Implementation of a Mental Health Consultation Program at an Early Childhood Education

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Implementation of a Mental Health Intervention Program at an

Early Childhood Education Center

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Capstone Project: A School Improvement Plan

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Abstract

Research shows that young children experiencing social–emotional difficulties in early childhood can have a lasting impact on later functioning in school and through their adult lives. Additionally, research has suggested that mental health intervention in young children can significantly help children navigate these challenges. With these research findings in mind, this school improvement plan was created to deliver early childhood mental health consultation to an early childhood program serving at-risk children in the Bay Area of California. This plan is comprised of a prevention-oriented approach that strengthens the capacity of school staff to prevent, identify, treat, and reduce the impact of mental health problems (MHPs) in children and their families. Furthermore, the plan seeks to enhance classroom relationships, create emotionally responsive environments, strengthen adult–child interactions, prevent challenging behaviors, and support social–emotional competencies in children and their families.

Keywords: Mental health, preschool, challenging behaviors, intervention
Implementation of a Mental Health Intervention Program at an Early Childhood Education Center

Teachers in early childhood classrooms encounter children with behavioral concerns, developmental delays, and young children who have experienced trauma on a daily basis. Preschoolers who exhibit aggressive behaviors, social disorders, or other cognitive delays often struggle to engage with their peers each day in school (Wlodarczyk et al., 2017). Some children who have experienced trauma such as emotional, physical, or sexual abuse; domestic violence; neglect; or serious accidents demonstrate deficits in their ability to learn, follow classroom expectations, and form healthy supportive relationships. Child and adolescent trauma exposure is prevalent, with trauma exposure-related symptoms, including post-traumatic stress, depressive, and anxiety symptoms often causing substantial impairment (Dorsey et al., 2017). Children with developmental delays often exhibit challenging behaviors in the classroom. Emotional and behavioral disorders represent a significant source of disability for children and adolescents (Ringeisen et al., 2017). The scientific community has come to accept that many disorders of childhood and adolescence may onset as early as preschool (Whalen et al., 2018).

Background

Regardless of the source, the aforementioned behaviors can often frustrate and overwhelm teachers when their classrooms feel chaotic and they worry how these behaviors can affect the ecosystem of their classrooms. Meanwhile, parents may worry about how their child’s behaviors may impact their school experience (Zulauf & Zinsser, 2019). An intervention model is needed that supports children, while arming teachers and parents with the tools needed to address concerns. Ample evidence shows that a wide range of evidence-based intervention programs and instructional practices can promote children’s social–emotional learning and
reduce behavior problems in the classroom successfully (Waschbusch et al., 2018). Interventions can be beneficial in improving mental health outcomes; therefore, researchers have identified the school environment as an important setting for implementing mental health-related programs (Brown & Dixon, 2020; Das et al., 2016; Jones et al., 2019). The school environment, as a backdrop for intervention, is ideal in that it is a safe, familiar, and continuous structured environment in which preschoolers spend most of their day.

Objective

To best support children experiencing these challenges, the implementation of a mental health intervention in the classroom is needed, particularly in low-income, at-risk communities. According to the nonprofit organization, Zero to Three (2017), which specializes in the science of early childhood:

Mental health is the developing capacity of the child from birth to 5-years-old to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn-all in the context of family, community and culture. (p. 1)

To help preschoolers develop positive mental health and to assist children in crises to build a mental health safety net, prevention and early intervention is key. Studies of prevention and intervention services and systems during children’s earliest years have shown positive and lasting effects compared to waiting until children are older (Mann et al., 2007; Miles et al., 2010; National Scientific Council on the Developing Child, 2010).

Scope

This school improvement plan integrates mental health consultation and intervention services in general education programming of an early childhood education center serving at-risk
children. Through this intervention plan, children, their families, and their teachers will receive the necessary support needed to promote positive outcomes for young children as they prepare to navigate formal schooling in the Bay Area of California.

**Review of the Literature**

Research for this school improvement plan was conducted using peer-reviewed articles from the Dewitt Library at Northwestern College. In addition, research was gathered from a peer-reviewed journal, *Young Children*, a publication of the National Association for the Education of Young Children. Search criteria included peer-reviewed articles published within the last 10 years; however, some publications dated in the early 2000s were used. Prior to the early 2000s, the concept of a preschooler with mental health disorders was rarely discussed, and there was little in the way of support for early childhood programs that served children with these challenges. Many people believed the time of early childhood was one of happiness, joy, and wonder, and that mental health concerns were more of a burden affecting older children or adults. Dougherty et al. (2015) noted more research in the early 2000s emerged that brought awareness of mental health, social–emotional concerns, and emotional intelligence in very young children. For this reason, research will be included that dates back 20–25 years when this topic started to become widely addressed. Overall content used was related to universal mental health assessments, mental health intervention in early childhood education, and preventative practices in early childhood education.

Mental health specialists who are able to provide direct consultation services in combination with teachers who possess the familiarity, expertise, and skills to create early childhood experiences that support development of the “whole child” are key to positive forward movement. Mental health intervention in the preschool setting will not only alleviate the stressful
experiences of a troubled child, lessen negative classroom impact, and alleviate the burden in the family dynamic, but will change the trajectory of the child’s life. Through practical and research-supported methods, this intervention model will promote positive social–emotional development that gives children the tools to navigate the world around them and encourage their sense of competency. Proven methods that are data driven will assist an early childhood education program to provide these much-needed services to their community.

