Evaluation of the Texas Infant and Early Childhood Mental Health Consultation (IECMHC) Pilot

Final Evaluation Report
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Authors:
Mackrain, M., Carlson, J., & Wakabayashi, T.

Contact:
Texas Institute for Excellence in Mental Health (TIEMH)
Steve Hicks School of Social Work
The University of Texas at Austin
The University of Texas at Austin
Email: txinstitute4mh@austin.utexas.edu
Web: https://www.tiemh.org

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Introduction

This report presents findings from an evaluation of the Infant and Early Childhood Mental Health Consultation (IECMHC) pilot program implemented as part of the Texas Preschool Development Grant Birth to Five (PDG B-5) initiative. The evaluation examines program implementation and early outcomes to inform ongoing improvement and future scaling of IECMHC services across Texas.

Program Background

Through PDG B-5, Texas invested funding over three years to establish a statewide IECMHC system. This investment included support of an IECMHC pilot in six community-based organizations serving ten counties. The Texas Institute for Excellence in Mental Health (TIEMH) at the University of Texas at Austin received funding to conduct this pilot from September 2024 through December 2025, with services delivered in 10 Texas counties over 12 to 14 months once IECMH consultant positions were filled.

IECMHC is a prevention-based approach that pairs mental health consultants with adults who work with infants and young children in various settings, including child care, preschool, home visiting, early intervention, pediatric, and home environments. This model equips professionals and caregivers with skills and knowledge to facilitate children's healthy social and emotional development.

Infant and Early Childhood Mental Health Consultants (IECMH Consultants) in the Texas pilot were highly skilled, Masters prepared licensed mental health clinicians who also completed the Infant and Early Childhood Mental Health Consultation Certificate Program through Georgetown University.

The PDG B-5 investment also funded a Training and Technical Assistance Center (TTA) with a dual focus on building statewide infrastructure (including landscape analysis, workforce development planning, evaluation design, and program manual development) and providing oversight, training, and technical support

to the six pilot programs. While initial investment covered one-time establishment and start-up costs, future spending is projected to be more cost-efficient as the system grows and benefits from economies of scale.

Evaluation Purpose and Scope

This evaluation assesses the pilot program's effectiveness, impact, and implementation fidelity. The evaluation examines alignment between program outcomes and established goals, identifies strengths, and areas for improvement, and provides evidence-based recommendations for program enhancement and statewide scaling.

Evaluation Framework

The evaluation is guided by the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance), which provides a comprehensive approach to assessing program impact and sustainability. This framework examines:

- **Reach:** The extent to which IECMHC services increased access for providers and families of children birth to five
- **Effectiveness:** The impact of services on child behavior, social-emotional development, provider practices, staff well-being, and family satisfaction
- **Adoption:** The integration of developmental screening and surveillance practices in early childhood settings
- **Implementation:** The delivery of IECMHC services, barriers addressed, and necessary supports including reflective supervision
- **Maintenance:** The sustainability of workforce capacity to deliver IECMHC services

Evaluation Questions

This evaluation addresses ten core research questions organized around implementation outcomes:

Adoption and Reach

- Has screening and surveillance of developmental and social-emotional competencies increased?
- Has access to IECMHC services increased for providers of children birth to five and families of children served?

Effectiveness

- Are IECMHC services associated with increased referrals to needed early childhood resources in local communities?
- Are IECMHC services associated with reductions in problematic child behavior and promotion of social-emotional skill development?
- Are IECMHC services associated with increased use of positive strategies in care settings?
- What is the reported impact of mental health consultation on staff and families, including changes in job-related stress or parenting stress?
- Are early childhood providers and parents/caregivers satisfied with IECMHC services?

Implementation

- How are IECMHC services implemented and how are barriers addressed?
- How many hours of reflective supervision are needed to support the implementation of IECMHC?

Workforce Capacity

- Has workforce capacity to provide IECMHC services increased?

Evaluation Design and Methods

To evaluate this program thoroughly, we looked at it from multiple angles, tracking measurable outcomes while also listening to the experiences of the people involved. We collected information through:

Quantitative Methods

- **Pre-post surveys:** Child behavior and social-emotional development (DECA-IT and DECA Clinical), classroom practices (TPOT/TPITOS Short Forms), and provider burnout (ProQOL)
- **Ongoing tracking:** Developmental screening completion (ASQ™-3 and ASQ™:SE-2), caseload logs documenting families and classrooms served, and referrals to community resources
- **Post-program surveys:** Participant satisfaction, training effectiveness (IOTTA), and workforce capacity assessment
- **Quarterly data collection:** Reflective supervision hours and implementation progress

Qualitative Methods

- **Interviews:** Exploration of perceived impact with IECMH consultants and providers.
- **Open-ended survey questions:** Capturing participant perspectives on service quality and outcomes
- **Quarterly narrative reports:** Analysis of implementation experiences, barriers, and adaptations

Data Quality and Analysis

We took care to make sure our findings were accurate and trustworthy. Our team regularly checked in on how data were being collected, compared information from different sources to verify what we were seeing, and kept careful track of what we had and what might be missing. The IECMH

consultants who worked directly with programs collected standardized assessments following established procedures, with support from our evaluation team to ensure consistency.

We analyzed the numbers to understand who the program reached, how services were used, and whether we saw changes in children's behavior and teachers' confidence over time. We also looked for patterns in referrals and screening practices. The interviews and feedback we gathered were carefully reviewed to identify common themes—what was working well, what got in the way, what helped things go smoothly, and how people felt the program made a difference.

Stakeholder Engagement

Throughout this evaluation, we stayed in close touch with the people doing the work, consultants, program staff, and the families and providers they served. Regular conversations and updates kept everyone informed and gave us a chance to adjust as we went. By listening to the TIEMH team, consultants, and the people receiving services, we made sure the evaluation captured what really mattered on the ground. This back-and-forth helped us generate findings that are actually useful for improving the program and thinking about next steps.

Report Organization

This report follows the evaluation questions we set out to answer. Each section digs into a specific question or group of related questions, sharing what we found, the evidence behind it, and what it means. Finally, we pull it all together and offer practical suggestions for strengthening and growing IECMHC services in Texas.

Results

Adoption and Reach

Screening and surveillance of developmental and social-emotional competencies

The ASQ™-3 (Ages & Stages Questionnaire, Third Edition) is a parent-completed developmental screening tool for young children (1 month to 5.5 years) that assesses five key areas: Communication, Gross Motor, Fine Motor, Problem Solving, and Personal-Social skills. Screening results can help families and professionals identify potential developmental delays to assist with planning appropriate supports. ASQ™-3s were completed for 61 of the 113 (54%) Child and Family Focused Consultation (CFF) cases, with one case having both an IECMH Consultant & Caregiver/Parent ASQ™-3s form completed. Of the 62 ASQ™ -3s completed, 60 (97%) were completed by Caregiver/Parent and 2 (3%) were completed by the IECMH Consultant. The table below summarizes cut-off data of those assessed. In sum, slightly more than one in three (35%) children assessed indicated moderate or high risk based on the ASQ™ -3 screening.

Table 1. ASQ™-3 Cut-off Data for Those Assessed

ASQ ™ -3 SECTION	ABOVE CUT-OFF: LOW RISK	CLOSE TO CUT-OFF: MODERATE RISK	BELOW CUT-OFF: HIGH RISK
COMMUNICATION	40 (65%)	5 (8%)	17 (27%)
GROSS MOTOR	49 (79%)	7 (11%)	6 (10%)
FINE MOTOR	45 (73%)	7 (11%)	10 (16%)
PROBLEM SOLVING	43 (69%)	9 (15%)	10 (16%)
PERSONAL-SOCIAL	37 (60%)	8 (13%)	17 (27%)

Of the 62 ASQ™ -3s administered, 44 (71%) obtained qualitative/overall responses that required follow-up from Section 2 of the ASQ™ -3 summary sheet. Of the 61 cases, ASQ™ -3 results led to referrals to a community resource for 36 children (59%). One case had missing referral data. Child/Family referrals were made to the following types of services: Brain Gym, Early Childhood Intervention (ECI) services, Psychiatric/Psychological services, autism-related services, Discovery Class, Speech Services, Occupational Therapy, Physical Therapy, Pediatrician, Pediatric Neurologist, Outside Therapy, Promoting First Relationships (PFR), Parenting Education Classes, and Nutritionist.

