
***Behavioral
Consultant Model
of Mental Health
Service Delivery***

Applications for
Education and Early
Childhood

Texas Early
Childhood
Education
Coalition



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Introduction

The early years of a child's life are characterized by rapid growth and spectacular maturation and development. The social, emotional, physical and intellectual development that occurs during this phase of a child's life lays a foundation upon which physical health, interpersonal relationships, emotions and academic capabilities are built. A range of environmental factors, coupled with the genetic blueprint, serves as a guide for who a child will become.

A growing body of evidence demonstrates the importance of these early years and the need for a solid, stable base upon which the child can grow. The events that shape a child's future successes contribute to the maturation of the human body including the nervous, neuro-endocrine, immune, skeletal and muscular systems. These highly interactive systems are the keys to one's ability to relate to others, hear, see, read, learn, move, play, heal from illnesses and respond to stress. Maladaptive development triggered by harmful stimuli and/or genetic coding can produce behaviors that are inappropriate and/or destructive.

Early childhood behavioral problems

A wide range of behavioral problems have been seen in pre-K programs. Perry et. al estimate that between 4 and 12% of young children manifest challenging behaviors that may impair their functioningⁱ. Externalizing behaviors such as physical and verbal

aggression against teachers and other children, internalizing behaviors (withdrawal, depression, anxiety), hyperactivity, self injuryⁱⁱ, sleep disordersⁱⁱⁱ, AD/ADHD, Oppositional Defiant and conduct disorders^{iv}, separation anxiety^v, and physical health problems^{vi} are often reported among the preschool age population.

“Children are coming into child care centers carrying with them the psychological pressures associated with neighborhood violence, child abuse and neglect, parental mental illness and substance abuse, and in some cases, very early onset of biologically based affective disorders”^{vii}.

In child care and early education classrooms, teachers routinely witness harmful behaviors. [Recognizing the signs as “bad behaviors” or the child as a slow learner, or a myriad of other conditions, many teachers are unaware of the link to home and community factors that contribute heavily to the manifested signs in the child.] The responses of the child care provider, teacher, counselor or administrator typically address the symptom, the behavior. This is analogous to treating a chronic fever without providing care for an underlying condition that may be life threatening. In the short term, the symptom may improve. However, over the long term, a deteriorating condition may develop into a permanent situation that will impact the child for the rest of his or her life.

Responses to Behavioral Problems

Responses to the behavioral conditions manifested by these children can range from tolerance of the behavior(s), to counseling, enrollment in a special education program, treatment with behavior altering medications, disciplinary actions including removal from the classroom into an alternative education program or expulsion. These responses typically fail to address the underlying causes which, unchecked, become more deeply ingrained into the child's physical and emotional makeup. Therefore, early intervention in response to the negative behaviors is critical to prevent a life of strained relationships, criminal activities, diminished intellectual successes, and mental and physical illnesses.

“More than one in three teachers report having expelled at least one preschool child in the past 12 months with many of these expulsions occurring in response to inappropriate behaviors against teachers and other students^{viii}”.

Reports have surfaced about an alarming trend of expulsions due to behavioral issues among children in early childhood education settings. The first national data on the rates of expulsion from preschool has underscored the widespread nature of this trend. A report by Perry, et al indicates that, on average, young children are being expelled from state-funded pre-kindergarten programs at three times the rate of children in kindergarten through grade 12 (K-12)^{ix}. More than one in three teachers report

having expelled at least one preschool child in the past 12 months with many of these expulsions occurring in response to inappropriate behaviors against teachers and other students^x.

In Texas, pre-kindergarten students are expelled at twice the rate of older students (k-12), with an estimated 662 pre-k students expelled during the 2003-2004 school year^{xi}. Additionally, many young children are being reassigned to Disciplinary Alternative Education Programs (DAEPs). Between 2000 and 2006, 103 school districts referred about 500 pre-k and kindergarten students to DAEPs. During the same time period, 2,700 first graders in Texas schools were referred to DAEPs^{xii}.