**Mental Health in Young Children**

In the early 2000s, much focus was centered on research on social–emotional disorders in young children. Challenging behaviors that disrupt classroom learning have become increasingly common and constitute one of the strongest predictors of later delinquency, aggression, antisocial behavior, and substance abuse (McCabe & Frede, 2007). Researchers have looked at these behaviors and categorized them into two categories: (a) emotional disturbances, or internalizing; and (b) behavioral disturbances, also known as externalizing behaviors. Internalizing behaviors refer to inner turmoil such as withdrawal, depression, and anxiety. Externalizing problems are the behaviors children exhibit such as noncompliance, deviancy, and acting out. These terms are used to describe two broad groupings of behavioral, social and emotional problems (Achenbach et al., 2016). Poulou (2015) included an extensive review of recent studies focused on emotional and behavioral disorders (EBDs) in preschool children through those 6 years old. The study aimed to identify the nature and varying aspects of EBDs to aid researchers, educators, and other professionals working with young children at risk of EBD. Of the studies retrieved, Poulou focused on peer-reviewed studies from within the last 2 decades conducted in community populations in western contexts. Palou found studies on externalizing behaviors focused on ADHD and disruptive behaviors, specifically aggression, to be the most
studied dimension of disruptive behavior. Palou also found internalizing problems are less commonly identified in young children. Although there is a reduction in certain kind of problems around 5 years, a wide range of disorders have their onset in the preschool years (Poulou, 2015). Poulou’s study highlighted the idea that the rapid developmental changes that occur during the preschool years contribute to the potential for children to experience EBDs and challenges. Furthermore, the literature confirmed the prevalence of EBDs in the preschool population included and documented the broad patterns of emotional and behavioral problems, along with a documented increase in reported problems. In terms of early identification and prevention of EBDs, there exists substantial research involving the teacher’s role in the support of children with these challenges. Researchers have posited that the preschool setting is potentially important for early identification and intervention program delivery for young children with emotional and behavioral difficulties (Poulou, 2015).

In a study by Randell et al. (2023), the researchers examined professionals’ views regarding early signs of EBD. The aim of Randell et al.’s study was to explore the experiences and challenges professionals face with early identification of psychosocial concerns in young children. Their study was based on a pilot model developed in Scotland, “Together for Every Child.” In this model, a family team was created consisting of professionals in health care services, preschools, and social services to identify and support children at risk of or with mild forms of EBD. The children were divided into three groups: one group of children with no difficulties, one group of children in need of extra attention, and one group needing immediate intervention. The children’s behavior and emotional levels were assessed after 18 months of intervention. Data were then collected from the family team in semistructured interviews to gather insight into the professionals’ views about early detection. Results of Randell et al.’s study
suggested it was difficult to identify children in need of mental health support at an early age, as early signs can be difficult to detect. Collaboration and consultation between professionals were described as important aspects in promoting well-being in children and preventing possible negative development in children at an early stage (Randell et al., 2023). The need for professionals working with children in early childhood to identify and then support mental health problems is a critical and necessary step. EBD can be linked to the (a) individual child (e.g., neurodevelopmental disorders, loneliness, mental and chronic diseases); (b) the family situation (e.g., economic matters, adverse childhood experiences, parental substance abuse, mental illness, intimate partner violence, criminal behavior); or (c) environmental factors (e.g., school, cultural, social, economic settings). Results of the study suggested both preventative interventions targeting all children and specific interventions for those in need of support are needed to promote health and well-being (Randall et al., 2023).

In another study, Achenbach et al. (2016) collected data from 250 parents who had children between the ages of 2–7. Achenbach et al. provided parents with multiple questionnaires with questions related to sociodemographic characteristics, future-oriented cognition, mental health problems, and general well-being. During analysis, the researchers looked at the correlations between indicators of mental health problems and well-being. Achenbach et al. pursued two aims. The first aim was to look at the association of children with mental health problems and how these problems affected their future-oriented cognition. The second aim was to investigate any correlation between parent-reported mental health in children and differences in their future-oriented cognition observed by parents in their daily lives. Achenbach et al. found early evidence for a connection between future-oriented cognition and mental health in children 3–7 years; they found children with more mental health problems showed reduced signs of
future-oriented cognition. Specifically, the study showed evidence of a link to externalizing problems and hyperactivity, well-being, optimism, and pessimism (Achenbach et al., 2016). Achenbach et al.’s study highlighted future-oriented cognition as another risk and protective factor for early mental health which has been somewhat neglected as previous studies on mental health focus on temperament, reactivity, and parental behaviors. The study recognized that future-oriented cognition in young children can be a critical factor for mental health and mental well-being as children progress through life into adulthood.

**Risk Factors**

Mental health problems in preschool-aged children are often affected by risk and protective factors (Wlodarczyk et al., 2017). Risk factors for children suffering from mental health issues include adverse parental mental health, difficult temperament, and low socioeconomic status. Protective factors that may impact a child’s resilience to these problems include the social environment comprised of family, peers, and school. Many personal, biological, and social factors have been linked to mental health problems (MHPs). Wlodarczyk et al.’s (2017) study included a random sample of 792 families with preschool-aged children in Germany who were sent the Strengths and Difficulties Questionnaire (SDQ). Questions on the SDQ were aimed at identifying risk factors for child MHPs, which included those related to parent mental health, low socioeconomic status, and children’s difficult temperament. In all, 391 families completed the paper-and-pencil questionnaires to provide information on the mental health of their children. Additionally, the study looked at two protective factors: parental social support and parental competence. Data from this study showed a strong correlation between difficult temperament and parental MHPs, with children exhibiting MPHs in the preschool years. However, factors such as low socioeconomic status and social support showed a lesser
significance in association. Results of Wlodarczyk et al.’s study underscored the importance of children’s difficult temperamental characteristics as a risk factor for MHPs in preschoolers and suggested these may also be an appropriate target for the prevention of preschool mental health problems.