The ASQ-SE2 (Ages & Stages Questionnaire: Social-Emotional, Second Edition) is a parent-completed screening tool for children from 1 month to 6 years, identifying potential social-emotional delays in areas like self-regulation, autonomy, and social interaction, using age-appropriate questionnaires that guide professionals on when further assessment or monitoring is needed. The ASQ-SE2 was completed on 59 of the 61 cases (95%), with one case involving two raters and another case missing data pertaining to the assessment results. The average cutoff score on the ASQ-SE2 was 88.48 (SD=13.11; Range=50-105). The average total score was 100.69 (SD=56.79; Range=5-305). Of the 58 ASQ-SE2s completed, 26 (45%) were above the cutoff indicating high risk, 18 (31%) were close to the cutoff indicating moderate risk, and 14 (24%) were below the cutoff indicating low risk. Follow-up based on answers to question 32 and 33 was required for 23 of the 58 (40%) cases and not required for 35 (60%). In sum, more than half of the ASQ-SE2s completed indicated moderate to high risk (76%) related to social-emotional development (e.g., self-regulation, autonomy, and social interaction).

Consultation Referrals and Case Characteristics

◆ Overview of Referrals and Case Initiation

During the pilot program, the six participating agencies received 235 referrals for consultative services across all three consultation models. Referrals included 162 for Child/Family Focused consultation (69%), 53 for Classroom/Group consultation (23%), and 20 for Programmatic consultation (9%).

Consent and agreement to proceed with services were obtained for 107 Child/Family Focused cases (66% of referrals), 32 Classroom/Group cases (60% of referrals), and 15 Programmatic cases (75% of referrals). Overall, approximately two-thirds (66%) of referrals progressed to active consultation through completion of case intake forms. Despite ongoing outreach, one-third (33%) of referrals were unable to be reached or unable to secure agreement for involvement in services.

◆ Child/Family Focused Consultation (CFF)

Based on 113 completed case intake forms, 107 Child/Family Focused consultation cases were initiated during the grant period. Of those, three cases had two intake forms and one case had three intake forms, reflecting ongoing or renewed consultation needs.

Referral Sources for CFF. Early childhood providers represented the primary referral source (75%), followed by program supervisors, managers, or administrators (12%). Other sources, including nurse family partnership programs, counseling services, and early intervention/speech-language pathologists, accounted for 7% of referrals. Direct referrals from parents or caregivers were least common (6%).

Target Behaviors and Concerns. The primary behavioral categories addressed through Child/Family Focused consultation included:

- Aggression (39%)
- Developmental concerns (29%)
- Regulatory issues (19%)
- Other concerns including sleep routines, inattention/hyperactivity, parent engagement challenges, parent mental health, loss/grief, trauma, and autism concerns (11%)
- Sensory integration difficulties (2%)

Consultee Demographics. Providers (consultees) participating in Child/Family Focused consultation were predominantly female (94%), White (84%), and Hispanic/Latino (75%). Additional demographic representation included Black providers (13%), Asian providers (1%), and those identifying with other racial/ethnic categories or not indicating (2%).

Child Demographics. Children involved in Child/Family Focused consultation were primarily male (64%), White (92%), and Hispanic/Latino (73%). Black children represented 7% of cases, with approximately 1% not indicated. Nearly all cases (96%) involved parent or caregiver participation in the consultation process.

◆ Classroom/Group Consultation

A total of 32 Classroom/Group consultation cases were initiated through completion of case intake forms during the grant period. These 32 cases encompassed 40 classrooms, impacting 430 children receiving care from participating providers.

Program Settings. The majority of Classroom/Group consultations occurred in childcare centers (94%), with the remainder taking place in public pre-kindergarten settings (6%).

Referral Reasons. Primary reasons for referral included:

- Supporting and managing difficult classroom dynamics (81%)
- Creating smoother transitions between activities (16%)
- Improving trauma-informed practices (3%)

Consultee Demographics. All providers (consultees) participating in Classroom/Group consultation were female (100%). The majority identified as White (97%), with 3% identifying as Black. Hispanic/Latino providers represented 56% of consultees, while non-Hispanic providers comprised 44%.

◆ Programmatic Consultation

A total of 15 Programmatic consultation cases were initiated through completion of case intake forms during the grant period. These 15 cases served 122 classrooms, reaching 1,566 enrolled children across participating programs.

Consultation Focus. The predominant focus of Programmatic consultation was promoting the well-being and functioning of staff, families, and children throughout the program (86%). One case focused on refining program policies and practices (7%), and one case did not report the primary focus for services (7%).

Consultee Demographics. Program managers and supervisors (consultees) involved in Programmatic consultation were predominantly female (93%), White (80%), and Hispanic/Latino (53%). Black program leaders represented 13% of consultees, while non-Hispanic program leaders comprised 40%. Seven percent of demographic characteristics were not indicated.

Summary of Consultation Reach

The pilot program demonstrated substantial reach across consultation services, serving varied populations through three distinct service delivery approaches:

- Child/Family Focused consultation addressed individual child behavioral and developmental needs through 107 cases, with nearly universal parent/caregiver involvement (96%) and primary focus on aggressive, developmental, and regulatory concerns.
- Classroom/Group consultation supported 40 classrooms serving 430 children, primarily addressing classroom dynamics and transition challenges in childcare center settings.
- Programmatic consultation provided systems-level support to 15 programs encompassing 122 classrooms and 1,566 children, focusing predominantly on promoting organizational well-being and functioning.

While no established benchmark exists for IECMHC referral-to-initiation rates, the observed 66% rate reflects solid engagement in a pilot context and provides a baseline for setting stronger engagement targets in future phases. The demographic profile of consultees shows the program successfully engaged a mixed workforce, with particularly strong representation of Hispanic/Latino providers (56-75% across consultation types) and predominantly female early childhood professionals (94-100% across consultation types). The varied referral sources and consultation foci demonstrate the program's capacity to address needs at individual, classroom, and organizational levels.

Effectiveness

Referrals to Community Resources

Of the 160 consultation cases initiated, case closure forms were obtained for 96 (60%). Among Child and Family Focused Consultation cases, closure forms were obtained for 64 of 113 (57%). Missing closure documentation does not necessarily indicate incomplete consultation; in several cases, services were ongoing at the close of the PDG-funded evaluation period or continued through other funding streams. Of those 64 CFF case completions, 37 (58%) cases involved the consultant linking the child/family to an outside referral/resource at case closure.

Case closures were obtained on 22/32 (69%) of the Group/Classroom Consultation cases initiated. The status of "need" at exit resolved/somewhat resolved in 17 cases (77%) and unresolved in 4 cases (18%) where consultation was not completed (i.e., the provider was unresponsive/no longer wished to receive consultation). One case (5%) did not report "need" at exit. Case closure forms were obtained on 10/15 (67%) of the Programmatic Consultation Cases initiated. The status of "need" at exit resolved/somewhat resolved in 8 cases (80%) and unsolved in 2 cases (20%; one case indicated the consultee became unresponsive, one case indicated the grant was ending).

Child Social-Emotional Development and Behavior

The DECA-Clinical assessment was administered to children presenting with behavioral concerns. The Clinical version measures both behavioral concerns and protective factors. Behavioral concerns include Attention Problems, Aggression, Emotional Control Problems, and Withdrawal/Depression. Protective factors include Initiative, Self-Control, and Attachment, with composite scores for Total Behavioral Concerns (TBC) and Total Protective Factors (TPF).