Intervention Strategies

“At-risk” children are described in many ways. At the heart of most definitions and descriptions is the concept of vulnerability, to many conditions including abuse or delinquency^{xiii}. The United States Census Bureau defines at-risk relative to personal and familial conditions. Personal conditions include disabilities, grade retention in school, and language barriers. Familial conditions include absentee parents, parents of foreign origin who recently immigrated, low family income, and unemployed parents^{xiv}.

Intervention strategies for “at-risk” children vary as widely as the providers delivering care services. Optimally, accurate assessments coupled with age and ethnicity appropriate responses can have a significant

impact on the well being of a child. A “one size fits all” approach to care is inappropriate and has the potential to cause additional problems for the child and waste valuable resources.

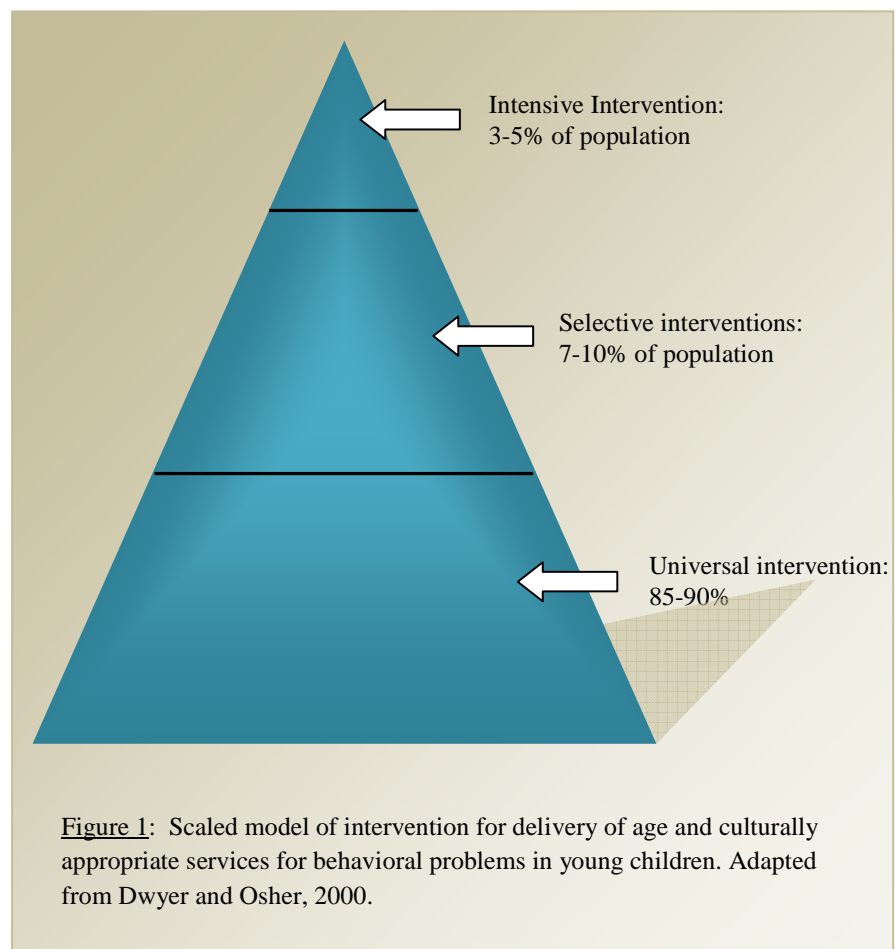
A measured strategy of intervention patterned as a three tiered structure of school-wide discipline (*universal, selected, and targeted/intensive* interventions) has been described by Luiselli et al, 2001^{xv}. Similarly, a measured intervention response has the potential to dramatically impact the disruptive behavior of a child. Ultimately, an intervention for a child with negative behaviors can significantly influence classroom decorum and the capacity to learn for every other child in the classroom.

