program as their mental health consultant?

Probes:

- What was difficult when you were first getting started?
- What helped you to overcome those challenges?
- Who did you turn to for information and support?

- Were there any challenges that you think are specific to providing mental health consultation with an urban / suburban Head Start program?

Question Two: 20 minutes (3:25-3:45) Start _____ Stop _____

5. Now I would like for you to imagine that you are in charge of hiring and training a mental health consultant to work with an urban / suburban Head Start program, and you have an unlimited budget for salary, training, and supervision.

- First, imagine that you are interviewing people who are applying for this mental health consultation job. What skills does a successful applicant need in order to be an effective mental health consultant for an urban / suburban Head Start program? **(10 minutes)**

Probes:

- What interpersonal skills does a successful applicant need to have in order to be an effective mental health consultant to a Head Start program?
- What skills does an applicant need to successfully work with Head Start families?
- What types of work experience does a successful applicant need to have had in the past?
- What type of education or training does a successful applicant need in order to be an effective mental health consultant for an urban / suburban program?

- What level of education does a successful applicant need in order to be an effective mental health consultant for an urban / suburban Head Start program (AA degree, Bachelors, Masters, PhD)?
- Now imagine that you have hired a person to be a mental health consultant. What information about mental health consultation in urban / suburban communities do you think is important to share with this recently hired mental health consultant? **(10 minutes)**

Probes:

- What information about Head Start do you think is important to share with this recently hired mental health consultant?
- What information about working with Head Start families in urban / suburban communities do you think is important to share with this recently hired mental health consultant?
- What type of supervision do you think that a new mental health consultant in an urban / suburban Head Start program should receive?
- What type of support do you think that a new mental health consultant in an urban / suburban Head Start program should receive?

Question Three: 15 minutes (3:45-4:00) Start _____ Stop _____

6. Now I am going to describe a scenario. Imagine that you are the mental health consultant for an urban / suburban Head Start program, and you are working with an excellent and experienced Head Start lead teacher. Unfortunately, you get the feeling that this teacher is not interested in working with you, because she shares

very little information with you. She says that everything in her classroom is fine, although during your observation of the classroom you noticed several children who had behaviors that concerned you. What are some ways that you might try to develop a partnership with this teacher?

Probes:

- Is there anything else you can think of that you would do to develop a positive relationship with this Head Start teacher?
- What do you think are some of the barriers between mental health consultants and Head Start teachers?
- How would you overcome those barriers?
- How might you work to develop your relationship if the teacher has a different background than you? (cultural, racial, socioeconomic, education, experience)
- What are some things that you think this Head Start program could do to help you and this teacher to build a positive relationship?

Conclusion: 2 minutes End time _____

That concludes our focus group questions. Thank you so much for participating. During this group I learned a great deal, such as

_____.

This was one of several focus groups that we will be holding. What advice do you have for us as we listen to others? Is there anything else about your experience as a mental health consultant that you would like to share?

Thank you so much for participating in this focus group. We will mail your \$20.00 compensation check to you early next week. You have each provided valuable information that will make a significant contribution to our knowledge of early childhood mental health consultation with Head Start programs. If you have any questions or concerns about this focus group, please feel free to contact me at 503.725.4113 or you may contact the PSU Human Subjects Research Review Committee at 503.725.4288 or toll free at 1.877.480. 4400. Goodbye.

Appendix F: Description of Codes
Attributes of Effective Head Start ECMH Consultants

Description of Codes

Knowledge of and Experience with Head Start and Early Childhood Education (HS experience)

- MHCs understand the challenges and constraints of early childhood group care and education
- MHCs have knowledge of and experience with early childhood education and early intervention systems
- MHCs recognize the strengths that early childhood staff bring to the table, thereby avoiding an “expert stance”
- MHCs recognize and acknowledge the important roles that early childhood staff play in the lives of children, as well as the knowledge and expertise required in those roles
- MHCs have specific knowledge of and experience with Head Start
- MHCs have an understanding of the HS Performance Standards and how they guide HS practices
- MHCs understand the structure of HS
- MHCs understand how HS is set up and how it operates

High level of comfort in working with families (Family)

- MHCs have knowledge of family systems and feel comfortable working with families of children enrolled in Head Start
- MHCs have prior experience interacting with parents and families
- MHCs feel confident in identifying and addressing the physical, emotional, and mental challenges of parenting
- MHCs believe that family involvement is an essential component for positive outcomes in mental health consultation
- MHCs recognize that positive relationships between the MHC and the parent / family are particularly important for young children, because they are dependent on their parents / families for accessing mental health services
- MHCs involve families in a variety of ways, such as conducting parent training and meeting with individual families
- Describe how MHCs develop relationships with families

Cultural competence (Culture)

- Culture is broadly defined and may include the culture of different socioeconomic groups, the culture of rural communities, etc.
 - MHCs understand how cultural histories contribute to communication styles, parenting practices, and perspectives on child development and child mental health

- MHCs have the skills to distinguish between unwillingness to change and a desire to continue practicing culturally appropriate activities
- MHCs understand and acknowledge how their own culture influences and colors their world view
- MHCs demonstrate cultural competence when working with children, families, and staff.
- MHCs understand and are knowledgeable about the community they are working with.