Behavioral Concerns

Baseline Characteristics: Sixty-one children completed pre-assessments for behavioral concerns. At baseline, mean T-scores ranged from 58.02 (SD=11.09) for Withdrawal/Depression to 65.46 (SD=8.90) for Emotional Control Problems, with

an overall TBC score of 64.51 (SD=8.74). These scores indicate elevated behavioral concerns at program entry, with Attention Problems, Emotional Control Problems, and Total Behavioral Concerns scoring in the at-risk range.

Table 2. DECA-Clinical Behavioral Concerns Pre-Post Assessment Results

MEASURE	PRE N	PRE M	PRE SD	POST N	POST M	POST SD	CHANGE
Attention Problems	61	64.15	11.17	20	65.30	9.11	+1.15
Aggression	61	58.57	12.28	20	54.45	13.54	-4.12
Emotional Control Problems	61	65.46	8.90	20	62.45	9.95	-3.01
Withdrawal Depressionı	61	58.02	11.09	20	54.50	10.28	-3.52
Total Behavior Concerns	61	64.51	8.74	20	61.80	9.97	-2.71

Post-assessment results (n=20) revealed encouraging improvements across most behavioral domains. Total Behavioral Concerns decreased by 2.71 points from 64.51 to 61.80, indicating overall reduction in problematic behaviors. Specific improvements included notable decreases in Aggression (-4.12 points), Withdrawal/Depression (-3.52 points), and Emotional Control Problems (-3.01 points). Attention Problems showed a slight increase (+1.15 points), though this represents minimal change. Attention-related behaviors are known to fluctuate developmentally in early childhood and may become more apparent as more overt behavioral concerns decrease. Given the small magnitude of change and reduced post-assessment sample size, this finding should be interpreted cautiously. Overall, the pattern of results reflects meaningful improvements

across multiple behavioral domains among children who completed the full consultation process. The smaller post-assessment sample (n=20 vs. n=61 at baseline) reflects children who completed the full consultation process, and the meaningful reductions across most behavioral domains demonstrate positive intervention impact.

◆ Protective Factors

Baseline Characteristics: Sixty-two children completed pre-assessments for protective factors. Baseline protective factor scores were relatively low, with Initiative at 44.37 (SD=11.34), Self-Control at 39.42 (SD=10.15), Attachment at 42.32 (SD=12.37), and Total Protective Factors at 41.08 (SD=10.91). These baseline scores suggest that children entering the program demonstrated below-average protective factors, highlighting the importance of strengths-based intervention.

Table 3. DECA-Clinical Protective Factors Pre-Post Assessment Results

MEASURE	PRE N	PRE M	PRE SD	POST N	POST M	POST SD	CHANGE
Initiative	62	44.37	11.34	20	46.85	10.48	+2.48
Self Control	62	39.42	10.15	20	43.20	7.76	+3.78
Attachment	62	42.32	12.37	20	52.15	15.91	+9.83
Total Protective Factors	62	41.08	10.91	20	46.75	10.19	+5.67

Post-assessment results (n=20) revealed encouraging improvements across all protective factor domains. Attachment showed the most substantial gain (+9.83 points), increasing from 42.32 to 52.15, suggesting that intervention efforts successfully strengthened children's relationships with caregivers. Total Protective Factors increased by 5.67 points to 46.75 (SD=10.19). Moderate improvements were also observed in Self-Control (+3.78) and Initiative (+2.48). These findings demonstrate that the program effectively built children's strengths and resilience through strengths-based approaches.

◆ DECA-Infant (DECA-I)

The DECA-Infant assessment evaluates protective factors in children aged 1 month to 18 months. Three infants completed pre-assessments and two completed post-assessments. The Infant version measures Initiative, Attachment/Relationships, and Total Protective Factors.

Baseline Characteristics: Baseline scores (n=3) indicated moderate protective factors, with Initiative at 39.33 (SD=12.86), Attachment/Relationships at 43.33 (SD=13.01), and Total Protective Factors at 41.33 (SD=9.61). Considerable variability in baseline scores suggests heterogeneous starting points for infant participants.

Table 4. DECA-Infant Pre-Post Assessment Results

MEASURE	PRE N	PRE M	PRE SD	POST N	POST M	POST SD	CHANGE
Initiative	3	39.33	12.86	2	45.00	2.83	+5.67
Attachment/ Relationships	3	43.33	13.01	2	39.00	2.83	-4.33
Total Protective Factors	3	41.33	9.61	2	42.00	1.41	+0.67

Post-assessment results (n=2) showed improved Initiative scores (+5.67 points), reaching 45.00 (SD=2.83), with more consistent performance as indicated by reduced standard deviation. However, Attachment/Relationships scores decreased by 4.33 points to 39.00 (SD=2.83). Total Protective Factors remained relatively stable with a modest increase of 0.67 points. The very small sample size limits the generalizability of these findings, though the improvement in Initiative is encouraging.

◆ DECA-Toddler (DECA-T)

The DECA-Toddler assessment measures protective factors in children aged 18 months to 3 years. Eleven toddlers completed pre-assessments and two completed post-assessments. The Toddler version assesses Attachment/ Relationships, Initiative, Self-Regulation, and Total Protective Factors.

Baseline Characteristics: At baseline (n=11), toddlers demonstrated relatively consistent protective factors across domains: Attachment/Relationships (M=37.55, SD=9.65), Initiative (M=39.73, SD=14.67), Self-Regulation (M=36.00, SD=8.77), and Total Protective Factors (M=37.09, SD=10.17). These baseline scores suggest room for growth in developing protective factors. All total protective factors are in the Area of Need Range.

Table 5. DECA-Toddler Pre-Post Assessment Results

MEASURE	PRE N	PRE M	PRE SD	POST N	POST M	POST SD	CHANGE
Attachment/ Relationships	11	37.55	9.65	2	37.50	4.95	-0.05
Initiative	11	39.73	14.67	2	49.50	17.68	+9.77
Self Regulation	11	36.00	8.77	2	40.00	14.14	+4.00
Total Protective Factors	11	37.09	10.17	2	41.50	10.61	+4.41

Post-assessment results (n=2) demonstrated positive trends across most domains. Initiative showed the strongest improvement (+9.77 points), increasing from 39.73 to 49.50. Self-Regulation improved by 4.00 points, reaching 40.00 (SD=14.14). Total Protective Factors increased by 4.41 points to 41.50 (SD=10.61). Attachment/Relationships scores remained stable with minimal change (-0.05). While the small post-assessment sample limits statistical power, the consistent positive trends across protective factor domains are promising.

◆ DECA Summary

Overall, the DECA assessment results reveal meaningful insights across the three developmental groups. For the Clinical assessment, a positive pattern emerges; behavioral concerns showed modest improvements alongside substantial gains in protective factors across all domains. Total Behavioral Concerns decreased by 2.71 points, with notable improvements in Aggression (-4.12 points), Withdrawal/ Depression (-3.52 points), and Emotional Control Problems (-3.01 points). This dual pattern of improvement suggests that the program successfully built children's strengths and resilience while also reducing problematic behaviors.

For both Infant and Toddler assessments, protective factors generally improved or remained stable, with Initiative showing the most substantial gains in both groups (+5.67 for infants, +9.77 for toddlers). This pattern suggests that program activities effectively promoted children's capacity for self-directed exploration and problem-solving across developmental stages. The consistency of Initiative improvements across all three age groups points to successful implementation of developmentally appropriate activities that foster autonomy and competence.

However, the very small post-assessment samples for Infant and Toddler groups (n=2 for both) necessitate cautious interpretation. The disparity between pre- and post-assessment sample sizes (Clinical: 61 pre vs. 20 post for behavioral concerns; 62 pre vs. 20 post for protective factors) raises important questions about retention, assessment timing, and data collection procedures that warrant further investigation. The smaller post-assessment sample reflects cases that completed the consultation process during the evaluation period; some cases remained open or continued beyond the PDG-funded timeframe and therefore did not have post-assessment data available

Provider Use of Positive Strategies

To evaluate how IECMHC services support the use of positive, evidence-based practices in early care and education settings, this evaluation included direct observation of provider practices using Pyramid Model–aligned tools. The TPOT Short Form and TPITOS Short Form were selected because they offer reliable, efficient measures of how well core social–emotional teaching and caregiving strategies are being implemented in real-world settings. These tools allowed the

evaluation to assess changes in practice, document implementation fidelity, and generate actionable feedback to guide coaching, consultation, and continuous quality improvement across participating programs.