In 2000, Sugai et al estimated that 85-90% of students are suitable for universal interactions, 7-10% of students require selective interventions, and 3-5% of students demand targeted / intensive interventions^{xvi}. Figure 1 adapted from Dwyer and Osher (2000)^{xvii}, details a strategy for a measured delivery of services that has been used to address the behavioral health needs of many young children and could be

applied to efforts in Texas.

Multiple levels of intervention were designed to provide appropriate services while extending the existing resources to reach the maximum number of children and families. These levels include:

- A. **Universal intervention strategy:**
Delivery of behavioral supports that target 85-90% of the population. Stress appropriate behaviors, positive social and emotional interaction. Prevent problems before they develop.



B. Selective intervention strategy:

Services and supports that address risk factors and build on protective factors for students at risk for severe emotional, academic or behavioral difficulties.

C. Intensive intervention strategy:

Coordinated, comprehensive, intensive, sustained, culturally appropriate and child and family focused services and supports.

Behavioral Health Consultant

“Mental health consultation in early childhood settings is 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 staff. Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, and systems to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age 6 and their families.”^{xviii}

“Consultation is commonly defined as an indirect method of providing psycho-educational services within a cooperative, problem solving framework”^{xix}

The behavioral consultant model, with its history of success, and widespread

applicability in preschool, elementary and secondary education, child care and afterschool programs, is a model that is responsive to children exhibiting harmful behaviors. Programs of this nature provide resources that help:

- Child / parent interactions
- Child / staff interactions
- Parent nurturing skills
- Program staff skills development for working with challenging children and their families
- Children work beyond their problems and continue with healthy, age appropriate development

The ultimate goal of the behavioral consultant program is to improve the quality of care for the child in response to a care giver’s / provider’s / staff member’s call for assistance in reacting to the behaviors of that child. Typically, the behavioral consultation services are initiated in response to a crisis situation.

The success of a behavioral consultant model is contingent upon the ability of the providers to adapt to suggestions that may be outside their existing capacity and/or capabilities.