Ability to develop positive working relationships with staff (Relationship)

- MHCs are able to work effectively with early childhood staff that have varying levels of education, experience, and cultural histories
- MHCs provides training to staff, consultation to individual teachers or groups of staff, and support for staff wellness
- MHC feels that they are part of the HS team
- MHC works to develop a positive working relationship with the HS staff
- MHC understands the roles and responsibilities of the staff

Knowledge of early childhood mental health best practices (Best practices)

- MHCs have the knowledge and skills necessary to integrate early childhood mental health practices across Head Start program components
- MHCs provide training and support to parents and staff on early childhood mental health best practices
- MHCs are able to access community based mental health services for children and families
- MHCs effectively work with Head Start program staff to jointly develop a shared vision of mental health services within the program and to provide effective services for children
- MHC promotes the social and emotional development of children
- Strong foundation in mental health
- MHCs provide information to families and staff about children's mental health

Adequate training, supervision, and support (Training)

- MHCs have a strong foundation in mental health
- MHCs represent a variety of professional affiliations, including social work, psychology, marriage and family therapy, psychiatry, and counseling
- MHCs should receive regular, ongoing support and supervision
- Supervision should address not only clinical skills in working with children and families, but it should also support the relationships between the MHC, the early childhood staff, and the program directors
- MHCs should have opportunities to engage in regular professional development trainings on topics such as assessment, cultural competency, or early childhood mental health best practices

- Training and support for MHCs working in rural areas may be particularly important, because they are often geographically isolated from colleagues and supervisors
- MHC has received training or information about the role as a MHC with HS

Role Confusion/Role Clarification (Role)

- MHC describes a personal need to better understand the role of a MHC
- MHC describes a need for the HS staff to better understand the role of a MHC
- MHC describes a need for the HS program to better understand the role of a MHC

Rural (Rural)

- Apply when there is any mention of “Rural”
- Rural includes small communities; agricultural communities; “the bush”

Appendix G: Parameter Estimates & Model Fit
Internalizing Behaviors & Knowledge of HS

	Model 1				Model 2				Model 3				Model 4				
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	
Fixed Effects																	
For Intercept (β_{0j})																	
Intercept (γ_{00})	2.61	.05	50.01	.00	2.76	.05	53.70	.00	2.60	.05	47.91	.00	2.59	.06	44.74	.00	
Totkids																	
(γ_{01})*					.00	.00	2.80	.01	.00	.00	.93	.36	.00	.00	1.47	.15	
Knowhs (γ_{02})*					-.06	.13	-.44	.67	-.16	.23	-1.32	.19	-.20	.233	-1.51	.14	
Rururb (γ_{03})*													-.17	.12	-1.35	.18	
Interaction																	
(γ_{04})													-.19	.28	-.67	.50	
For HS Exp Slope (β_{1j})																	
HS Exp (γ_{10})*	.01	.01	1.40	.17					.01	.01	1.29	.20	.01	.01	1.18	.24	
For HS Race Slope (β_{2j})																	
HSRace (γ_{20})	.35	.08	4.51	.00					.35	.08	4.48	.00	.37	.08	4.67	.00	
Random Effects																	
Intercept (u_{0j})	.20	.04	48.53	.10	.28	.08	105.60	.00	.22	.05	48.93	.06	.22	.05	45.18	.08	
HS exp. Slope																	
(u_{1j})	.02	.00	44.20	.19					.02	.00	44.35	.19	.02	.00	44.51	.19	
HSRace Slope																	
(u_{2j})	.22	.05	43.47	.22					.20	.04	43.46	.22	.20	.04	43.05	.23	
Level-1 (e_{1j})	.72	.52	43.47	.22	.75	.57			.72	.52			.72	.52			
Model Fit	Dev.	Param			Dev.	Param			Dev.	Param			Dev.	Param			
	951.98	7			982.02	2			969.54	7			969.80	7			

Note. *Grand mean centered

Parameter Estimates & Model Fit
Internalizing Behaviors & MHC Comfort with Parents

	Model 1				Model 2				Model 3				Model 4				
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	
Fixed Effects For Intcpt (β_{0j})																	
Intercept (γ_{00})	2.61	.05	50.01	.00	2.76	.05	54.39	.00	2.61	.05	49.34	.00	2.61	.05	50.20	.00	
Totkids* (γ_{01}) Comfpar* (γ_{02})		.00	2.40	.02	.00	.00	2.40	.02	.00	.00	.75	.46	.00	.00	1.81	.24	
Rururb* (γ_{03}) Interaction (γ_{04})		.10	.08	1.18	.24	.06	.07	.82	.42	.05	.07	.77	.45	.07	.77	.45	
For HS Exp Slope (β_{1j})																	
HS Exp* (γ_{10})	.01	.01	1.40	.17					.01	.01	1.43	.16	.01	.01	1.22	.23	
For HS Race Slope (β_{2j})																	
HSRace (γ_{20})	.35	.08	4.51	.00					.34	.08	4.11	.00	.33	.08	4.06	.00	
Random Effects	Std. Dev.	Var. Comp	χ^2	p	Std. Dev.	Var. Comp	χ^2	p	Std. Dev.	Var. Comp	χ^2	p	Std. Dev.	Var. Comp	χ^2	p	
Intercept (u_{0j})	.20	.04	48.53	.10	.27	.07	103.02	.00	.21	.04	49.79	.05	.19	.04	46.14	.06	
HS exp. Slope (u_{1j})	.02	.00	44.20	.19					.02	.00	44.06	.20	.02	.00	44.07	.20	
HSRace Slope (u_{2j})	.22	.05	43.47	.22					.21	.04	44.06	.20	.20	.04	43.83	.20	
Level-1 (e_{1j})	.72	.52	43.47	.22	.75	.57			.72	.52			.72	.52			
Model Fit	Dev.	Param.			Dev.	Param.			Dev.	Param.			Dev.	Param.			
	952.00	7			982.44	2			971.33	7			972.08	7			