Jarvers et al. (2023) looked at the impact of school attendance, parental stress, mental health, and the development of internalizing problems in preschool-aged children. In all, 128 parents of preschoolers participated in the study by completing online surveys at three different points during the COVID-19 global pandemic: (a) before the nationwide lockdown, (b) during the lockdown, and (c) after the lockdown. Participants answered questions related to internalizing problems and externalizing problems, along with assessing their own anxiety and depressive symptoms. Linear mixed-effects models were then used to compute results. Results of Jarvers et al.’s study suggested higher parental stress, parental anxiety, parental education, attachment problems, and inconsistent school attendance were strong predictors for internalizing and externalizing problems in preschoolers. Results showed a rapid increase in children’s tendency to internalize and externalize problems from the time before the lockdown to the time during the lockdown, while also remaining high after the lockdown (Jarvers et al., 2023). Specifically, internalizing problems were associated with parent stress levels, yet regular attendance in preschool had a positive effect on these behaviors during the pandemic. Externalizing problems were associated with the same risk factors but were impacted positively by levels of parental education. This study showed significant data from a very recent traumatic event that affected children worldwide. Preschool-aged children as of 2024 have lived through the lockdown and the impact of the COVID-19 global pandemic on the mental health of children and their families has continued to be an issue in society (Jarvers et al., 2023).
Similar results regarding parental stress as a risk factor for mental health problems were found in a study by Hattangadi et al. (2020). Hattangadi et al. studied the association between early parenting stress and MHPs in preschoolers in Toronto, Canada. Their study included 148 healthy, urban preschool-aged children recruited during wellness visits from primary practices participating in The Applied Research Group for Kids! In the study, research assistants administered standardized questionnaires to gather information on child and parent health. The Preschool Strengths and Difficulties Questionnaire (P-SDQ) and the Parent Stress Index Short Form (PSI-SF) were completed by parents of the child participants. Results of this study found stress in the parent–child system during infancy were associated with subsequent mental health problems in preschool-aged children (Hattangadi et al., 2020). Hattangadi et al. also found the effect of parent stress during infancy on child mental health extends beyond that of the effects of temperament on MHDs. The researchers found healthy preschoolers with parents reporting stress during infancy were two times higher in MHPs at 3 years old. The researchers recognized that parental stress is potentially a modifiable factor that may contribute to MHDs in young children. The impact of early parenting stress reinforces that mental health interventions for children must regularly assess parental well-being and include programs to assist parents in managing parenting-related stress to benefit young children. In addition, regular assessment of parenting stress can support clinicians in identifying preschool-aged children at higher risk of clinical MHPs (Hattangadi et al., 2020).

A study of 981 pregnant women in South Africa followed mother–child pairs over 3 years and analyzed the mental health of the child at 42 months. The study assessed pre and postnatal exposures and risk factors for MHDs in the children (Malcolm-Smith et al., 2023). The study, known as the Drakenstein Child Health Study (DCHS), recruited mothers from healthcare
clinics and used self- and parent-report questionnaires administered in interview format. This strategy was used to address low literacy levels in the population. Participant mothers were assessed in the following measures: socioeconomic status, prenatal psychological distress, prenatal substance abuse, prenatal depression, domestic violence, postpartum depression, maternal exposure to community violence, and perceived social support. Child assessments were completed at 42 months by trained psychologists and research assistants and assessed the following measures: temperament, general cognition, self-regulation, and internalizing and externalizing problems. Results of Malcolm-Smith et al.’s study identified two risk pathways to externalizing problems: (a) biological risk factors and (b) contextual factors involving mothers (e.g., substance abuse, exposure to violence). What is already clear from this initial work is that supportive, multifaceted prenatal interventions for mothers—targeting not only use of alcohol, but also use of tobacco and mental health—are essential to avoid negative consequences in early childhood (Malcolm-Smith et al., 2023).

Considering these studies, substantial research has identified several risk factors for MHPs in young children. One of the strongest indicators across the studies was the role of parents and parental stress in children’s mental health. Child temperament and the relationship of parenting stress was highlighted across all studies. Clearly, MHPs emerge early and have long-lasting impacts on social, emotional, and behavioral outcomes in children.

**Evidence-Based Interventions**

Evidence-based interventions in preschool mental health include child-centered play therapy, art therapy, and social–emotional intervention classroom strategies to help children develop self-regulation and social skills. Behavioral-based parenting interventions offer opportunities for parents to support children with MHPs. In an effort to determine the efficacy of
mental health intervention programs for children 4–9 years old, Hudson et al. (2023) conducted a review of meta-analytic and systematic reviews of intervention literature. In all, 152 articles met the inclusion criteria, which focused on interventions of general mental health concerns; internalizing symptoms and externalizing symptoms; anxiety and depression; trauma; symptoms of attention-deficit/hyperactivity disorder; and mental health concerns associated with autism. According to Hudson et al. (2023):

When targeting mental health difficulties broadly in children, papers of moderate to high quality suggested that behavioral based parenting interventions had the strongest evidence and were efficacious in reducing externalizing symptoms and disruptive behaviors, as well as improving social skills. (p. 632)

Hudson et al. also found compared to older children and adults, preschool-aged children were not receiving adequate treatment. An overwhelming substantial body of quality evidence was collected as part of this review, showing convincingly that mental health professionals can alter this trend immediately through widespread implementation of targeted intervention programs in the early schooling years (Hudson et al., 2023).