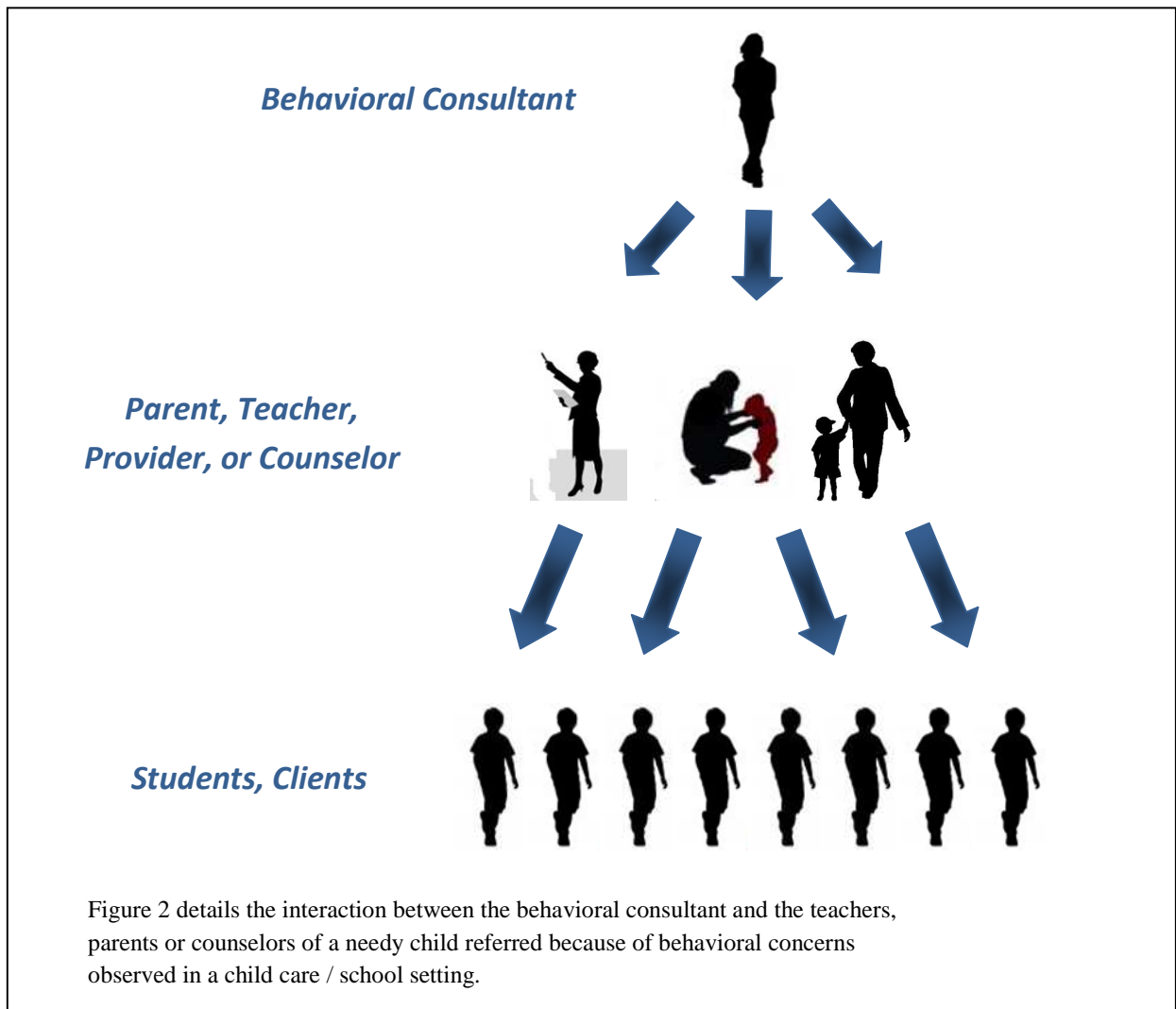
“A sensible approach is to inquire about the feasibility of implementing any suggestion and be open to modifying recommendations based on what is reasonable and realistic for the staff. So simultaneously, the consultant must enthusiastically offer ideas about intervention or interaction based on understanding of the child’s needs while remaining

aware of what is possible for the teacher to provide.^{xx}

The *behavioral consultation* model (detailed in Figure 2 below) is characterized as “an indirect ‘problem-solving’ process between a specialist (e.g., special educator, school psychologist, mental health provider, social worker) and one or more persons (e.g., parents, teachers) to address concerns presented by a client (e.g., student, classroom, system)^{xxi}”. Generally, the behavioral consultant does not act as an independent mental health professional

(except on rare occasions). Instead, the behavioral health consultant acts as a “team leader” to:

- Provide information
- Consult with teachers
- Coach parents
- Help families/staff understand the importance of mental health services for children
- Coordinate access to services for children and families
- Train staff members.



The Behavioral Consultant Model

The Behavioral Consultant model of intervention for children is a process of care that is unique from direct service models. Distinct steps characterize this model of intervention with adaptations to the original model contributing to the alternative models of care.

Following the identification of a child in need of assistance, four steps are involved in the delivery of the basic behavioral consultant model. These steps, described by Kratochowill and Bergan in 1990^{xxii}, are set in motion by the referral of a teacher, counselor, or parent, include:

Step 1. Problem Identification: A group of concerned adults (the team) meet to describe the problem and contributing environmental factors, and identify specific objectives of the consultation. The team attempts to describe positive characteristics of the observed behavior and develop methodology and protocols for data collection related to the manifestation of the behavior and treatment regimen.

Step 2. Problem Analysis: The team meets to reach a consensus about the goals for behavioral change, identify contributing factors and potential consequences to the plan, design a treatment strategy and determine the acceptability of such a plan. During this phase, data collection procedures are reaffirmed and the baseline data is analyzed.