Across both tools, the short forms provide programs and consultants with actionable data that can guide coaching, professional development, and quality improvement efforts. Their brevity allows for more frequent use, reduced observation burden, and timely feedback while still maintaining alignment with the core Pyramid Model practices that strengthen social–emotional foundations in early childhood settings.

◆ TPITOS Findings

Seven classrooms (47% of the original 15) completed TPITOS post-assessments following Infant and Early Childhood Mental Health Consultation (IECMHC) services. Despite partial follow-up, results show substantial and consistent improvement in classroom practices supporting infant and toddler social–emotional development.

Overall, practice quality increased significantly, with average scores rising from 80.07 at pre-assessment to 94.29 at post-assessment, reflecting a 14.22-point (17.75%) improvement. Just as important, variation across classrooms decreased dramatically, indicating more consistent implementation of high-quality practices.

The greatest improvements occurred in areas previously identified as needs, including:

- Individualized scheduling
- Adults following the child's lead
- Children having opportunities for choice
- Engagement of disengaged children
- Use of redirection
- Cultural and linguistic responsiveness
- Adults supporting children's emotional expression

Notably, individualized scheduling showed complete transformation, shifting from widespread "rarely/never" use at baseline to 100% of classrooms demonstrating consistent implementation at post-assessment.

Concerning practices were fully eliminated at post-assessment, including:

- Punitive discipline
- Harsh or negative speech toward children

Across all observed items, more than 83% of practices were rated at the highest level of implementation (“Almost Always”), reflecting strong fidelity to Pyramid Model–aligned practices following consultation.

While the 47% post-assessment completion rate limits generalizability, the magnitude, consistency, and targeted nature of the improvements provide compelling evidence that IECMHC services were effective in strengthening classroom environments, improving individualized and responsive caregiving, and eliminating harmful practices.

◆ TPOT Short Form Findings (Preschool Classrooms)

The TPOT Short Form was used to assess preschool classroom practices supporting children’s social–emotional development. Twenty-two classrooms completed pre-assessments, and 12 completed post-assessments following Infant and Early Childhood Mental Health Consultation (IECMHC), representing a 55% completion rate.

Overall practice quality improved substantially, with average scores increasing from 77.95 to 95.67, a 17.71-point (22.72%) gain. Variation across classrooms decreased sharply, indicating more consistent implementation of evidence-based practices at post-assessment. Post-assessment scores clustered tightly between 88–104, compared to a wide baseline range of 3–104.

The largest gains occurred in core social–emotional teaching practices, including:

- Emotion coaching and anger management
- Supporting children’s problem-solving
- Teachers actively joining children’s play
- Adapting instruction for individual children
- Improved preparation and organization

Notably, teachers' positive, calm, and supportive tone reached 100% implementation at post-assessment, reflecting a complete transformation in this critical aspect of classroom climate.

Classrooms also showed improved engagement during transitions, increased discussion of emotions, stronger positive behavior support, and reduced reliance on negative or punitive practices.

Children and adults were observed as happier and more engaged at post-assessment, indicating improvement in overall classroom climate and adult well-being.

While the 55% post-assessment rate limits generalizability, the magnitude, consistency, and targeted nature of improvements across participating classrooms provide strong evidence that IECMHC services were highly effective in strengthening preschool social–emotional practices and teaching quality.

IECMHC Case Closures

During the pilot program, consultants documented case closure information for completed consultation cases across all three service delivery types. This section presents case closure data including reasons for closure, resolution status of identified needs, and consultant-rated effectiveness.

◆ Child/Family Focused Consultation

Of the 107 Child/Family Focused cases initiated with completed consent (66% of 162 referrals), consultants completed closure documentation for 64 cases (60%).

Reasons for Case Closure. The most common reasons for case closure were:

- Program goals met (24 cases; 38%)
- Grant ending with services continuing (13 cases; 20%)
- Child left the center (10 cases; 16%)
- Lost contact with family (9 cases; 14%)
- Parent or caregiver declined services (7 cases; 11%)
- Other reasons (1 case; 2%)

Resolution Status at Closure. At case closure, consultants rated the status of identified needs as:

- Unresolved (26 cases; 41%)
- Fully resolved (20 cases; 31%)
- Somewhat resolved (18 cases; 28%)

Consultant-Rated Effectiveness. Consultants rated their effectiveness in meeting consultation case needs as:

- Moderately effective (21 cases; 33%)
- Very effective (18 cases; 28%)
- Extremely effective (15 cases; 23%)
- Slightly effective (7 cases; 11%)
- Not effective (3 cases; 5%)

Consultants described strong outcomes when families remained engaged throughout the consultation process. Cases rated as "extremely effective" or "very effective" (52% combined) typically involved families who actively participated in sessions, implemented recommendations, and maintained consistent communication. Representative consultant comments include:

"Family was very receptive and applied all recommendations. By closure, we saw significant improvements in the child's behavior and the parent's confidence in managing challenging situations."

"Built strong rapport with the family. They were engaged throughout and expressed gratitude for the support. The mother reported feeling more equipped to support her child's emotional development."

Cases with unresolved needs often involved families who lost contact with services (14%), left the program (16%), or declined services (11%). Consultants noted that some families required longer-term support than the 12-14 month pilot timeframe allowed, particularly families facing multiple stressors or children with more complex needs.

◆ Classroom/Group Consultation

Of the 32 Classroom/Group cases initiated with completed consent (60% of 53 referrals), consultants completed closure documentation for 22 cases (69%).

Reasons for Case Closure. The primary reasons for case closure were:

- Goals met (13 cases; 59%)
- Provider discontinued services (8 cases; 36%)
- Not indicated (1 case; 5%)

Resolution Status at Closure. At case closure, consultants rated the status of identified needs as:

- Fully resolved (9 cases; 41%)
- Somewhat resolved (8 cases; 36%)
- Unresolved (4 cases; 18%)
- Not indicated (1 case; 5%)

Consultant-Rated Effectiveness. Consultants rated their effectiveness in meeting consultation case needs as:

- Extremely effective (7 cases; 32%)
- Very effective (7 cases; 32%)
- Not effective (3 cases; 14%)
- Moderately effective (2 cases; 9%)
- Slightly effective (2 cases; 9%)
- Not indicated (1 case; 5%)

Consultants noted particularly strong outcomes when teachers actively engaged with the consultation process and implemented recommended strategies. Cases rated as "extremely effective" or "very effective" (64% combined) consistently demonstrated teacher receptivity to feedback and observable improvements in classroom practices. Representative consultant comments include:

"The head teacher was new to her role and asked for guidance to improve classroom management skills. She was always open and receptive to feedback and applied all recommendations. At closure, her confidence and abilities had noticeably improved and her classroom was doing very well."

"Was able to help the teacher focus on their goals while maintaining a supportive stance. The teacher successfully navigated a position change with our support, and classroom goals were met."

Cases where goals were not met or were minimally effective often involved providers who discontinued services before completing the full consultation process.

◆ Programmatic Consultation

Of the 15 Programmatic cases initiated with completed consent (75% of 20 referrals), consultants completed closure documentation for 8 cases (53%).

Reasons for Case Closure. The primary reasons for case closure were:

- Grant ending with services continuing (4 cases; 50%)
- Program goals met (3 cases; 38%)
- Lost contact (1 case; 13%)

Resolution Status at Closure. At case closure, consultants rated the status of identified needs as:

- Somewhat resolved (4 cases; 50%)
- Fully resolved (2 cases; 25%)
- Unresolved (2 cases; 25%)

Consultant-Rated Effectiveness. Consultants rated their effectiveness in meeting consultation case needs as:

- Very effective (4 cases; 50%)
- Extremely effective (2 cases; 25%)
- Slightly effective (1 case; 13%)
- Not effective (1 case; 13%)

For cases with fully resolved needs, consultants provided an average of 7 sessions totaling 14 hours (range: 4-10 sessions, 8-20 hours). Both consultants rated themselves as "extremely effective" and reported "good to strong adherence" to core consultation steps. Representative comments include:

"We supported this program during their PBS Play to Learn classes. The director and parents were very involved and participated in sessions. The director was committed to receiving feedback during social-emotional classes, and parents were open to services. This client wants to continue as an IECMHC client during the next school year."