Note. *Grand mean centered

Parameter Estimates & Model Fit
Internalizing Behaviors & MHC Positive Relationship with Parents

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
For Intept (β_{0j})																
Intercept (γ_{00})	2.61	.05	50.01	.00	2.76	.05	53.81	.00	2.61	.05	48.51	.00	2.67	.08	35.51	.00
Totkids* (γ_{01})																
Postrel					.00	.00	2.79	.01	.00	.00	.91	.37	.00	.00	1.18	.24
* (γ_{02})					-.01	.12	-1.10	.27	-.03	.11	-2.29	.03	.06	.16	.41	.69
Rururb* (γ_{03})																
Interaction																
(γ_{04})																
For HS Exp Slope (β_{1j})																
HS Exp* (γ_{10})	.01	.01	1.40	.17					.01	.01	1.37	.18	.01	.01	1.18	.25
For HS Race Slope (β_{2j})																
HSRace (γ_{20})	.35	.08	4.51	.00					.34	.08	4.27	.00	.35	.08	4.34	.00
Random Effects																
Intercept (u_{0j})	.20	.04	48.53	.10	.28	.08	105.52	.00	.21	.05	48.73	.06	.22	.05	45.51	.07
HS exp. Slope (u_{1j})	.02	.00	44.20	.19					.02	.00	44.27	.19	.02	.00	44.48	.19
HSRace Slope (u_{2j})	.22	.05	43.47	.22					.21	.04	43.75	.21	.21	.04	43.64	.21
Level-1 (e_{ij})	.72	.52	43.47	.22	.73	.57			.72	.52			.72	.52		
Model Fit																
Dev.	952.00	7			982.80	2			970.83	7			972.02	7		

Note. *Grand mean centered

Parameter Estimates & Model Fit
Internalizing Behaviors & MHC Adequate Training, Supervision, and Support

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
For Intercept (β_{0j})																
Intercept (γ_{00})	2.61	.05	50.01	.00	2.76	.05	53.42	.00	2.60	.05	48.30	.00	2.67	.07	36.97	.00
Totkids* (γ_{01})					.00	.00	2.59	.01	.00	.00	.59	.56	.00	.00	.78	.44
Adeqtr * (γ_{02})					.06	.09	.64	.52	.11	.10	1.13	.26	.15	.08	1.79	.08
Rururb* (γ_{03})									-.13	.11	-1.16	.25				
Interaction (γ_{04})									.26	.16	1.62	.11				
For HS Exp Slope (β_{1j})																
HS Exp* (γ_{10})	.01	.01	1.40	.17					.01	.01	1.27	.21	.01	.01	1.07	.29
For HS Race Slope (β_{2j})																
HSRace (γ_{20})	.35	.08	4.51	.00	.35	.08	4.32	.00	.36	.08	4.32	.00	.36	.08	4.30	.00
Random Effects																
	Std. Dev.	Var. Comp.	χ^2	p	Std. Dev.	Var. Comp.	χ^2	p	Std. Dev.	Var. Comp.	χ^2	p	Std. Dev.	Var. Comp.	χ^2	p
Intercept (u_{0j})	.20	.04	48.53	.10	.27	.08	104.58	.00	.19	.04	46.45	.09	.18	.03	43.31	.11
HS exp. Slope (u_{1j})	.02	.00	44.20	.19					.01	.00	44.20	.19	.02	.00	44.73	.18
HSRace Slope (u_{2j})	.22	.05	43.47	.22					.22	.05	43.36	.22	.24	.06	43.60	.21
Level-1 (e_{1j})	.72	.52	43.47	.22	.73	.57			.72	.52			.72	.52		
Model Fit	Dev. Param.	952.00	7		Dev. Param.	983.28	2		Dev. Param.	970.03	7		Dev. Param.	970.70	7	

Note. *Grand mean centered

Parameter Estimates & Model Fit
Internalizing Behaviors & MHC Knowledge of MH Best Practices