Step 3. Treatment Implementation: Step 3 begins the treatment phase of the program. The behavioral consultant begins work with teachers, counselors, parents and any others that are involved with the child. During this phase, the consultant monitors the integrity of the treatment and provides feedback about the direction of the treatment. Data collection continues.

Step 4. Treatment Evaluation: In this final phase, the team assesses the treatment effectiveness and establishes whether the treatment goals were met. The team, at this point, determines the next steps for the treatment and strategies for maintaining the treatment gains. Finally, the team provides input about the consultant effectiveness and schedules future meetings as needed.

Alternative Models

In 2007, Wilkinson described a variation on the behavior consultation model that incorporates an assessment of protocol integrity into the treatment paradigm^{xxiii}. The Expanded Behavior Consultation Model mimics the basic consultation process and adds a review mechanism for examination of the treatment protocol fidelity. Providers, under the guidance of the behavioral consultant, are able to review the process of care for the child and examine the behavioral changes that occur following the start of the treatment regimen.

The model consists of five elements; the *Problem Identification Interview* is the first interview between the consultant and, usually, the child care provider. The goal of

that first interview is to decide what the problem behavior is and what the goal for the consultation should be. The second interview, the *Problem Analysis Interview*, is when the consultant and the provider design an intervention to address the problem behavior. The third stage is *Implementation*. During the implementation, the consultant conducts the *Treatment Monitoring Interview* with the provider to assess the intervention's progress and provide feedback and support. The final element is the *Treatment Evaluation Interview* at which time the consultant and provider assess the efficacy of the intervention and discuss whether the plan should be continued, changed, or ended^{xxiv}.

While the behavioral interventions are frequently completed in a school or care center setting, the problem behavior often has roots in the child's home environment. The Conjoint Behavioral Consultation Model involves the family in the behavioral intervention to ensure parental support in the intervention, to promote parent involvement in their child's school activities, and to build relationships between schools and families^{xxv}.

The model consisted of three stages when it was first conceived, but a fourth has been added to increase protocol validity, making it similar to the Expanded Behavioral Consultation Model. In the first interview, the *conjoint problem identification interview*, the consultant, teacher/care provider, and family discuss the goals of the intervention, decide on the behavior to address, and discuss how to collect data on

the behavior. The second interview, the *conjoint problem analysis interview*, lets the teacher, family, and consultant discuss the data collected since the first interview and decide on an intervention strategy for the teacher and family to implement. After the intervention has begun, the consultant conducts the *conjoint treatment monitoring interview* to check on the data recording and provide support and feedback to the teacher and family. The final interview, the *conjoint treatment evaluation interview* assesses the efficacy of the intervention, whether the intervention met the goals the teacher and family established, and if the intervention should be changed, continued, or ended.

The Functional Behavioral Assessment Model diverges from the basic Behavioral Consultant Model in that it relies more heavily on the behavioral consultant / specialist to design and implement the intervention. It is based on the *functional behavior assessment*, "a process for understanding an individual's problem behavior, identifying events that predict and maintain it, and using this information to design behavior support plans that minimize problem behavior and maximize functional, prosocial behavior"^{xxvi}.

The Functional Behavioral Assessment Model has three phases. In the first phase, the consultant interviews the teacher and the family of the referred child regarding the problem behavior and to develop goals for the intervention. After the interview, the consultant observes the child and develops an initial hypothesis. The second phase consists of an intense one-on-one functional

analysis, during which the consultant verifies his hypothesis about the cause of the behavior and determines an effective reward system for the child. The consultant also designs, implements, and tests an intervention strategy. In the final phase, the consultant meets with the teacher and family to evaluate the progress toward the initial goals, train the teacher and family in the intervention strategy, and set up follow-up meetings to offer feedback and support of the intervention^{xxvii}.