Skale et al. (2020) found similar results in a study of the implementation of evidence-based practices (EBPs) for young children in a large urban county. As Skale et al. conducted an online survey with 20 program managers at mental health agencies and found all participants stressed the need for early childhood mental health interventions; however, there is a need to identify strategies to improve the early childhood education field’s ability to offer adequate EBPs to children from birth to 5 years old, particularly for at-risk families.

A study by Nayak et al. (2023) of the Massachusetts Multi-City Young Children’s System of Care Project (MA-SOC), a federally funded program to provide mental health services
in primary care settings for families with preschool-aged children, identified four themes critical for intervention. Nayak et al. used focus groups and semistructured interviews for 19 key stakeholders of MA-SOC to gather evidence regarding the program’s ability to implement interventions. The four themes included: (a) strong multilevel working relationships for successful intervention integration, (b) capacity-building activities can be leveraged to build solidarity and improve implementation, (c) financial challenges are a primary barrier to building efficacious systems of care, and (d) flexibility and resourcefulness can help overcome logistical challenges in integration. Access to evidence-based treatments and specialized clinics is a common challenge for families with young children needing mental health supports (Nayak et al., 2023). According to Nayak et al. (2023), “The workforce development activities of MA-SOC allowed stakeholders to build their networks and nurture supportive partnerships that increased motivation and strengthened the overall system for Early Childhood Mental Health in the state” (p. 770).

Considering these findings, work is needed to ensure very young children receive the necessary treatment for MHPs and their families are engaged and part of the treatment. Developing a long-term, sustainable system to provide evidence-based interventions involves bringing together a network of agencies and collective resources to work on behalf of the children and their families.

**Interventions in a School Setting**

Challenging behavior may be the result of emerging mental health problems or problems with social–emotional development (Ocasio et al., 2015). In the study by Ocasio et al. (2015), 150 preschoolers and their teachers in four urban schools were studied and offered mental health services for a period of 3 years. These services included (a) implementation of a classroom-based
A curriculum focused on listening, focusing attention, self-talk, and being assertive; (b) teacher consultation; and (c) individual play therapy. Ocasio et al. found the children benefited from the program. Statistically significant improvements were seen in all areas of behavior assessed by the PKBS-2: social cooperation, interaction, and independence, along with externalizing and internalizing problems (Ocasio et al., 2015).

A 2-year study by Bekar et al. (2017) explored the effectiveness of an onsite integrated school mental health services program. In a sample of 47 children and their parents across three preschool programs serving a low-income urban community, Bekar et al. studied the effects of children engaged in a twice-weekly therapeutic playgroup as opposed to children not receiving the intervention. Parents and preschool teachers completed questionnaires at two intervals throughout the 2-year process to determine effectiveness. Bekar et al. found at-risk children at the beginning of the study were consistently rated by their parents as lower functioning compared with more typically functioning children in the areas of behavioral problems, social competence, and psychopathological symptoms. By the second rating, there was a significant improvement in the children’s behavioral functioning and symptom levels. This finding suggested although the children began the playgroup demonstrating the most challenging of behaviors for which they were referred, the small playgroup setting then came to provide them with a forum in which they developed better regulation and practiced a range of communication, play, and social skills (Bekar et al., 2017). Similarly, in a study by Mathis et al. (2022), data indicated in 390 children receiving early childhood mental health consultation services in their preschool, the children overwhelmingly had more positive classroom behavior; fewer observed social–emotional challenges; and higher academic achievement in math, literacy, and writing by the end of a full school year of intervention. This finding is particularly important for
marginalized and under-resourced communities who often face higher levels of adversity and mental health needs with fewer available resources as a result of structural factors, including racism and underinvestment of public funds (Mathis et al., 2022).

Barnes et al. (2018) studied the effects of interventions that teach social problem solving (SPS) as an intervention for children in reducing internalizing and externalizing problems. The researchers examined both interventions based in the home and based in the preschool setting. Barnes et al. conducted a meta-analytic review of 31 peer-reviewed articles across seven databases that included the following search criteria: (a) SPS, problem solving, cognitive behavior; (b) behavior intervention, treatment, therapy; and (c) preschool, young children, childcare. Findings of the study showed a promise in using teachers to successfully implement interventions with an SPS component in the classroom. In addition, Barnes et al. found most studies reviewed used preschool teachers as interventionists. As the link between social–emotional development, academic, and life outcomes becomes clearer, it will be essential to include SPS-relevant social–emotional learning as a part of the curricula in early childhood settings (Barnes et al., 2018).

Because the preschool teacher is seen as an integral part of the mental health intervention, Sinai-Gavrilov et al. (2019) conducted a study to explore the attitudes of multidisciplinary team members and their approaches to delivering service in a preschool setting for children with autism. The researchers interviewed 21 team members across 11 preschools in Israel with questions related to the children they serve, the parents with whom they work, the supervision and training they receive, and the interventions they deliver in the classroom setting. The three themes gathered after analyzing the data were (a) the challenge of working in preschools with autistic children, (b) the challenges professionals face when working on
multidisciplinary teams, and (c) solutions to barriers that prevent effective collaboration and teamwork. Results showed although the effects of interventions are overwhelmingly positive, there are challenges when bringing together multiple professionals to provide services in the preschool setting. Conversely, research has also shown the importance of multiple informants in mental health screening and intervention. De Los Reyes et al. (2015) found a multiple-informant approach to examining behaviors in preschoolers can help to show variations across contexts.