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T- ratio	p	Coef	SE	T- ratio	p	Coef	SE	T- ratio	p	Coef	SE	T- ratio	p
For Intcept (β_{0j})																
Intercept (γ_{00})	2.61	.05	50.01	.00	2.77	.05	55.84	.00	2.62	.05	50.42	.00	2.68	.06	41.75	.00
Totkids* (γ_{01})																
MHpract					.00	.00	2.59	.01	.00	.00	1.03	.31	.00	.00	1.35	.18
* (γ_{02})					.25	.12	2.20	.03	.18	.12	1.44	.15	.16	.13	1.32	.19
Rururb* (γ_{03})																
Interaction																
(γ_{04})																
For HS Exp Slope (β_{1j})																
HS Exp* (γ_{10})	.01		1.40	.17					.01		1.39	.17	.01		1.26	.21
For HS Race Slope (β_{2j})																
HSRace (γ_{20})	.35	.08	4.51	.00	.32	.08	4.00	.00	.34	.08	4.00	.00	.34	.08	4.06	.00
Random Effects																
Intercept (u_{0j})	.20	.04	48.53	.10	.26	.07	98.14	.00	.20	.04	49.06	.06	.20	.04	45.98	.07
HS exp. Slope (u_{1j})	.02	.00	44.20	.19					.02	.00	44.15	.20	.02	.00	44.23	.19
HSrace Slope (u_{2j})	.22	.05	43.47	.22					.22	.05	44.23	.19	.22	.05	43.79	.21
Level-1 (e_{1j})	.72	.52	43.47	.22	.75	.57			.72	.52			.72	.52		
Model Fit	952.00	7			979.35	2			969.06	7			970.88	7		

Note. *Grand mean centered

Parameter Estimates & Model Fit
 Externalizing Behaviors & MHC Adequate Training, Supervision, & Support

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
Fixed Effects																
For Intep (β_{0j})																
Intercept (γ ₀₀)	2.76	.06	44.21	.00	2.87	.05	52.44	.00	2.75	.06	44.12	.00	2.79	.09	31.16	.00
Totkids*																
(γ ₀₁)	.00	.00	1.56	.12	.00	.00	1.56	.12	.00	.00	.68	.50	.00	.00	.69	.49
Adeqtr* (γ ₀₂)	.08	.09	.87	.39	.13	.10	1.27	.21	.15	.10	1.50	.14	.15	.10	1.50	.14
Rururb																
(γ ₀₃)																
Interaction																
(γ ₀₄)																
For HSExp Slope (β_{1j})																
HS Exp* (γ ₁₀)	.01	.01	1.12	.27	.01	.01	1.03	.31	.01	.01	1.03	.31	.01	.01	.95	.35
For HSEth Slope (β_{2j})																
HSEth (γ ₂₀)	.27	.08	3.25	.00	.27	.09	3.08	.00	.27	.09	3.08	.00	.27	.09	3.06	.00
Random Effects																
Intercept (u _{0j})	.27	.07	47.77	.11	.29	.09	110.90	.00	.26	.07	45.02	.12	.26	.07	42.66	.12
HS exp.																
Slope (u _{1j})	.02	.00	43.77	.21	.02	.00	43.77	.21	.02	.00	43.77	.21	.02	.00	43.97	.20
HSrace Slope (u _{2j})	.11	.01	35.97	>.50	.12	.01	35.90	>.50	.14	.02	35.91	>.50	.14	.02	35.91	>.50
Level-1 (e _{1j})	.74	.54			.76	.58			.74	.54			.74	.54		
Model Fit	Dev. Param.	972.60	7		Dev. Param.	993.25	2		Dev. Param.	990.20	7		Dev. Param.	993.25	7	

Note. *Grand mean centered

Parameter Estimates & Model Fit
Externalizing Behaviors & MHC Comfort with Parents

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T- ratio	p	Coef	SE	T- ratio	p	Coef	SE	T- ratio	p	Coef	SE	T- ratio	p
Fixed Effects																
For Intercept (β_{0j})																
Intercept (γ_{00})	2.76	.06	44.21	.00	2.87	.05	53.63	.00	2.76	.06	44.66	.00	2.77	.06	45.79	.00
Totkids*																
(γ_{01})					.00	.00	2.63	.01	.00	.00	1.02	.31	.00	.00	1.27	.21
Comfpar*									.06	.08	.74	.46	.04	.08	.52	.61
(γ_{02})																
Rururb																
(γ_{03})																
Interaction (γ_{04})																
For HS Exp																
Slope (β_{1j})									.01	.01	1.16	.25	.01	.01	1.09	.28
HS Exp* (γ_{10})	.01	.01	1.12	.27												
For HSrace Slope (β_{2j})									.25	.09	2.91	.01	.24	.09	2.75	.01
HSrace (γ_{20})	.27	.08	3.25	.00												
Random Effects																
Intercept (u_{0j})	.27	.07	47.77	.11	.30	.09	53.63	.00	.28	.08	48.54	.06	.27	.08	44.72	.08
HS exp. Slope (u_{1j})	.02	.00	43.77	.21					.02	.00	43.71	.21	.02	.00	43.71	.21
HSrace Slope (u_{2j})	.11	.01	35.97	>.50					.10	.01	36.32	>.50	.10	.01	36.47	>.50
Level-1 (e_{1j})	.74	.54			.76	.58			.74	.54			.74	.54		
Model Fit	Dev	Param.			Dev	Param.			Dev	Param.			Dev	Param.		
	972.60	7			993.28	2			991.74	7			993.09	7		