The Behaviors Analytic Consultation Model (BACS)^{xxviii} is similar to the Functional Behavior Assessment Model in that it relies less heavily on teachers and child care providers to provide the intervention. In this model, the work is mostly completed by a behavior consultant/specialist who then informs the teacher/provider of the intervention and trains them in its use.

BACS consists of eight components. It starts off with the consultant conducting a *functional behavior assessment* by observing the child and noting possible external causes of the problem behavior. The next step is for the consultant to conduct a one-on-one *functional analysis* of the child's difficult behavior to double check the cause of the behavior and to determine a reward that would be effective with this child. The third and fourth elements are the *treatment selection* and *treatment evaluation* when the consultant chooses, tests, and evaluates an intervention to address the child's problem behavior. The teacher is brought into the process in the fifth and sixth stages, *teacher training* and *evaluation of the teacher-*

implemented treatment, when the consultant trains the teacher and evaluates the teacher's efficacy with the intervention. Next, the consultant conducts *generalization evaluations*, in which the intervention is conducted in different environments (classrooms similar to those the child is in normally, and classrooms with more people in them) to ensure that it is effective when the consultant is no longer present. Finally, the consultant conducts an *assessment of social validity issues* to evaluate the process and ensure that the intervention and information about the child's behavior are useful to the teacher (Mueller & Nkosi, 2007).

The Positive Schools Model is a good example of how the Behavioral Consultation Model can be implemented on a larger scale. This model is designed to affect all the children in a school to improve student performance and social skills; decrease student discipline referrals, detentions, and suspensions; and to increase the skills, satisfaction, and retention of school personnel.

The model uses a four-step framework. To use this model, the consultant will work with the whole staff of teachers and administrators to *predict problems*. The first step is simple observation, noting who will "fail" at a task (such as following directions or walking in line), what that will look like, when and where that "failure" is most likely to take place, and why that "failure" occurs under those conditions. Once that information is known, the consultant can work with the staff to *develop specific rules*,

routines, and physical arrangements to prevent those predictable problems. This phase involves creating consistent rules across the school, creating environments to help children follow the rules, and developing routines to remind them of appropriate behavior. The third step is to implement the discussed strategies school-wide in a consistent manner. Finally, the consultant and teachers *collect data* to evaluate the intervention^{xxix}.

The Behavioral Consultant

The focal point of the Behavioral Consultant Model^{xxx} of intervention is the Consultant, a professional with a role distinct from direct service providers. The Behavioral Consultant is a credentialed applied-behavior analyst or person from a related discipline who holds either a Masters or Doctoral degree. The Consultant may be board certified, having successfully passed an examination that assesses the professional's knowledge and skills of behavioral analysis.

The Behavioral Consultant's role is to offer guidance and oversight in the care and treatment of the child in need. The Behavior Consultant is trained to conduct functional analyses of child behaviors and assess the factors that may be contributing to the problem behaviors. However, the consultant, who may be trained as a direct service provider, generally acts in that capacity only in extreme cases.

The Behavioral Consultant is an educator who can train other providers about the

assessment and service delivery to the child(ren) in need. The training offered by the Behavioral Consultant will include an evaluation protocol to assess the progress of those receiving the training. Further, the Consultant can provide guidance, training and advice to teachers, parents and others who are involved with the child and are frequently in contact with the child either at home or in child care/school.

Once a child enters services, the Behavioral Consultant's role shifts toward coordination and collaboration. The consultant collaborates with other professionals to obtain the best care available for the child. The Behavioral Consultant continues to monitor the needs of the child during the care regimen, is responsible for ensuring that the integrity of the treatment regimen is maintained. Further, the Behavioral Consultant, with input from the team, will make recommendations about adaptations to the treatment protocol for the child.

Finally, the Behavioral Consultant also serves as a key component of the data collection and analysis activities for the team. As the leader of the team, the Behavioral Consultant is instrumental in the development, implementation, assessment, and adaptation of the data collection process. Upon completion of the treatment, the Behavioral Consultant will receive the results of the data analysis and will use the information to assess the impact of the treatment program.