As has become glaringly clear from research on MHPs in preschoolers, children with challenging behaviors have become increasingly common in preschool classrooms. Studies have also shown that MHPs in early childhood are a strong predictor of later delinquency and antisocial behaviors. Most importantly, the review of the literature showed early identification and intervention is critical to helping children develop the social–emotional skills needed to move forward in their schooling successfully. The need for a multiple disciplinary team including parents, teachers, and mental health consultants is most effective. Mental health consultation services in the preschool setting will support the student and their families, along with their current and future teachers.

School Profile

The Creative Montessori Learning Center (CMLC) is a private, nonprofit preschool program serving the East Palo Alto community in the San Francisco Bay Area of California. CMLC is the only state-subsidized program that offers a Montessori curriculum in the Bay Area. CMLC was founded in 1967 by the Catholic Archdiocese of San Francisco and through the efforts of Sister Christina Trudeau, head of the Montessori Teacher Training Center at the College of Notre Dame in Belmont, California (CMLC, 2023). In 1976, the Archdiocese withdrew its financial support, and the CMLC became incorporated and accepted funding from
the California State Department of Education and began to offer subsidies for low-income families. CMLC has continued to provide high-quality Montessori education to one of the most at-risk communities in the San Francisco Bay Area.

**District Characteristics**

CMLC is situated within the boundaries of the Ravenswood School District in East Palo Alto. According to the school’s website, in the Ravenswood School District in 2023, there were 1,489 students enrolled. In this student population, 88% were socioeconomically disadvantaged, 57.2% were English language learners, and .2% were foster youth. In an equity report, students in the Ravenswood district scored 107.1 points below standard in English language arts and 138.7 points below standard in mathematics. In the district, 43.4% of students were chronically absent and 5.3% of students had been suspended for at least 1 day. Standards were met in the local indicator of Basics: Teachers, Instructional Materials, Facilities. This measure identifies the percentage of appropriately assigned teachers; students’ access to curriculum-aligned instructional materials; and safe, clean, and functional school facilities. Standards were also met in the local indicator of Parent and Family Engagement. This measure includes parent input in decision making and promotes parental participation in education programs for students.

**School Characteristics**

At the time of this study, CMLC served 75 children aged 2–4 years old in four classrooms. In all, 100% of families earned less than 75% of the state median income. As far as demographics, 80% of families were Hispanic, 16% Black, and 4% Middle Eastern. Additionally, 75% of children were classified as English as a second language learners. Six children had individualized education plans (IEPs) in place with the local school district and four
were receiving speech and language therapy through the school district. Finally, 94% of families identified as single-parent households.

**School Mission and Vision**

The CMLC (2023) philosophy states:

We believe that each child is unique and that the appropriate time and materials for a given child depends not only on age, culture, and experience, but on the personal characteristics of the child. The glue that holds the environment together is the mutual care, respect, and trust that children, teachers, and parents have for one another. CMLC provides an environment designed to allow children to grow and learn in a loving atmosphere. CMLC respects the natural intelligence of the child and the process by which they develop. The job of the teacher is to meet their growing intelligence with the appropriate activities at the appropriate time. (p. 4)

**Current Student Learning Goals**

The educational goals of the CMLC (2023) are derived from the views of the child as an individual and total being who shares universality with all other children and all human beings. This whole view recognizes the child has needs on many levels (i.e., social, physical, spiritual, mental, and emotional) that deserve to be addressed and met by the curriculum and environment. The curriculum and environment at CMLC address these needs by emphasizing the following elements: physical health, nutrition, motor development, social–emotional health, social interactions, independence, academic skills, and love and respect for others.

The CMLC (2023) classroom environment is a prepared environment that provides limits and allows for freedom within these limits. When structure and freedom are in balance, the child is in an ideal learning environment, gaining independence through their environment. Freedom
fosters self-confidence and responsibility for one’s own work and activities. There are seven areas in each classroom: practical life, math, language, sensorial, art, science, and music. In the practical life area, children are offered materials so they can learn to take care of themselves such as washing, folding, and pouring. They also learn to take care of the environment with activities such as sweeping, dusting, and mopping. In the math area, children learn, recognize, and count quantities; they learn to write and recognize numerals that stand for certain quantities and learn to use these numerals to solve problems. CMLC recognizes that language development occurs from the moment the child enters the environment. In these settings, children get experience in verbalizing and listening and learn to recognize letters and the sounds associated with letters. These students also learn to write and recognize letters in the environment. The Montessori materials teach reading in the same way that they learn to put sounds together to read words.