"The early childcare center director worked closely with the IECMH consultant to revise the center's parent handbook, increasing clarity of policies and procedures and creating greater transparency for parents. All core steps of programmatic consultation were completed. The changes will make a positive and lasting impact on service quality."

For cases with somewhat resolved needs, consultants provided services ranging from 1 to 15 sessions. Most consultants in this category (3 of 4) rated themselves as "very effective" and indicated "good adherence" to consultation steps. These cases typically involved ongoing work that continued beyond the reporting period.

The two cases with unresolved needs involved limited engagement. One consultee became unresponsive after an initial training session, and one case involved only a single session with no follow-up. Consultants noted frustration when clients sought only training rather than ongoing consultation, highlighting the importance of clarifying service expectations during initial outreach.

Summary of Case Closure Patterns

Several patterns emerge from the case closure data across consultation types:

- High Completion Rates When Engagement Maintained. Cases where consultees remained actively engaged throughout the consultation process showed high rates of goal achievement and positive resolution, with consultants rating their effectiveness as "very" or "extremely" effective in the majority of these cases.
- Time-Limited Services Present Challenges for Complex Cases. Consultants noted that some families and programs required support beyond the 12-14 month pilot timeframe, particularly those addressing multiple concerns or complex behavioral challenges. This was reflected in the proportion of cases (20% of Child/Family cases and 50% of Programmatic cases) that continued services beyond the official grant end date.
- Strong Core Model Adherence Associated with Better Outcomes. Cases where consultants reported "good" or "strong" adherence to core consultation steps consistently showed better resolution rates and higher effectiveness ratings compared to cases with "weak adherence" or limited engagement.

- Attrition Patterns Vary by Consultation Type. Child/Family Focused consultations faced higher attrition due to families losing contact or children leaving programs (30% of closures combined), while Classroom/ Group consultations more often concluded when providers voluntarily discontinued services (36% of closures). Programmatic consultations showed the lowest attrition, with most continuing beyond the pilot period.

These findings suggest that maintaining consistent engagement, adhering to core consultation principles, and providing adequate time for relationship development are critical factors in achieving positive consultation outcomes.

Impact of Consultation on Staff and Family Well-Being

To understand how IECMHC services affected the adults who deliver and receive early childhood services, the evaluation included multiple measures of provider well-being, perceived impact, and experience. This pilot project used the Professional Quality of Life Scale (ProQOL-5) to assess changes in compassion satisfaction, burnout, and secondary traumatic stress among providers, and a Participant Experience Survey and key informant interviews to capture satisfaction with IECMHC, perceived usefulness, and implementation experiences. Together, these tools provide a complementary picture of how IECMHC influences the workforce's capacity, stress, and day-to-day practice.

◆ Professional Quality of Life (ProQOL-5)

The Professional Quality of Life Scale (ProQOL-5) is a 30-item self-report measure that assesses three domains relevant to helping professionals: burnout, compassion satisfaction, and secondary traumatic stress. We used the ProQOL-5 to examine the perceived impact of IECMHC on staff well-being and their capacity to sustain emotionally demanding work with young children and families.

A total of 166 ProQOL questionnaires were completed between January 16 and November 20, 2025. An additional 11 were started but not finished and were excluded from the analysis. Of the 166 completed surveys, 117 were marked as pre-consultation (completed prior to or at the start of consultation) and 49 as post-consultation (completed after or at the end of consultation). The online system was not set up to link individual pre and post responses, so analyses compared pre and post groups rather than matched pairs. Independent

samples t-tests were conducted to assess whether mean scores differed significantly from pre- to post-consultation. As shown in Table 6, All changes were statistically significant at $p < .05$. Effects were in the desired direction:

- Burnout
- Secondary Traumatic Stress
- Compassion Satisfaction

These findings suggest that participation in IECMHC was associated with reduced burnout and secondary traumatic stress and increased satisfaction in one's professional role among respondents.

We also examined ProQOL scores by consultation type (child/family-focused, classroom/group, and programmatic consultation. Across all consultation types, mean burnout and secondary traumatic stress scores decreased from pre to post, while compassion satisfaction scores increased, indicating similar beneficial patterns regardless of how consultation was delivered.

Table 6. Combined ProQOL scores

N	MIN	MAX	MEAN	STD. DEVI-ATION	STD. ERROR MEAN
Overall Score Pre-Consultation	117	67	113	82.7521	9.81897
Overall score Post-Consultation	49	68	92	79.6122	5.66354
Burnout Pre-Consultation	117	10	36	20.2564	6.58519
Burnout Post-Consultation	49	10	28	17.2857	4.83046

N	MIN	MAX	MEAN	STD. DEVI-ATION	STD. ERROR MEAN
Compassion Fatigue Pre-Consultation	117	29	50	42.3162	5.35893
Compassion Fatique Post-Consultation	49	35	50	44.7959	4.7914
Secondary Traumatic Stress Pre-Consultation	117	10	38	20.1795	6.82871
Secondary Traumatic Stress Post Consultation	49	10	28	17.5306	4.81794

◆ Participant Experience Survey

To further understand how IECMHC was experienced by providers and parents/caregivers, the evaluation used a PDG Participant Experience Survey developed by the evaluator. The survey included 24 multiple-choice items and 13 open-ended questions. Items covered respondent role and program type, type of IECMHC received, satisfaction with services, perceived impact on practice, perceived changes in self-efficacy, and reflections on what was most helpful or challenging.

Between August 7 and November 6, 2025, 22 surveys were completed; three additional surveys were incomplete and excluded. Most respondents (20; 91%) reported receiving child/family-focused consultation, and two (9%) reported receiving classroom/group consultation, so findings primarily reflect perceptions of child/family-focused IECMHC. Respondents represented a mix of roles (e.g., directors, home visitors, early intervention staff, therapists, parents) and counties (Table 4).

Across 16 rating items on impact and satisfaction (Table 5), a large majority of respondents (generally over 80%) agreed or strongly agreed that IECMHC was helpful and that they were satisfied with services. Very high proportions reported that IECMHC helped them do their job better, feel more supported, and that they would use IECMHC again. Ratings of consultants were also highly positive, with strong agreement that consultants were trustworthy, understood needs, and met those needs.

Self-efficacy items showed similarly strong endorsement. Most respondents felt comfortable describing IECMHC to others and felt competent using what they learned. Two items showed slightly lower—but still generally positive—ratings:

- Comfort providing reflective supervision, which was not applicable for nearly half of respondents.
- Capacity to address broader program challenges, with 68.1% indicating increased capacity.

This suggests that while IECMHC strongly supported individual practice and child-focused challenges, there may be additional opportunities to further strengthen support for program-level change.

◆ Open-Ended Survey Responses – Key Themes

Nine open-ended questions provided rich detail about how IECMHC was experienced and where additional support is needed. Key themes included:

- Trusting, relational partnerships

Respondents consistently highlighted communication and active listening as central to trust-building. Many emphasized feeling heard, not judged, and supported. Consultants' warm, genuine demeanor and follow-through on commitments were frequently noted as critical to building trust.

For example, one provider shared,

"My IECMH consultant was able to discuss difficult situations within families that were directly affecting child's behavior. She gently guided parents to reflect on how their past experiences were influencing their parent-child relationship, some of which parents had not realized. She empowered parents to build confidence and follow a plan."

- Strategies that "stick" in day-to-day practice

Participants described continuing to use strategies related to behavior support and emotion regulation (e.g., de-escalation, breathing, playful redirection, routines), as well as communication strategies (e.g., changing wording, being clear and direct, language for talking with parents). Respondents also valued strategies for working with neurodivergent children and for supporting parent–child relationships.