Benefits of Behavioral Consultation

The return on an investment in establishing and maintaining Behavioral Consultant services can be significant. Interventions assisted by the behavioral consultant have been shown to improve problem behaviors in children, improve staff capabilities and attitudes and shape institutional policies in dealing with children and families (reviewed in MacLeod, et.al^{xxxvi}, Fuchs, et.al^{xxxvii}, and Sheridan, et.al.^{xxxviii})

Behavioral intervention strategies in response to a comprehensive assessment of a child's behavior can have profound effects in both the short and long term. Interventions have been shown to positively influence social and emotional development. Further, programs using the mental health consultant model showed improvement in areas of initiative, self control attachment and behavior^{xxxix, xl}.

Intervention strategies have also been shown to decrease disruptive behaviors; a benefit that can contribute to improved learning and environmental conditions not only for the child exhibiting the behavioral problem, but for all the children in the classroom^{xli}. The improvement in behaviors ultimately contributes to the reduced expulsion rates for pre school children^{xlii, xliii}.

Child care providers / teachers also benefit from intervention strategies coordinated by a behavioral consultant^{xliiii}. Teachers struggling with the disruptive behavior of a single student are often forced to focus upon the behavior at the expense of the lesson

plan. Frustration, leading to eventual burn out, forces highly qualified teachers and caregivers from the profession contributing to the shortage of qualified professionals seen across the nation and the state.

For example, project SUCCEED, a Head Start program in Oregon, (as cited by Florida State University, 2006) found that teachers in classrooms participating in behavioral health consultation reported less stress than their counterparts in comparison classrooms^{xl}.

A child care center that implemented program-wide consultation found that providers who participated in the consultation intervention viewed themselves as more effective, as more able to appropriately and effectively respond to children in distress, and more likely to communicate regularly with parents. This finding is particularly encouraging because teachers who highly rate their self-efficacy are more hopeful about the futures of the children they work with and more confident in their ability to make a difference in children's lives. They also view themselves as more effective at handling difficult situations and as more likely to continue their careers in early education^{xli}.

Promising programs




San Francisco: Day Care Consultants Program

The Day Care Consultants program in San Francisco, California was established in 1988 as an expansion of the Infant-Parent Program to help teachers learn how to manage children with problematic behavior^{xlii}. The program employs licensed therapists with a degree or training in early childhood education as consultants^{xliii}. The consultants provide programmatic consultation for all children in a participating child care center and receive referrals for individual consultation.

Most consultations begin with an observation period similar to a functional behavior assessment to determine the cause of the child's difficult behavior and evaluate the child's fit at the child care center^{xliv}. In most cases, the consultant works closely with the teacher to improve their relationship with the child and enhance their capacity to appropriately respond to problem behaviors. The consultant meets weekly with the child care center staff to support their efforts. In an estimated less than 10% of cases, the behavior requires more intensive services and the consultant works directly with the child and family^{xlv}. The consultant works with the family to, "assess the impact of the child's past experiences on current functioning, provide guidance by suggesting available resources related to parenting practices, help parents explore and implement more appropriate child-rearing practices, and promote better understanding and mutual support between parents and child care staff"^{xlvi}.

The length of the consultation depends on the circumstances of the case, but the average length is 10 weeks. As of 2003, the Day Care Consultants program served 46 low income child care centers across five counties. The project's annual budget is \$1.3 million, which includes training and supervision services to the 15 consultants and consultation services to the 46 centers^{xlvii}. An evaluation of this program showed that in centers served by Day Care Consultants, directors and teachers find it useful, teachers believe themselves to be more effective teachers after consultation, and centers that use consultation are more likely to offer developmentally appropriate activities^{xlviii}.

Day Care Consultants Program: San Francisco, CA.