Note. *Grand mean centered

Parameter Estimates & Model Fit
Externalizing Behaviors & Knowledge of HS

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
Fixed Effects																
For Intercept (β_{0j})																
Intercept (γ_{00})	2.76	.06	44.21	.00	2.87	.05	53.42	.00	2.76	.06	43.31	.00	2.75	.07	42.30	.00
Totkids*																
(γ_{01})		.00	3.03	.00	.00	.00	3.03	.00	.00	.00	1.26	.21	.00	.00	1.50	.14
Knowhws*																
(γ_{02})	.05	.17	.30	.76	.05	.17	.30	.76	-.03	.15	-.22	.83	-.07	.17	-.40	.69
Rururb																
(γ_{03})																
Interaction																
(γ_{04})																
For HSExp Slope (β_{1j})																
HS Exp*																
(γ_{10})	.01	.01	1.12	.27	.01	.01	1.11	.27	.01	.01	1.11	.27	.01	.01	1.05	.30
For HSEth Slope (β_{2j})																
HSEth																
(γ_{20})	.27	.08	3.25	.00	.26	.08	3.03	.00	.26	.08	3.03	.00	.30	.09	3.09	.00
Random Effects																
Intercept (u_{0j})	.27	.07	47.77	.11	.30	.09	112.53	.00	.29	.08	48.04	.07	.30	.09	46.02	.07
HS exp.																
Slope (u_{1j})	.02	.00	43.77	.21	.02	.00	43.74	.21	.02	.00	43.74	.21	.02	.00	43.82	.21
HSracc Slope																
(u_{2j})	.11	.01	35.97	>.50	.09	.01	36.12	>.50	.08	.01	36.12	>.50	.08	.01	35.91	>.50
Level-1 (e_{1j})	.74	.54			.76	.58			.74	.54			.74	.54		
Model Fit	Dev.	Param.			Dev.	Param.			Dev.	Param.			Dev.	Param.		
	972.60	7			992.39	2			990.47	7			992.07	7		

Note. *Grand mean centered

Parameter Estimates & Model Fit
 Externalizing Behaviors & MHC Knowledge of MH Best Practices

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
Fixed Effects																
For Intercept (β_{0j})																
Intercept (γ_{00})	2.76	.06	44.21	.00	2.87	.05	53.94	.00	2.77	.06	45.86	.00	2.80	.08	34.71	.00
Tofkids*																
(γ_{01})		.00		1.81	.08	.00		.16	.00		1.43	.16	.00		1.51	.14
Mhpract*																
(γ_{02})		.25	.14	1.80	.08	.21		.16	.15		1.4	.16	.20		1.42	.16
Rururb																
(γ_{03})																
Interaction																
(γ_{04})																
For HSExp Slope (β_{1j})																
HS Exp*																
(γ_{10})	.01	.01	1.12	.27					.01	.01	1.10	.28	.01	.01	1.05	.30
For HSEth Slope (β_{2j})																
HSEth																
(γ_{20})	.27	.08	3.25	.00					.23	.09	2.71	.01	.24	.09	2.72	.01
Random Effects																
Intercept (u_{0j})	.27	.07	47.77	.11	.28	.08	104.82	.00	.26	.07	47.58	.08	.26	.07	45.23	.08
HS exp.																
Slope (u_{1j})	.02	.00	43.77	.21					.02	.00	43.76	.21	.02	.00	43.64	.21
HSpace Slope																
(u_{2j})	.11	.01	35.97	>.50					.12	.01	36.68	>.50	.12	.01	36.30	>.50
Level-1 (e_{1j})	.74	.54			.76	.58			.74	.54			.74	.54		
Model Fit	Dev.	Param.			Dev.	Param.			Dev.	Param.			Dev.	Param.		
	972.60	7			990.06	2			989.13	7			990.42	7		

Note. *Grand mean centered

Parameter Estimates & Model Fit
 Externalizing Behaviors & MHC Positive Relationship with HS Staff

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
Fixed Effects																
For Intercept (β_{0j})																
Intercept (γ_{00})	2.76	.06	44.21	.00	2.87	.06	52.17	.00	2.76	.06	44.75	.00	2.80	.09	30.87	.00
Toikids*																
(γ_{01})	.00	.00	1.62	.11	.00	.00	1.03	.31	.00	.00	1.03	.31	.00	.00	1.26	.21
Postrel* (γ_{02})	.08	.14	.55	.58	.07	.12	.57	.57	.13	.16	.83	.41	.13	.16	.83	.41
Rururb																
(γ_{03})																
Interaction																
(γ_{04})																
For HSExp Slope (β_{1j})																
HS Exp*	.01	.01	1.12	.27	.01	.01	1.13	.26	.01	.01	1.13	.26	.01	.01	1.04	.30
(γ_{10})																
For HSEth Slope (β_{2j})																
HSEth	.27	.08	3.25	.00	.25	.09	2.96	.01	.26	.09	2.98	.01	.26	.09	2.98	.01
(γ_{20})																
Random Effects																
Intercept (u_{0j})	.27	.07	47.77	.11	.30	.09	112.12	.00	.28	.08	48.27	.07	.28	.08	45.56	.07
HS exp.																
Slope (u_{1j})	.02	.00	43.77	.21	.02	.00	43.70	.21	.02	.00	43.70	.21	.02	.00	43.83	.20
HSRace Slope																
(u_{2j})	.11	.01	35.97	>.50	.11	.01	36.20	>.50	.10	.01	36.14	>.50	.10	.01	36.14	>.50
Level-1 (e_{1j})	.74	.54			.08	.13	.61	.54	.74	.54			.74	.54		
Model Fit	Dev.	Param.			Dev.	Param.			Dev.	Param.			Dev.	Param.		
	972.60	7			992.85	2			991.00	7			992.93	7		