CMLC also offers sensorial activities to help students develop their senses as a means of acquiring detailed and accurate knowledge of the child’s daily lives. There are activities for all the senses: sight, hearing, smell, taste, and touch. The children learn about shapes, colors, textures, and sounds. Art allows for the expression of the inner self. Varied art and design activities develop creativity and a sense of beauty, along with motor skills and concentration. Many different materials are made available to the student, including crayons, paint, various types of paper, and recycled materials. The science area provides the opportunity for the child to discover the everyday world. Materials develop curiosity and the capacity to order and categorize. The music component provides opportunities for the students to express themselves through their voices, instruments, and physical movements.
Parent Involvement

CMLC (2023) recognizes that parents are their child’s first teachers and the best schools encourage parents and teachers to work together in the best interest of the children. CMLC actively engages parents through the Parent Advisory Committee (PAC), which is a group of parents who provide support and active involvement in school functions. Parents complete surveys at the beginning of each year to provide feedback on topics of interest, and workshops are provided in English and Spanish throughout the year to address their needs. Parents are invited to volunteer in the classroom, on the board, or in the office at CMLC.

Teacher Work and Professional Development

CMLC (2023) believes a quality Montessori school requires trained staff. The CMLC staff and board are committed to the goal of a fully certified, fully trained staff. CMLC reimburses staff for their early childhood education (ECE) courses, ECE training, and Montessori certificate training. CMLC closes twice yearly for 2 full-day staff development days and 1 half day per month to engage in professional training as a team. A professional library is maintained at the school and teachers are encouraged to visit other programs in the area to learn and engage with their peers.

Assessment Practices

The CMLC (2023) uses the Desired Results System of Assessment (DRDP) for their children. The DRDP is a required tool for all programs offering subsidized preschool service in California (Desired Results, n.d.). This system is designed to assess the development of children from birth through 12 years old and through its use, improve the quality of programs and services to children. The DRDP bases its assessment on six desired results for children and their families, which include: DR1 Children are personally and social competent; DR2 Children are
Effective learners; DR3 Children show physical and motor competence; DR4 Children are safe and healthy; DR5 Families support their child’s learning and development; and DR6 Families achieve their goals (Desired Results, n.d.). The DRDP tool has four components: the DRDP child assessment tool, Desired Results Parent Survey, Environment Rating Scale (ERS), and the Program Self-Evaluation. These tools provide a whole system to support the child, their family, and their teachers to help each child meet their learning goals. The assessment tool allows the teacher to assess each student across all developmental domains including social–emotional, cognitive, physical, and self-help skills. Teachers are able to compile results of the children in their classrooms to identify strengths and areas needing improvement to guide and revise their curriculum throughout the school year. The Desired Results Parent Survey allows CMLC to support their families’ goals by offering an avenue for them to voice satisfaction and needs. The ERS allows teachers and administrators to assess each classroom for appropriateness of the children’s environment. The Program Self Evaluation is the final component to support the child, family, and teacher team by assessing program quality. The results of the four-component model are used to improve services for children, support the needs of the family, offer support to teaching staff, and ensure the CMLC provides high-quality preschool services to the community.

**Needs Assessment**

The CMLC (2023) serves at-risk children from a very low-income, predominantly Latino and Black community. Many children at CMLC exhibit challenging behaviors in the classroom. In addition to teaching their preschoolers the basic skills needed to prepare for kindergarten, CMLC teachers spend a great deal of time addressing difficult behaviors, including aggression and children with symptoms related to anxiety, fear, and social withdrawal. As executive director for the program, I had access to internal school data indicating that during the 2022–2023 school
year, CMLC sent eight children home 5 or more times for violent behavior toward another student or a teacher, with one expulsion of a student that year. At the point of the 2023–2024 school year at which this study was conducted, CMLC had referred 11 children for assessment to either the local school district for children over 3 years old or to Golden Gate Regional Center for those under 3 years old. CMLC currently had six children with IEPs who are headed to kindergarten in 2024–2025. CMLC administrators has also referred 75% of families to local food pantries and Samaritan House low-income housing assistance, and 40% of families to legal aid for immigration-related issues.

The internal data also suggested that CMLC teachers have struggled with balancing the needs of all students, particularly those showing symptoms of behavioral problems. Teachers have voiced concerns regarding a lack of training in working with challenging children despite all staff having ECE credentials through the state of California. School personnel have shared concerns regarding a lack of resources for children, their parents, and themselves in being able to identify risk factors, support the students and their families, and ensure the students are given the time and attention they need. In the 2022–2023 CMLC end-of-year survey, 80% of teachers shared concerns regarding sending children home for aggressive behavior or terminating services for aggressive behaviors. Their concerns included: (a) feeling as though school was the safest and most stable place for the children, (b) the stigma around preschool expulsion, (c) fear of the parent’s response to the teacher and the child, and (d) having insufficient training to handle adverse behaviors.

In 2017, California put a statute in place that bars state-subsidized programs such as CMLC from expelling children unless an exhaustive process aimed at supporting the child and family is followed first (CMLC, 2023). CMLC has followed this process and uses expulsion as
an absolute last response. CMLC (2023) is committed to not only preventing a child from being expelled, but removing the need to expel a child altogether. Sending a child home for bad behaviors and/or expelling a child is against everything that is best practice for children, families, and early childhood programs.

To best meet the needs of children, parents, and preschool teachers, a mental health consultation program for CMLC would create a responsive system for supporting the teachers as they in turn support the children and families. By working with mental health consultants in the school setting, teachers and administrators can gain the tools and training to better address difficult child behaviors and develop positive learning environments. Mental health consultants can help children work through their challenges using therapeutic methods, use professional judgment to refer them to specialists outside of the classroom when needed, provide support to stressed parents, and work with teachers through hands-on coaching specific to each child. Mental health consultation can offer teachers an opportunity to receive training, professional development, and help teachers communicate with parents, who can often be defensive about their child’s behavior.

