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Infant & Early Childhood
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Status of the Evidence for Infant and Early Childhood Mental Health Consultation

Infant and Early Childhood Mental Health Consultation (IECMHC) is an evidence-based service in which mental health professionals, with early childhood training, partner with the adults in young children's lives to build their capacity to foster healthy social-emotional development. With roots in infant mental health and community psychiatry, IECMHC enhances equity by strengthening caregiving environments for children who are at risk for negative mental health outcomes and affected by systemic inequities.

IECMHC is currently being implemented in a range of settings including early childhood education (ECE), home visiting, primary care, and child welfare in states, localities, and tribal communities across the country. While each setting may have unique outcomes for consultation, the mechanisms through which IECMHC leads to outcomes are thought to be universal. As depicted in the theory of change for IECMHC, the activities of consultation are inextricably linked to the characteristics of the consultant and consultee(s), and the relationship they form. These factors directly affect the consultees' change in knowledge, attitudes and behaviors, and indirectly lead to outcomes for children, their families, and early childhood programs.

The Center of Excellence (CoE) for Infant and Early Childhood Mental Health Consultation has undertaken an exhaustive review of the literature base for IECMHC, including both peer-reviewed literature and program evaluation reports. The purpose of the current document is to synthesize the current status of the literature base as of Spring 2023 and to provide an agenda for next steps in IECMHC research.

Much of the research and evaluation on IECMHC to date has been motivated by persistent disparities in rates of expulsion from preschool for boys of color. For this reason, the majority of studies reviewed in this brief have been implemented in community child care, Head Start and preschool/pre-kindergarten programs. Despite this limitation, the vast majority of the findings presented in this brief are consistent with the theory of change for IECMHC; because the theory of change is thought to be agnostic to the setting in which IECMHC is being implemented, there is reason to believe that these findings would generalize to IECMHC delivered in other settings (i.e., home visiting, early intervention for infants and toddlers with disabilities, child welfare, etc.). Nevertheless, more work in those settings is needed to build the evidence base for the effectiveness of IECMHC. Further, while there is considerable evidence that IECMHC leads to

positive impacts for children, providers, and programs, most studies have not been focused on quantifying reductions in disparities and have not disaggregated outcomes by race/ethnicity. More research is needed to measure the role of IECMHC in enhancing equity for young children.

WHAT IS THE EVIDENCE FOR IECMHC?

Of central importance to policy, practice, and community audiences is the question: does IECMHC have positive outcomes? According to findings from dozens of studies, children and adults involved in IECMHC show improvement in a range of domains after engaging in consultation.

Children's social-emotional wellbeing improves. Specifically, children demonstrate both increased social-emotional competency[1–15] as well as reduced challenging behavior[1,2,6,10,12–14,16–18] over the course of consultation. Social-emotional competencies that increase after consultation include social skills, self-regulation, protective factors, and adaptive behaviors. Challenging behaviors that decrease after consultation include hyperactivity, defiance, and aggression. Research has not yet demonstrated an impact of IECMHC on children's internalizing behaviors (e.g., anxiety). Critically, studies show that after consultation in ECE settings, children's expulsion and/or suspension risk decreases[5,6,8,9,13,14,19–23]. Overall, these positive impacts for children have been replicated many times with different settings, measures, and research designs, underscoring their credibility.

Consultees' improve their social-emotional support for young children. Specifically, consultees demonstrate changes to their knowledge, attitudes, and behavior over the course of consultation—and these changes align with best practices in fostering social-emotional development. For instance, consultees report improved knowledge about social-emotional development[2,5,9,10,24–27] and increased self-efficacy in managing challenging behavior[2,7,8,24,28,29]. Further, consultees' observed and self-reported interaction styles with children become more positive and sensitive to mental health needs, characterized by reduced permissiveness and detachment and increased sensitivity and closeness[1,3,4,8,23,30–33]. Some studies found lower stress[4,25,34] and reduced turnover[3,4,24] for consultees after consultation. These changes in provider capacity accumulate into healthier social-emotional climates for young children.

IECMHC may yield programmatic changes. In ECE, consultation for teachers has been linked with improvements to classroom climate[3,4,7–9,12,28–30,32,35,36] and to center quality[24]. Because consultation is a multilevel service, consultants intervene across spheres of influence, including leadership, to affect program policies and program culture. The rates of expulsion and/or suspension from ECE programs have been shown to be lower after consultation [3,4,17,20–22,37], although there is no evidence to date that it closes the well-documented racial disparities in expulsion and suspension rates.