Note. *Grand mean centered

Parameter Estimates & Model Fit
 Prosocial Behaviors & MHC Comfort with Parents

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
Fixed Effects																
For Intcept (β_{0j})																
Intercept (γ_{00})	2.95	.07	44.22	.00	3.05	.05	55.79	.00	2.95	.07	44.71	.00	2.94	.07	44.32	.00
Totkids*																
(γ_{01})					.00	.00	1.17	.25	.00	.00	.00	1.00	.00	.00	.63	.53
Commpar*																
(γ_{02})*					.05	.08	.65	.42	.05	.08	.65	.52	.06	.08	.80	.43
Rururb (γ_{03})																
Interaction																
(γ_{04})									.01	.01	2.08	.04	.01	.01	1.98	.05
For HSExp Slope (β_{1j})																
HS Exp* (γ_{10})	.01	2.08	.04						.23	.09	2.75	.01	.24	.09	2.76	.01
For HSEth Slope (β_{2j})																
HSEth (γ_{20})	.24	.08	2.81	.01												
Random Effects																
Intercept (u_{0j})	.31	.09	45.21	.17	.31	.10	123.69	.00	.31	.10	45.84	.10	.32	.10	42.28	.13
HS exp.																
Slope (u_{1j})	.01	.00	51.05	.06					.01	.00	51.02	.06	.01	.00	51.14	.06
HTrace Slope																
(u_{2j})	.09	.01	32.98	>.50					.08	.01	32.97	>.50	.09	.01	33.00	>.50
Level-1 (e_{1j})	.73	.53			.74	.55			.73	.53			.73	.53		
Model fit																
Dev	959.23	7			978.55	2			979.04	7			981.57	7		

Note. *Grand mean centered

Parameter Estimates & Model Fit
 Prosocial Behaviors & MHC Positive Relationship with HS Staff

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T- ratio	p	Coef	SE	T-ratio	p	Coef	SE	T- ratio	p	Coef	SE	T- ratio	p
Fixed Effects																
For Intercept (β_{0j})																
Intercept (γ_{00})	2.95	.07	44.22	.00	3.05	.05	56.35	.00	2.95	.06	46.28	.00	3.04	.09	34.21	.00
Totkids*																
(γ_{01})					.00	.00	1.09	.28	-.00	.00	-.17	.87	.00	.00	.57	.57
Posrel*																
(γ_{02})					.15	.12	1.28	.21	.15	.13	1.23	.23	.14	.16	.90	.37
Rururb (γ_{03})													-.16	.12	-1.29	.21
Interaction																
(γ_{04})													-.20	.30	-.68	.50
For HSExp Slope (β_{1j})																
HS Exp* (γ_{10})	.01	.01	2.08	.04					.01	.01	2.07	.04	.01	.01	1.97	.05
For HSEth Slope (β_{2j})																
HSEth (γ_{20})	.24	.08	2.81	.01					.24	.08	2.79	.01	.24	.08	2.90	.01
Random Effects																
Intercept (u_{0j})	.31	.09	45.21	.17	.31	.10	120.81	.00	.30	.09	45.48	.11	.29	.09	42.05	.13
HS exp.																
Slope (u_{1j})	.01	.00	51.05	.06					.01	.00	50.89	.06	.01	.00	51.01	.06
HSRace Slope																
(u_{2j})	.09	.01	32.98	>.50					.09	.01	32.87	>.50	.10	.01	32.78	>.50
Level-1 (e_{1j})	.73	.53			.74	.55			.73	.53			.73	.53		
Model fit	Dev	Param	AIC	BIC	Dev	Param			Dev	Param			Dev	Param		
	959.23	7			976.84	2			977.31	7			977.98	7		

Note. *Grand mean centered

Parameter Estimates & Model Fit
 Prosocial Behaviors & MHC Adequate Training, Supervision, and Support

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
Fixed Effects																
For Intercept (β_{0j})																
Intercept (γ_{00})	2.95	.07	44.22	.00	3.05	.05	56.80	.00	2.94	.06	46.33	.00	3.01	.09	32.57	.00
Totkids*																
(γ_{01})					.00	.00	.93	.36	-0.00	.00	-0.37	.72	.00	.00	.12	.91
Adeqtr*																
(γ_{02})					.15	.09	1.71	.09	.18	.10	1.84	.07	.18	.09	2.13	.04
Rururb (γ_{03})																
Interaction																
(γ_{04})																
For HSExp Slope (β_{1j})																
HS Exp* (γ_{10})	.01	2.08	.04		.01	.01	1.88	.07	.01	.01	1.88	.07	.01	.01	1.78	.08
For HSEth Slope (β_{2j})																
HSEth (γ_{20})	.24	.08	2.81	.01	.25	.09	2.91	.01	.25	.09	2.91	.01	.25	.09	3.00	.01
Random Effects																
Intercept (u_{0j})	.31	.09	45.21	.17	.30	.09	117.12	.00	.28	.08	42.26	.19	.29	.08	39.20	.21
HS exp.																
Slope (u_{1j})	.01	.00	51.05	.06	.01	.00	51.09	.06	.01	.00	51.09	.06	.01	.00	51.23	.06
HSRace Slope																
(u_{2j})	.09	.01	32.98	>.50	.11	.01	32.79	>.50	.12	.01	32.77	>.50	.12	.01	32.77	>.50
Level-1 (ϵ_{1j})	.73	.53			.74	.55			.73	.53			.72	.53		
Model fit	Dev	Param	AIC	BIC	Dev	Param	Dev	Param	Dev	Param	Dev	Param	Dev	Param	Dev	Param
	959.23	7			976.16	2	975.87	7	978.69	7	978.69	7	978.69	7	978.69	7