According to national organization Zero to Three (2017), “Positive outcomes for children, staff, and programs have been attributed to Early Childhood Mental Health Consultation services” (p. 5). The U.S. Department of Health and Human Services Agency’s Head Start Program (2021) stated, “Mental health consultants help develop a culture of mental health in childcare programs by building the adults’ capacity to strengthen and support the healthy social and emotional development of young children” (p. 1). A strong mental health consultation program, with coordination of resources for the children, families, and staff of CMLC, will provide a stable and efficient path for success in the community of East Palo Alto.
Data Analysis

Data from the 2022–2023 school year were used to evaluate mental health challenges in 60 preschool-aged children enrolled at CMLC. Data included findings from the DRDP assessments for all enrolled children in May 2023. Data were additionally collected from the 20 teaching and support staff who provide education, care, and resource and referral services to the 60 children and their families. Further data were collected from parent enrollment intake forms regarding demographics, including race, household size, head-of-household information, immigration, and socioeconomic status.

Data Collection

The DRDP tool measures a child’s developmental level across multiple domains; however, for this study, the focus was on (a) Approaches to Learning-Self Regulation and (b) Social and Emotional Development (Desired Results, n.d.). Approaches to Learning-Self Regulation includes attention maintenance, engagement and persistence, and curiosity and initiative. Self-regulation skills include self-comforting, self-control of feelings and behavior, imitation, and shared use of space and materials. The Social and Emotional Development domain assesses children’s ability to form positive relationships with peers and adults, and the ability to understand and interact with others (Desired Results, n.d.). Skill areas include identity of self, social–emotional understanding, and symbolic and sociodramatic play. The developmental levels are organized into four categories: (a) responding, (b) exploring, (c) building, and (d) integrating. These levels represent a developmental continuum that shows growth from infancy to kindergarten entry. Preschool students should be at the “integrating” level in the spring term prior to kindergarten.
As part of the DRDP system, a staff survey was conducted at the end of each school year to give teachers and administrative staff an opportunity to offer feedback regarding curriculum and school programming that is evaluated by the executive director and the board of directors. Staff answered questions pertaining to their ability to meet the needs of their student population, and what supports they need to improve overall service to children and their families.

Program Challenges

In looking at the DRDP results of 60 children in the area of Approaches to Learning-Self Regulation, only one child was assessed at the integrating level or having fully mastered their self-regulation skills (see Figure 1). There were 38 children who scored at the building level, which is typical for preschool children at the start of the school year. These findings suggested 21, or 35%, of children were functioning at the exploring or responding level at the end of their preschool year, nearing the point of kindergarten entry. This result showed a significant delay in self-regulation skills in over one third of children transitioning into kindergarten.
Figure 1

Approaches to Learning-Self-Regulation

Note. $n = 60$. How many children scored in (a) responding, (b) exploring, (c) building, (d) integrating? (Children prepared to enter kindergarten would score at the integrating level)

In Social and Emotional Development, only two children fully mastered their social–emotional skills, and 34 children scored at the building level (see Figure 2). There were 24, or 40%, of children significantly behind in age-appropriate social–emotional skills.
Figure 2

_Social and Emotional Development_

![Social and Emotional Development Chart]

*Note.* *n* = 60. How many children scored in (a) responding, (b) exploring, (c) building, (d) integrating? (Children prepared to enter kindergarten would score at the integrating level)

CMLC is in East Palo Alto, sandwiched between some of the highest earning zip codes in Silicon Valley, including Menlo Park, Atherton, and Mountain View (Property Shark, 2023). East Palo Alto is one of a few cities in the Bay Area that has a high number of low-income, at-risk families trying to navigate the high cost of living in California. According to data collected through parent intake forms, 70% of CMLC families were recent immigrants to the United States, with 75% of families identifying as English as a second language (see Figure 3). All families attending CMLC are low income, earning less than 75% of the state median income. Of the 94% of single head of households at CMLC, all but one are single mothers. All 60 families
requested resource and referrals upon enrollment for food and housing assistance. Of the 60 families, 12 indicated they had concerns about their child’s development in terms of behavioral problems and/or speech and language delays.

**Figure 3**

*Parent Demographics*

![CMLC Parent Demographics](chart)

*Note.* $n = 60$. How many families identify with the following risk factors: (a) earning less than 75% of state median income, (b) recent immigrant to the U.S., (c) single head of household, (d) English as a second language, (e) in need of food and housing referral?

At the conclusion of the 2022–2023 school year, 20 staff anonymously participated in a survey to evaluate the program. Staff were given specific questions and opportunities to make suggestions to improve their experience working at CMLC. Of the 20 staff, 16 expressed feelings of inadequacy in handling the increasing number of children with challenging behaviors.
Although all staff had completed ECE units to earn a California Child Development Permit, which included a three-unit course in Children with Challenging Behaviors, teachers stated they lacked skills in redirecting and managing the behaviors. Furthermore, staff expressed fears in addressing the child’s challenges with the parents for two reasons: (a) fear of parent reaction toward them, and (b) fear of parent reaction toward the child. All staff requested additional training in handling behaviors, with 80% requesting hands-on coaching or mentoring.

**Program Strengths**

CMLC has a core group of dedicated staff who are committed to the well-being of the children and their families. Staff have expressed a desire for additional resources to support their students. With the passage of Assembly Bill 2806 in California in 2022, the Preschool Expulsion Bill, there has been forward movement in the early childhood field to provide mental health services. In the years since Assembly Bill 2806’s passage, state-funded preschool programs have been given additional resources to support children with mental health challenges. Funding has become available to support programs seeking mental health support (LegiScan, 2022). These funds are at the discretion of the program administrator and can be used toward the addition of contractors providing early mental health consultation services.