Emerging findings. The evidence base for IECMHC includes a range of other important findings that were not mentioned above because they have not been extensively replicated. Nevertheless, they provide additional insight into IECMHC's outcomes and mechanisms of impact and provide a starting point for future research. The findings explained below can be categorized as pertaining to additional outcomes, mechanisms, and populations.

Outcomes:

- Consistent with the theory of change, one study demonstrated **a reduction in racial disparities** over the course of consultation. The data revealed that teachers rated their conflict with Black children as significantly higher than their conflict with White children prior to consultation. This disparity was eliminated after six months of consultation and reversed after one year of consultation such that Black children had lower ratings of conflict than White children[23].
- Staff, including both educators and home visitors, demonstrated growth in two measures of **reflective capacity** after participating in one year of Illinois' IECMHC program[38,39].
- One consultation program serving pre-kindergarteners in public charter schools found that children in schools receiving IECMHC had higher **academic achievement** scores (math, literacy, and writing) after one academic year of consultation. Strikingly, this applied to all children in the schools receiving consultation even if they were not in a classroom that received consultation[12].

Mechanisms of change:

- **The centrality of relationships** has been assessed in several studies, which demonstrated that the strength of the consultant-consultee relationship predicted better outcomes for consultees and children[28,40]. Furthermore, the relationship may be a particularly salient predictor of child and teacher outcomes when the child is a boy of color, and when the consultant has expertise in cultural diversity, suggesting that relationships may be particularly important when exploring issues of culture, race, and bias[29].
- **Reflective supervision** has been shown to bolster consultants' ability to engage in reflective practice with consultees[41]. Additionally, teachers with higher reflective capacity were more likely to perceive more social-emotional strengths in children than teachers and home visitors with lower reflective capacity[39].
- For some outcomes, a higher **"dose" of consultation** (i.e., frequency and duration of consultation) predicted greater positive changes[4,9,17,24,31,33,40].
- In one study, the impact of IECMHC on child challenging behaviors was mediated by improved **parent-child interactions**. In other words, participation in IECMHC affected parent-child interactions, which in turn affected child behavior[42].

- A study of Arkansas' IECMHC program demonstrated that higher **teacher engagement in the consultation process** (as rated by the consultant) predicted lower levels of child behavioral concerns and higher prosocial behaviors post-consultation[1].
- Implementation of a pilot IECMHC program in Virginia was studied using consultant logs, participant surveys and focus groups. Researchers describe three main tensions that arose during the implementation of IECMHC and describe how these tensions have implications for program scale-up[43].

Populations/Settings:

- **Home visitors** who worked with an IECMH consultant reported increased knowledge of child and adult mental health[27]. In another study utilizing the Illinois Model of IECMHC home visitors demonstrated higher responsiveness to the families they were serving after receiving consultation services[44].
- IECMHC is provided to caregivers who are not formally licensed or accredited child care providers (often referred to as **Family, Friend and Neighbor care** or FFN). A research team articulated considerations for integrating IECMHC into FFN and a created a theory of change to guide future work [45].

HOW DO WE KNOW?

These findings can be best understood in the context of the participants and research methods used.

Setting. The vast majority of the studies evaluated ECE-based IECMHC programs[1,2,6–8,11–17,19–24,26,28,31,33,37,42,46–49] with a subset in Head Start[18,32,40,50].
While the literature based on IECMHC in home visiting has grown in the past several years no studies have reported impacts on children and families to date[27,38,44,51].

Participants. Most of the recipients of IECMHC in these studies were ECE teachers; other recipients included childcare directors, home visitors, and parents. Outcome data are also commonly reported for children who are the indirect beneficiaries of IECMHC. Samples of teachers and young children varied in terms of racial/ethnic makeup, including studies of predominantly White communities[6,7,23,42], predominantly Black communities[12,18,32], and predominantly Latinx communites[30,491]. Study samples also included both rural[7,11,48] and urban communities[2,20,24,32].