Note. *Grand mean centered

Parameter Estimates & Model Fit
 Prosocial Behaviors & MHC Knowledge of MH Best Practices

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T- ratio	p	Coef	SE	T-ratio	p	Coef	SE	T- ratio	p	Coef	SE	T- ratio	p
Fixed Effects																
For Intcpt (β_{0j})																
Intercept (γ_{00})	2.95	.07	44.22	.00	3.05	.05	58.34	.00	2.96	.06	45.72	.00	3.00	.08	36.87	.00
Totkids*																
(γ_{01})					.00	.00	1.33	.19	.00	.00	.30	.77	.00	.00	.66	.51
MHpract*					.31	.14	2.29	.03	.26	.15	1.80	.08	.25	.13	1.91	.06
(γ_{02})																
Rururb (γ_{03})																
Interaction																
(γ_{04})																
For HSExp Slope (β_{1j})																
HS Exp* (γ_{10})	.01		2.08	.04	.01		1.94	.06	.01		1.94	.06	.01		1.91	.06
For HSEth Slope (β_{2j})																
HSEth (γ_{20})	.24	.08	2.81	.01	.22	.09	2.50	.02	.23	.09	2.60	.01	.23	.09	2.60	.01
Random Effects																
Intercept (u_{0j})	.31	.09	45.21	.17	.29	.08	112.24	.00	.30	.09	44.27	.14	.28	.08	39.21	.21
HS exp.																
Slope (u_{1j})	.01	.00	51.05	.06	.01	.00	50.80	.07	.01	.00	50.80	.07	.01	.00	50.59	.07
HSrace Slope																
(u_{2j})	.09	.01	32.98	>.50	.06	.00	33.13	>.50	.08	.01	32.75	>.50	.08	.01	32.75	>.50
Level-1 (e_{1j})	.73	.53			.74	.55			.73	.53			.73	.53		
Model fit	Dev	Param	AIC	BIC	Dev	Param			Dev	Param			Dev	Param		
	959.23	7			973.19	2			975.27	7			975.26	7		

Note. *Grand mean centered

Parameter Estimates & Model Fit
Positive Relationship with MHC & MHC Knowledge of HS

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
Fixed Effects																
For Intercept (β_{0j})																
Intercept (γ_{00})	3.28	.06	57.90	.00	3.32	.05	70.08	.00	3.28	.06	56.46	.00	3.27	.06	54.33	.00
Totkids																
(γ_{01})*		.00		.79	.43											
Knowhs (γ_{02})*		-.02		-.19	.85											
Rururb (γ_{03})*																
Interaction																
(γ_{04})																
For HSExp Slope (β_{1j})																
HS Exp (γ_{10})*	.01	.00	1.96	.05					.01	.00	1.96	.05	.01	.00	1.79	.08
For HSEth Slope (β_{2j})																
HSEth (γ_{20})	.11	.07	1.54	.13					.11	.07	1.51	.13	.11	.07	1.48	.14
Random Effects																
Intercept (u_{0j})	.28	.08	73.86	.00	.30	.08	148.55	.00	.28	.08	73.86	.00	.30	.09	72.42	.00
HS exp. Slope																
(u_{1j})	.01	.00	46.88	.13					.01	.00	46.87	.13	.01	.00	46.89	.13
HS Race Slope																
(u_{2j})	.08	.01	52.41	.05					.90	.01	52.40	.05	.11	.01	52.45	.05
Level-1 (ϵ_{1j})	.58	.34			.59	.34			.58	.34			.58	.34		
Model fit																
Dev	784.84	Param	7	AIC	798.20	Param	2	BIC	804.10	Dev	806.84	Param	7	Var. Comp.	7	Var. Comp.