-  Serves 46 low income child care centers.
-  Teachers report improved effectiveness as educators
-  Centers provide more developmentally appropriate activities

Ohio: Daycare Plus




The Daycare Plus program in Ohio is part of the Positive Education program. Daycare Plus consultants seek to improve the capacities of parents and teachers to work with children with difficult behaviors and to improve the social, behavioral, and emotional functioning of at-risk children^{xlix}. In addition to program-wide consultation, Daycare Plus also offers a 'response team'

to provide more intensive services to individual children and their teachers. The consultants are not required to be licensed mental health professionals, but all have master's degrees in social work, special education, or family therapy. Consultants are supervised by a licensed mental health professional once a month^l.

Established in response to queries about child care expulsion rates in Cuyahoga County, Ohio, the goal of the Daycare Plus program is to improve the teacher-student relationship and train the teacher in how to respond to problematic behaviors. As in the Day Care Consultants program, an estimated 10% of students need more intensive services^{li}. To meet their needs, the response team has access to wraparound funds that allow them to provide a child with one-on-one care and supervision, provide environmental changes, and/or purchase materials.

Daycare Plus serves about 500 children annually; most children receive consulting services for six months. In 2005, there were approximately 25 families receiving individualized, intensive services. The program employs 5 full time consultants and one half time consultant. Each full time consultant can handle a case load of five intensive consultation sites or four intensive sites and three to four 'follow-along' sites.

Ohio- Daycare Plus

-  Serves 500 children annually
-  Reduced expulsion rates
-  Increased participation rates

Program costs are \$20,000-\$25,000 per center per year. This provides for the consulting fee as well as money for other services such as transportation and resources for the family^{lii}. Preliminary results from a study on this program indicate a reduction in expulsion rates and an increase in participation rates in participating centers.

Colorado Springs: Child Care Intervention Team

The Child Care Intervention Team in Colorado Springs was established to work primarily with teachers to improve their relationship with their students and teach skills on handling difficult behaviors. The team focuses on children who exhibit signs of emotional, behavioral, mental, or developmental problems^{liii}. The original program used licensed therapists as consultants, but found that they did not adapt well to a hectic classroom environment. Now, consultants are early childhood education professionals cross-trained in mental health. They are supervised by a licensed clinical social worker once a week^{liv}.

The consultants observe the child in the classroom and then work with teachers to design an intervention strategy. Their work is based on social skills instruction and Positive Behavior Support techniques rather than therapy solutions. They also make use of the *Conscious Discipline* curriculum by Dr. Becky Bailey^{lv} and *Love and Logic* by Jim Faye and Foster Cline^{lvi}. When needed, consultants refer a child or family requiring

Child Care Intervention Team:
Colorado Springs, CO.

- ✚ Services for at-risk children in Early Childhood Education settings
- ✚ Stresses strong teacher-child interactions
- ✚ 3-6 month intervention
- ✚ Children needing mental health services referred out

mental health services to outside clinical providers; approximately 3% of the children served^{lvii}. The average intervention in this program lasts approximately 3 to 6 months at a cost of \$1,725 per child served. Outcomes are evaluated using a series of pre- and post evaluation instruments.

Conclusion

A January 2008 report commissioned by the Foundation for Child Development offered a series of recommendations for reducing the prekindergarten expulsion rate^{lviii}. Included is a recommendation that “all early education and child care teachers have regular access to early childhood mental health consultation to help teachers address challenging behaviors in the classroom^{lix}”.

The behavioral health consultation model of intervention is an established form of intervention that addresses concerns of the child, parents, teachers/caregivers and systems. This model of care is designed to be flexible and responsive to the needs of the program administrators as well as the

child and their family. Further, a growing body of scientific evidence has reported on the efficacy of the model and the significant improvements that have been observed in response to the implementation of this model of service delivery.

Finally, in an environment of growing fiscal restraints and diminishing resources, the behavioral consultant allows providers to maximize their resources and obtain the greatest return on those limited child care and early education dollars. In the end, this program has the potential to be a powerful tool for early childhood programs across the state of Texas.

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