- Reflective supervision and self-care

Examples of successful reflective supervision focused on thinking together about children and families, planning tailored strategies, and supporting staff in their own stress management and self-care. Respondents described increasing their own grounding, gratitude, and reflective capacity as a result of consultation.

- Most helpful aspects of IECMHC

The most frequently cited benefits were feeling understood and supported, having a trusted partner to problem-solve with, and developing effective, collaborative plans for children and families. Participants valued both concrete tools (e.g., specific curricula, trainings, resources) and the opportunity to reflect on difficult situations with a knowledgeable, compassionate consultant.

- Personal impact on providers and parents

Respondents reported that IECMHC gave them "a place to go" when they did not know next steps, increased their confidence in addressing behavioral concerns, and supported their own emotional regulation and communication. Some described improvements in their relationships with their own children. For example, one consultant shared,

"IECMHC helped me to listen to all versions before jumping to conclusions, as well as control my reactions when uncomfortable situations happen with coworkers, family and friends. She was helpful in modeling a balance between assertiveness, kindness, empathy and emotional strength."

- Training and resource needs

Participants appreciated exposure to specific trainings and resources (e.g., Brain Gym, CARE, Conscious Discipline, Pyramid Model, play-based guidance, Autism resources) and indicated a desire for more training opportunities and extended PD sessions.

- Challenges and suggestions

The most frequently mentioned challenge was scheduling, including difficulty finding time to meet and limited IECMHC capacity relative to demand. A small number of respondents mentioned needing clearer processes, more resources, or sadness about the ending of the project, often paired with hope that IECMHC would continue or expand.

Overall, open-ended responses paint a consistent picture of IECMHC as relationship-based, practical, and deeply supportive—helping adults feel less alone, more capable, and better equipped to support children and families.

◆ Key Informant Interviews

To complement survey findings, we conducted five virtual interviews via Zoom with three IECMH Consultants and two child care program directors. Recordings were transcribed, cleaned, and coded in Dedoose. Codes were first aligned with the 15 interview questions and then consolidated into broader topics: Background, Demystifying IECMHC, and Perceived Impact (Table 7).

Across interviews, several cross-cutting themes emerged:

- Strong, complementary expertise

Consultants brought deep training in mental health and child development; directors brought extensive early childhood and administrative experience. Both emphasized that this combination created a powerful partnership, especially for addressing trauma, supporting staff, and responding to complex family needs.

- Clarifying "therapy vs. consultation"

Interviewees described ongoing work to explain what IECMHC is—and is not. Consultants noted that families and partners often initially expect weekly "therapy," and that time is needed to clarify the preventative, capacity-building nature of consultation. IECMHC was frequently framed as providing "tools" or a "vaccine" that adults can then apply in their ongoing work with children and families.

- Fit, readiness, and consultant qualities

A good fit for IECMHC and for the consultant role was described as strong boundaries, curiosity, non-judgment, cultural humility, and solid grounding in child development. Interviewees emphasized that not every mental health professional is well-suited to this community-based, relationship-intensive role, and that programs also vary in readiness to fully engage.

- Perceived impact at multiple levels

Directors and consultants reported benefits for teachers/providers (increased confidence, better communication with families, clearer understanding of children's needs), families (greater understanding of children's behavior, more effective parenting strategies, reduced stigma around diagnosis), and children (improved regulation, decreased challenging behavior, reduced risk of expulsion or placement change). For example one provider shared, "I would recommend it. I would definitely tell them that it is an additional support system for directors and staff... it's not just about benefiting the teachers and myself, but it benefits the children. And that's the most important thing... if we can get them the right help at the right time, then it's going to make the biggest difference in the world." IECMHC was also seen as supporting staff self-care and burnout prevention, echoing the ProQOL findings.

- Value of community and collaboration

Consultants described the PDG B-5 IECMHC network—shared reflective supervision, cross-site collaboration, and joint learning—as a key source of professional support. This "big community" reduced feelings of isolation and strengthened practice across sites. For example, one consultant shared, "Even though I'm the only one here [in my agency], it doesn't feel lonely... I have this community of peers... we're all on the same boat. We're all dealing with very similar things, and we can all relate to each other... That has definitely been a very, very awesome part of the experience and something that I will carry with me."

The ProQOL data, participant surveys, and interviews point to a consistent pattern: providers who received IECMHC reported improvements in both their classroom practices and their own professional well-being. While the sample sizes were modest and we can't rule out other factors that may have contributed to these changes, the alignment across multiple data sources is encouraging

Satisfaction with IECMHC Services

A sixteen item participant experience survey, completed at the end of services was completed by twenty-two recipients of services. Table 8 summarizes the self-ratings of these multiple choice questions. A large majority of respondents (over 90%) agreed or strongly agreed that IECMH consultant was helpful and that they were satisfied with services. Very high proportions reported that IECMHC helped them do their job better, feel more supported, and that they would use IECMHC again. Ratings of consultants were also highly positive, with strong agreement that consultants were trustworthy, understood needs, and met those needs.

Self-efficacy items showed similarly strong endorsement. Most respondents felt comfortable describing IECMHC to others and felt competent using what they learned.

Table 8. Self-Reported Impact of IECMHC services

IMPACT OR SATISFACTION	%AGREE/STRONGLY AGREE
IECMHC HELPED ME DO MY JOB BETTER.	95.5
IECMHC HELPED ME TO FEEL SUPPORTED IN MY JOB.	90.9
I WOULD USE IECMHC AGAIN IN THE FU-TURE,	95.4
MY IECMH CONSULTANT'S PRESENCE IN MY PROGRAM WAS COMFORTABLE.	95.5
MY IECMH CONSULTANT LISTENED AND UN-DERSTOOD WHAT I NEEDED.	95.4
MY IECMH CONSULTANT MET MY NEEDS.	95.4

IMPACT OR SATISFACTION	%AGREE/STRONGLY AGREE
MY IECMH CONSULTANT WAS ABLE TO BUILD A SENSE OF TRUST WITH ME.	95.4
ENGAGING IN IECMHC HELPED ME BETTER IDENTIFY THE PARALLELS THAT MAY EXIST BETWEEN MY WORK/RESPONSES AND THE EXPERIENCES OF THE FAMILIES AND INFANTS (OR STAFF) THAT I SUPPORT.	86.4
SELF-EFFICACY	**% Comfortable or Competent/Very Comfortable or Very Competent**
HOW COMFORTABLE ARE YOU IN DESCRIBING WHAT INFANT & EARLY CHILDHOOD MENTAL HEALTH CONSULTATION (IECMHC) IS TO SOMEONE WHO HAS NEVER HEARD OF IT OR EXPERIENCED IT, LIKE A NEIGHBOR OR A NEW COWORKER?	95.4
HAS YOUR COMFORT LEVEL IN PROVIDING REFLECTIVE SUPERVISION CHANGED? (NOT APPLICABLE=45.5%)	54.6
I FEEL COMPETENT USING WHAT I LEARNED FROM IECMHC.	91
HAS YOUR CAPACITY TO ADDRESS CHILD FOCUSED CHALLENGES IN YOUR PROGRAM INCREASED AS A RESULT OF IECMHC?	85.0
HAS YOUR CAPACITY TO ADDRESS CHALLENGES IN YOUR PROGRAM INCREASED AS A RESULT OF IECMHC?	68.1
HELPFULNESS	**%Helpful/Very Helpful**
IECMHC HELPED ME TO ADDRESS MISATTUNEMENTS THAT OCCURRED WITH STAFF OR FAMILIES.	86.4
DID IECMHC SERVICES, SUCH AS CASE CONSULTATION, HELP YOU FEEL PREPARED TO SUPPORT FAMILIES?	81.9
WERE THE STRATEGIES YOU AND YOUR IECMH CONSULTANT PLANNED TOGETHER HELPFUL?	95.5

Reflective Practice of Providers Receiving IECMHC

To better understand how IECMHC supports the reflective dimensions of practice within those receiving IECMH Consultation, this evaluation included the Reflective Capacity Self-Efficacy Scale, a 17-item self-report measure assessing early care and education professionals' confidence in core reflective capacities central to work with families. The scale was completed by early care and education professionals receiving consultation services, rather than by consultants, and asked respondents to reflect on their own reflective capacities in the context of their participation in IECMHC.