Note. *Grand mean centered

Parameter Estimates & Model Fit
Positive Relationship with MHC & MHC Comfort with Parents

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T- ratio	p	Coef	SE	T-ratio	p	Coef	SE	T- ratio	p	Coef	SE	T- ratio	p
Fixed Effects																
For Intercept (β_{0j})																
Intercept (γ_{00})	3.28	.06	57.90	.00	3.32	.05	72.24	.00	3.28	.06	59.45	.00	3.26	.06	56.87	.00
Totkids																
(γ_{01})*					.00	.00	.11	.91	-0.00	.00	-0.71	.48	-0.00	.00	-0.27	.79
Commpar					.15	.08	1.93	.06	.15	.07	2.13	.04	.14	.06	2.29	.03
(γ_{02})*																
Rururb (γ_{03})*																
Interaction																
(γ_{04})									.32	.13	2.46	.02	.01	.00	2.15	.04
For HSEExp Slope (β_{1j})																
HS Exp (γ_{10})*	.01	.00	1.96	.05	.01	.00	2.16	.04	.01	.00	2.16	.04	.01	.00	2.15	.04
For HSEth Slope (β_{2j})																
HSEth (γ_{20})	.11	.07	1.54	.13	.10	.07	1.47	.15	.08	.07	1.13	.26	.08	.07	1.13	.26
Random Effects																
Intercept (u_{0j})	.28	.08	73.86	.00	.28	.08	139.76	.00	.27	.07	73.38	.00	.27	.07	70.16	.00
HS exp. Slope	.01	.00	46.88	.13	.01	.00	47.01	.13	.01	.00	47.16	.12	.01	.00	47.16	.12
HSrace Slope	.08	.01	52.41	.05	.04	.00	52.52	.05	.06	.00	52.83	.04	.06	.00	52.83	.04
Level-1 (e_{1j})	.58	.34			.58	.34			.58	.34			.58	.34		
Model fit	784.84	7	Param	AIC	796.03	2	Param	BIC	801.48	7	Param	Dev	801.09	7	Param	7

Note. *Grand mean centered

Parameter Estimates & Model Fit
 Positive Relationship with MHC & MHC Positive Relationship with HS Staff

	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
Fixed Effects																
For Intercept (β_{0j})																
Intercept (γ_{00})	3.28	.06	57.90	.00	3.32	.05	71.98	.00	3.28	.06	58.86	.00	3.28	.06	52.93	.00
Totkids*																
(γ_{01})					.00	.00	.28	.78	-0.00	.00	-0.61	.55	-0.00	.00	-0.15	.88
Posret*					.22	.08	2.69	.01	.21	.09	2.44	.02	.24	.16	1.49	.14
(γ_{02})																
Rururb* (γ_{03})																
Interaction																
(γ_{04})																
For HSExp Slope (β_{1j})																
HS Exp* (γ_{10})	.01	.00	1.96	.05	.01	.00	2.08	.04	.01	.00	2.08	.04	.01	.00	1.91	.06
For HSEth Slope (β_{2j})																
HSEth (γ_{20})	.11	.07	1.54	.13	.11	.07	1.48	.15	.11	.07	1.52	.13	.11	.07	1.52	.13
Random Effects																
Model 1																
Intercept (u_{0j})	.28	.08	73.86	.00	.28	.08	140.53	.00	.27	.07	75.06	.00	.28	.08	73.51	.00
HS exp. Slope																
(u_{1j})	.01	.00	46.88	.13	.01	.00	46.89	.13	.01	.00	46.89	.13	.01	.00	46.92	.13
HSrace Slope																
(u_{2j})	.08	.01	52.41	.05	.05	.00	52.42	.05	.05	.00	52.42	.05	.05	.00	52.46	.05
Level-1 (e_{ij})	.58	.34			.58	.34			.58	.34			.58	.34		
Model fit																
Dev	784.84	7	AIC	BIC	795.88	2	801.81	7	804.64	7	804.64	7	804.64	7	804.64	7

Note. *Grand mean centered

Parameter Estimates & Model Fit
Positive Relationship with MHC & MHC Knowledge of MH Best Practices

Fixed Effects	Model 1				Model 2				Model 3				Model 4			
	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p	Coef	SE	T-ratio	p
For Intercept (β_{0j})																
Intercept (γ_{00})	3.28	.06	57.90	.00	3.32	.05	72.26	.00	3.28	.06	57.99	.00	3.27	.06	57.84	.00
Totkids																
(γ_{01})*					.00	.00	.784	.44	-.00	.00	-.12	.91	.00	.00	.03	.98
MHpract																
(γ_{02})*					.15	.15	.31	.76	.00	.14	.02	.98	-.00	.13	-.32	.98
Rururb (γ_{03})*																
Interaction																
(γ_{04})									-.29	.28	-1.04	.31				
For HSExp Slope (β_{1j})																
HS Exp																
(γ_{10})*	.01	.00	1.96	.05					.01	.00	2.00	.05	.01	.00	2.03	.05
For HSEth Slope (β_{2j})																
HSEth (γ_{20})	.11	.07	1.54	.13					.11	.07	1.49	.14	.11	.07	1.53	.13
Random Effects																
Intercept (u_{0j})	.28	.08	73.86	.00	.29	.08	147.81	.00	.28	.08	73.91	.00	.28	.08	70.69	.00
HS exp.																
Slope (u_{1j})	.01	.00	46.88	.13					.01	.00	46.87	.13	.01	.00	46.97	.13
HSrace Slope																
(u_{2j})	.08	.01	52.41	.05					.09	.01	52.40	.05	.10	.01	52.49	.05
Level-1 (e_{1j})	.58	.34			.59	.35			.58	.34			.58	.34		
Model fit	Dev	Param	AIC	BIC	Dev	Param	Dev	Param	Dev	Param	Dev	Param	Dev	Param	Dev	Param
	784.8															
	4	7			798.78	2			804.73	7			806.98	7		

Note. *Grand mean centered