[1] Here, "predominantly" is defined as 75% or more of the study group

Research Methods. To date, IECMHC has been evaluated in two **randomized-controlled trials**[15,16], a rigorous research design that allows for causal claims. The vast majority of peer-reviewed studies employed **quasi-experimental**[2,6,7,13,14,23–26,28–30,33,35] research designs. These designs collect data about participants in IECMHC before and after consultation to measure change. They cannot claim that IECMHC *caused* changes from pre- to post-consultation (because unmeasured variables could have driven the change) nor can they assert that the changes would not have happened over time without intervention. A handful of the quasi-experimental studies use a **comparison group**[1,12,17,18,39,42,44,49] meaning that they are able to analyze whether individuals participating in IECMHC demonstrated greater improvement in key outcomes from baseline to follow-up when compared to individuals who did not engage in consultation. In terms of data analysis, most studies analyzed outcomes using traditional inferential statistics (e.g., linear regression, t-tests). Some studies levels used **multilevel modeling**[11,16,21,28,29,32,35,39,50] to statistically account for the nested nature of variance in the data (e.g., multiple children per classroom and multiple classrooms per consultant). Many studies used **mixed methods**, meaning that they incorporated both quantitative and qualitative data (e.g., interviews and focus groups) into their studies[11,24,27,30,52], while a handful of studies use only **qualitative data**[19,46,48]. Qualitative methods bring essential voices from the field into the evidence base and allow for exploration of nuanced and subjective topics. Additionally, a number of reviews of IECMHC literature[22,34,36,53–57] have synthesized the literature based from different perspectives over time, and additional articles have described IECMHC programs or practices without reporting data[58–69].

FUTURE DIRECTIONS FOR RESEARCH

1. Most of the evidence base describes and assesses the overall (or average) effects of IECMHC for all participants. The next generation of research should shift to focus on whether and how IECMHC enhances equity. To answer these questions requires intentional focus on providing services and engaging in evaluation with children and programs from historically marginalized communities and demographic groups. Some important questions to answer include:
    a. Does IECMHC close disparities in outcomes other than teacher-child conflict? If so, which outcomes, for whom, and with what intervention?
    b. What are the disparities in access to consultation based on child characteristics (e.g., race/ethnicity, gender, age, disability, child welfare involvement, linguistic background) as well as caregiver and program-level variables?
    c. What are the outcomes of consultation that more explicitly incorporates issues of race, bias, and disparities into discussion with consultees and families? What are the best practices for doing so, how can consultants be trained, when is it most useful, and how do consultees react?

   d. How can the future workforce of consultants be diversified via the creation of additional pathways into the work such that the consultant workforce better aligns with the cultural and linguistic backgrounds of programs served? And, how can the current workforce, which primarily consists of White women, be supported to better serve communities of color through cultural humility and anti-racist action?

2. Strong evidence is when one conclusion is supported by a range of "ways of knowing" rather than centering the priorities and practices of Western science. As new evaluations and studies are designed, they should utilize a community-engaged approach in which individuals embedded in the community help develop the research questions, adapt the theory of change for their own context, define and measure success, and interpret and disseminate findings, using diverse methods.
3. As mentioned above, the evidence base is primarily comprised of ECE-based studies. This no longer reflects the current state of IECMHC implementation, which has been growing into other child-serving systems. While these studies have made valuable contributions, the next generation of studies should be conducted in settings other than ECE (e.g., home visiting, child welfare) to fill in gaps in the literature.
4. When adequate funding is available, it is useful for some researchers to continue to design increasingly rigorous studies that allow for causal claims. While these methods are not superior to other methods, they may be more impactful in advocacy efforts. There has not yet been an RCT evaluating outcomes from a consultation model of longer than three months, which is shorter than most programs, so the results may underrepresent the true impact of IECMHC.
5. Additionally, researchers should investigate the sustained impact of IECMHC on outcomes and disparities in outcomes, as well as predictors of sustained impact. These longitudinal findings are critical for practice and policy audiences.
6. Research to date has focused on the outcomes of IECMHC. With solid evidence for its main effects, future research should include how those impacts are achieved. The IECMHC Theory of Change articulates pathways whereby IECMHC is thought to yield its positive impact; each should be empirically tested.

This synthesis represents our current assessment of the evidence base for IECMHC. This synthesis will be updated as more studies become available over time. Further, there are likely additional evaluation reports and articles that were unintentionally excluded from this review. If readers are able to share additional resources that may add to the literature review, please email them to iecmhc@georgetown.edu. Program evaluation reports that are not published in scholarly journals are particularly welcome contributions as they often represent innovative, community-based studies.

We are grateful to the evaluators for their contributions to this field, as well as the participants in these studies who have shared their experiences with evaluation teams.

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