The scale captures confidence across reflective domains essential to effective practice with young children and families, including noticing and naming emotional responses, using observation to guide practice, engaging in reflective dialogue and supervision, and repairing relational ruptures. Together, these capacities represent the "inner work" that supports providers' ability to remain curious, attuned, and responsive in emotionally complex situations.

By measuring perceived changes in reflective capacity associated with consultation participation, the Reflective Capacity Self-Efficacy Scale offers insight into early workforce and practice-level outcomes that are foundational to IECMHC impact.

◆ Sample and Administration

The scale was completed by eight early care and education professionals receiving IECMHC between November 13, 2024, and December 19, 2024. Most responses were collected pre-consultation (6 respondents; 75%), with a smaller number completed post-consultation (2 respondents; 25%). Respondents were evenly split between those engaged in classroom/group consultation (4; 50%) and child/family-focused consultation (4; 50%).

Given the small sample size—particularly for post-consultation responses—findings are considered exploratory and descriptive rather than definitive.

◆ Overall Confidence in Reflective Capacities

Across all 17 items and all respondents, overall confidence levels were moderately high:

- **Mean rating:** 3.51 (SD = 0.89) on a 5-point scale
- **Median rating:** 4.0 (“High Confidence”)
- Ratings ranged from 2 (“Low Confidence”) to 5 (“Extremely High Confidence”)

Most item-level responses clustered in the upper range:

- **High Confidence (4):** 46.3% of all ratings
- **Average Confidence (3):** 27.2%
- **Low Confidence (2):** 16.2%
- **Extremely High Confidence (5):** 10.3%

The modal response was “High Confidence”, indicating that, as a group, respondents generally felt confident in their reflective skills, with some meaningful room to grow.

◆ Areas of Relative Strength and Growth

Item-level means show a nuanced picture of reflective practice:

- The highest-rated capacity was the ability to discuss difficult emotional responses (M = 3.75), suggesting providers felt relatively strong in naming and talking about emotionally charged experiences.
- Several other capacities clustered closely behind (M = 3.62–3.75), including feeling safe discussing emotions, examining one’s thoughts and feelings, remaining open to feedback, describing observations of parents, using assessment to guide intervention, and understanding the reasons for IECMHC.
- Capacities with slightly lower, but still moderate confidence included describing observations of children, building trusting relationships with IECMH consultants, identifying parallels between one’s own emotional responses and those of families, and using consultation to understand one’s own capacities (M = 3.38).

- The lowest mean rating was for addressing ruptures with IECMH consultants (M = 3.25), followed closely by addressing ruptures with coworkers or families (M = 3.38).

These patterns suggest that while respondents felt reasonably confident overall, navigating and repairing relational ruptures may be an area where additional support, modeling, or scaffolding could be beneficial.

◆ Pre- vs. Post- Confidence

Although the sample is small, pre- and post- averages show a noteworthy pattern:

- **Pre-consultation (n = 6):** Mean = 3.23 (SD = 0.81), range 2–5
- **Post-consultation (n = 2):** Mean = 4.35 (SD = 0.49), range 4–5

On average, post-consultation respondents rated their confidence 1.13 points higher than pre-consultation respondents on the 5-point scale. Post-consultation ratings were also more clustered in the high range (4–5), indicating both higher and more consistent confidence after consultation.

While these results cannot support causal claims due to the very small and cross-sectional sample, they are directionally consistent with the intended role of IECMHC—to deepen reflective capacities, strengthen providers' confidence, and enhance their ability to use reflective consultation in their work.

Taken together, these early findings suggest that Providers receiving IECMHC generally report moderately high confidence in key reflective capacities. Additionally, discussing and processing emotional responses appears to be an emerging area of strength.

Repairing ruptures in relationships, particularly with IECMH consultants, may represent a meaningful growth edge for future training and consultation focus.

Higher confidence among post-consultation respondents is promising and aligns with the broader evaluation findings on provider well-being and perceived impact.

However, these findings must be interpreted with caution. The small total sample (N = 8)—and especially the very small post-consultation group (n = 2)—limits generalizability and prevents robust statistical comparison. In addition, the cross-sectional nature of the data (rather than matched pre–post responses) means we cannot attribute changes in confidence directly to IECMHC.

Workforce Capacity

Training and Workforce Development

More than 800 IECMHC-related workforce professionals participated in over 30 service-related training courses provided across 2024-2025. As reported by participants on post-training outcome surveys, more than 9 out of 10 (92%) respondents indicated they had achieved intermediate or higher levels of mastery/competence related to training goals. A breakdown of participants by training year is provided below.

In 2024, three trainings (DECA, Facilitating Attuned Interactions, and Preschool Pyramid Model) related to IECMHC services were offered across five days in October and November. These courses involved more than 60 workforce participants. Participant post-survey results indicated 93% had achieved intermediate or higher level of mastery/competence on skills/information taught.

In 2025, four trainings (Foundational Pyramid Model-Infant/Toddler & PreK; Advanced Pyramid Model; Foundational Reflective Supervision; Intensive Reflective Supervision) were offered across 22 days in September, October, and November. Participant training outcome surveys were obtained from 778 workforce participants. Participant post-survey results indicated 92% had achieved intermediate or higher level of mastery/competence on skills/information taught.

Summary of Key Findings

This evaluation of the Texas IECMHC pilot program assessed effectiveness across 113 families, 32 providers (reaching 430 children), and 15 program managers (impacting 1,566 children) in ten counties.

The findings below reflect outcomes associated with participation in the Texas IECMHC pilot program and its core consultation strategies, child/family, classroom/group and programmatic consultation and targeted workforce support. Results are drawn from administrative data, standardized assessment tools, and participant feedback and should be interpreted within the context of a pilot initiative focused on systems building and early implementation.

- Screening and Referrals. ASQ assessments were completed for 61 children (54% of Child and Family Focused cases), with 59% referred to appropriate community resources. Of 96 closed cases, 58% of Child and Family Focused consultations resulted in referrals, and 77-80% of Group/Classroom and Programmatic consultations resolved or partially resolved presenting concerns.
- Child Outcomes. DECA assessments demonstrated meaningful improvements in both behavioral concerns and protective factors for children who completed consultation. Among children with behavioral concerns (n=20 post), Total Behavioral Concerns decreased by 2.71 points, with notable reductions in Aggression (–4.12), Withdrawal/Depression (–3.52), and Emotional Control Problems (–3.01). Protective factors showed even stronger gains: Total Protective Factors increased by 5.67 points, driven by substantial improvement in Attachment (+9.83), as well as increases in Self-Control (+3.78) and Initiative (+2.48). For infants and toddlers with completed post-assessments, protective factors generally improved or remained stable, with Initiative showing the most consistent growth across age groups.
- Provider Wellbeing. ProQOL data demonstrated statistically significant improvements: Burnout decreased 2.97 points (Cohen's d = 0.485, p = 0.002), Compassion Satisfaction increased 2.48 points (Cohen's d = -0.477, p = 0.004), and Secondary Traumatic Stress decreased 2.65 points (Cohen's d = 0.42, p = 0.005). To contextualize this finding providers shared that IECMH consultants built trust with them by " asking questions, active listening, and giving good feedback and resources." One respondent wrote, "She would listen to my concerns without judgment."

- Satisfaction. Over 95% of participants agreed that IECMHC helped them do their jobs better, that their IECMH consultant listened and understood their needs, and that they would use services again. Reflective capacity self-efficacy scores increased 1.13 points from pre- to post-consultation.
- Workforce Development. Over 800 professionals completed training across 30+ courses, with 92% achieving intermediate or higher competency levels.

Strengths of the IECMHC Pilot

- State-Level Training and Technical Assistance (T/TA) Support. The T/TA Center played a pivotal role in ensuring consistency, quality, and coherence across the pilot. Through comprehensive training offerings, ongoing technical assistance, and structured guidance on model implementation, the Center strengthened IECMH consultant skills, supported fidelity to the IECMHC approach, and fostered a statewide learning community. This infrastructure enabled rapid onboarding, reinforced reflective and relationship-based practices, and provided IECMH consultants with accessible, responsive support throughout the pilot.
- Strong Relationships. Participants consistently identified IECMH consultants' active listening, non-judgmental approach, and genuine warmth as key to program success. Communication and trust-building emerged as the foundation for all other intervention outcomes.
- Evidence-Based Assessment. The integration of standardized assessments (DECA, ASQ, ProQOL, TPOT/TPITOS) provided data to guide consultation and document outcomes, IECMH Consultants and participants valued these tools for establishing baselines and demonstrating progress.
- Flexible Service Models. Three consultation types (Child/Family Focused, Group/Classroom, Programmatic) enabled responsive service delivery across program settings and needs.
- Measurable Impact. Findings from this pilot demonstrate clear and multi-level impact of IECMHC services. Providers experienced statistically significant improvements in burnout, compassion satisfaction, and secondary traumatic stress, strengthening workforce stability and capacity. Children showed reductions in challenging behaviors and notable gains in protective factors that support long-term resilience. Importantly, over 95%

of participants reported they would use IECMHC services again, providing strong evidence that state investment resulted in services that are both effective and valued.

Implementation Learning and Lessons to Sustain Effective Practice

The IECMHC pilot launched with core infrastructure in place, including consultant orientation, data systems, assessment protocols, communication expectations, and a defined consultation timeframe. As services were delivered across participating sites, implementation experience generated valuable learning about how these elements function in practice and where targeted refinements can strengthen consistency, efficiency, and impact.

- Program Understanding and Ongoing Communication.

Initial orientation and explanatory materials supported a strong start to implementation. Over time, consultants observed the benefit of reinforcing IECMHC's prevention-focused role through consistent, plain-language communication with families, providers, and program leadership. Periodic reinforcement helped align expectations, clarify the consultant role, and support sustained engagement across the service period.

- Data Systems and Documentation Practices.

Data systems and reporting requirements were established prior to service delivery, enabling early monitoring and accountability. Active use of these systems during implementation highlighted opportunities to further support consultants through hands-on coaching, streamlined workflows, and protected documentation time, ensuring data requirements complemented—rather than competed with—direct consultation work.

- Assessment Implementation and Evaluation Readiness.

Assessment tools, timelines, and administration protocols were clearly defined at the outset of the pilot. Variation in pre- and post-assessment completion across sites provided important insight into where additional implementation supports

—such as embedded workflows and enhanced tracking—can strengthen consistency and increase the usefulness of evaluation data, particularly later in the consultation cycle.

- Communication and Coordination with Program Leadership.

Established expectations for communication between IECMH consultants and program leadership supported collaboration throughout the pilot. Feedback suggested that more standardized, routine program-level updates—focused on general strategies and themes rather than individual cases—could further strengthen coordination, shared understanding, and alignment while maintaining appropriate confidentiality.

- Consultation Duration and Intensity.

The 12–14 month consultation model allowed programs to experience meaningful depth of support within the pilot period. Implementation experience also indicated that flexibility in consultation intensity and duration is important for responding to differing levels of program and family need. Clear guidance to support these decisions can help ensure consultation resources are used responsively and effectively.

Recommendations for Statewide Scaling

The recommendations below build on substantial infrastructure, protocols, and supports that were developed and implemented during the pilot start-up phase. In many cases, core elements—including consultant onboarding, data systems, assessment protocols, and dosage guidance—were established prior to or concurrent with service delivery, reflecting the realities of launching a complex system while implementation was underway. The recommendations therefore focus on strengthening, standardizing, and deepening these existing structures based on lessons learned during early implementation, rather than introducing entirely new components.

- Maintain a Statewide T/TA Infrastructure. Preserve and strengthen the centralized Training and Technical Assistance (T/TA) structure to ensure consistency, fidelity, and high-quality implementation across regions. A statewide T/TA center provides essential functions—including IECMH consultant onboarding, reflective supervision support, fidelity monitoring,

and access to shared tools and resources—that help maintain alignment with the IECMHC model as the system grows. This infrastructure also fosters statewide learning, reduces variability in service delivery, and supports continuous quality improvement during expansion.

- Build on existing data systems to enable linked pre–post assessments. Strengthening system functionality to support matched analyses would enhance evaluation rigor and allow baseline data to be more readily used by consultants and providers to inform consultation planning and continuous quality improvement.
- Build on Pilot Success. The significant improvements in provider wellbeing (effect sizes 0.42-0.49) and high satisfaction rates (>95%) provide strong evidence for expansion. Maintain core elements: relationship-centered approach, evidence-based assessment, reflective supervision, and flexible service models.
- Evaluate and strengthen IECMH consultant credentialing standards. Using lessons learned from the pilot and the 2024 competencies and training framework, assess alignment between consultant preparation, training content, and practice expectations, and formalize statewide credentialing requirements accordingly.
- Strengthen and diversify sustainable funding strategies. Build existing PDG B-5 investments by further exploring and formalizing mixed funding streams. Develop and test blended funding models to reduce reliance on single funding sources and support long-term sustainability.
- Scale strategically using a phased approach. Build on pilot implementation by prioritizing expansion in regions with established infrastructure and strong community readiness. Use a phased rollout that incorporates lessons learned at each stage to guide capacity building and continuous quality improvement, rather than pursuing immediate statewide coverage.
- Strengthen and expand the IECMH consultant workforce pipeline. Build on existing training and professional development efforts by partnering with universities and training programs to expand the IECMH consultant workforce. Consider formalizing degree pathways, scholarships, and field placement opportunities aligned with IECMHC competencies and practice settings.
- Support a Next-Phase Evaluation. Conduct a next-phase evaluation of the Texas IECMHC model, including dosage guidance. Building off pilot findings, a future evaluation—with dedicated funding—should examine

consultation dosage in relation to fidelity, case closure, and outcomes. This work would support refinement of dosage benchmarks and strengthen guidance as IECMHC infrastructure and site readiness continue to mature.

- Strengthen Access Across Communities. Build on existing outreach and service delivery efforts to strengthen access to IECMHC services statewide, with targeted strategies to reach communities that have historically had limited access, including rural areas and low-income families. Continue monitoring service utilization and outcomes across demographic groups to identify access gaps and inform ongoing improvement.

Conclusion

This evaluation provides strong evidence that IECMHC services meaningfully improve outcomes for children, families, and early childhood professionals. Statistically significant reductions in provider burnout ($p = 0.002$) and secondary traumatic stress ($p = 0.005$), coupled with improvements in compassion satisfaction ($p = 0.004$) and child protective factors (5.67 points), demonstrate measurable program impact. Participant satisfaction exceeding 95% across multiple indicators confirms that services are valued and perceived as helpful.

The pilot successfully delivered services to 107 families and 47 providers/managers across program types, reaching more than 200 classrooms with an overall impact on more than 2000 children, established effective assessment and consultation protocols, and built a supportive professional community through reflective supervision and peer learning opportunities. These accomplishments, achieved within a 12-14 month implementation period, demonstrate program feasibility and effectiveness.

Opportunities for improvement include enhancing public awareness, streamlining data systems, maximizing assessment completion rates, and developing sustainable funding mechanisms. Addressing these areas while preserving core program strengths will position Texas for successful statewide expansion.

The evidence in this pilot demonstrates that IECMHC services in Texas have achieved meaningful outcomes and established a strong foundation for early childhood mental health support. The evaluation identifies both notable successes and opportunities for enhancement. Should stakeholders decide to

pursue expanded services, the findings suggest that strategic, phased scaling—informed by the documented effective practices and lessons learned—could strengthen Texas's early childhood mental health infrastructure. Implementation of any expansion would be enhanced by addressing the improvement areas and leveraging the successful strategies identified throughout this report.