**Assessment Needs and Analysis**

Through this data collection and analysis, the need for mental health services for CMLC children is quite clear. The goal for CMLC children is to have 100% of graduating children scoring at the integrating level in both Self-Regulation and Social and Emotional Development by May of each school year. These improvements will prepare children for kindergarten readiness and success in later schooling. Also, mental health services will support families at risk, including low socioeconomic status, parental mental health needs, and other traumas.
affecting low-income communities. CMLC staff will receive onsite coaching and mentoring to improve their ability to identify risk factors and provide a healthy, safe, and developmentally appropriate learning environment for at-risk children.

Further research could assess the long-term effects of early mental health consultation on preschool children by tracking their progress as they advance in school. Research can also be conducted regarding the impact this service has on teaching staff and their feelings of adequacy and success in working with at-risk children and their families.

**Action Plan**

**Strategies**

After a thorough review of research related to MHPs in early childhood years, the evidence-based approach that pairs mental health professionals with early childhood programs supports this plan to provide a mental health intervention program at the CMLC. The mental health consultation will address the following areas: (a) child- and family-focused consultation, (b) classroom consultation, (c) program consultation, and (d) mentoring and coaching of staff (i.e., professional development). This multipronged intervention program will support children in their development and school readiness and will build teachers’ and parents’ capacities to meet their needs.

Implementing a mental health consultation program that provides direct support for children with behavioral difficulties or developmental challenges and includes parents, builds relationships, and collaborates respectfully supports the overall well-being of the family unit. Wlodarczyk et al. (2017) found parental MHPs and parental socioeconomic status had a significant impact on the MHPs of their children. This finding supports the need to include parents and the family unit as part of the intervention plan. Furthermore, in a study by Hudson et
al. (2023), data collected indicated including both parents and children as part of an intervention plan delivers better outcomes than the parent or child alone. In addition to direct evidence-based intervention for the children, offering 1:1 support to parents, along with parenting resources, ensures both child and family receive the appropriate support and treatment.

Classroom consultation is a critical aspect of the intervention plan. Mental health consultation helps classroom staff to create safe environments, maintain consistent schedules and routines, and develop appropriate social–emotional strategies. Not every classroom environment works for every child; consultants can help staff reorganize and restructure classroom environments to best meet the needs of their current students. In a study by Bekar et al. (2017), findings indicated small playgroups in the classroom setting provide children with a safe space in which they can develop better regulation and practice a range of communication, play, and social skills. Bekar et al. found the classroom setting provides a group experience for children that can help each child work through their own unique mental health needs such as social facility, communication, language development, emotional control, or anger management. Mental health consultation will give teachers the tools they need to meet these varying needs in the context of the classroom.

Program consultation for administrators provides an additional layer of support in helping those who can implement changes at the program level. Administrators can assist classroom teachers in navigating schedule changes, providing additional help in the classrooms, securing funding, and distributing resources to the parent community. In a study by Nayak et al. (2023), data indicated that strong, multilevel work relationships were critical for integration of mental health intervention. Nayak et al. also found flexibility and resourcefulness could help overcome logistical challenges in integration of intervention. Considering these data, support of the
administrative team at the school that has the authority to create change or opportunities is necessary in the delivery of these services to children and their families.

Lastly, mental health consultation (a) will meet the need for professional development of staff, (b) will strengthen program quality overall, and (c) will enhance the way in which the teaching staff address the varying needs of their students. The consultants will assess the training needs of the staff at CMLC to provide a tailored professional development plan for staff. The consultant will develop and facilitate learning groups that will offer peer-to-peer support and live trainings on staff wellness and the mental health of children and families. Nayak et al.’s (2023) data highlighted the value of professional development and capacity-building activities to increase knowledge in the area of mental health services among primary care teams in schools.

This evidence-based model of mental health consultation will be a preventative intervention aiming to build social–emotional competence in preschool classrooms at CMLC. These strategies will support the development of social–emotional health for children and will help teachers manage and minimize challenging and undesirable behaviors in their students. The delivery of services will be a combination of child, classroom, and program-focused consultation.

**Implementation and Timeline of School Improvement Plan**

For the successful integration of the mental health consultation program at CMLC, a thorough timeline was created to execute the program for the 2024–2025 school year. The CMLC board of directors must formally approve the plan by June 2024, once approved, the CMLC executive director (ED) will begin interviewing candidates for the two mental health consultant positions. When both positions have been hired, the ED will meet with and review the plan for the 1st year of consultation services. Consultation services will begin in August 2024. In
August 2024, teaching staff will be introduced to the consultants and the plan for consultation will be presented. A monthly checklist of consultation services will be reviewed with CMLC staff (see Table 1).

**Table 1**

*Monthly Mental Health Consultation Checklist*

<table>
<thead>
<tr>
<th>Month</th>
<th>Checklist</th>
</tr>
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</table>
| **August** | Staff introduction to mental health consultants (MHCs)  
Consultant A assigned to Green Room and Yellow Room  
Consultant B assigned to Blue Room and Purple Room  
Consultants to meet with individual room teams the Thursday of Prep Week |
| **September** | Biweekly meetings begin  
MHCs to meet with each classroom team twice monthly (2nd and 4th Thursday at naptime)  
MHCs to observe children and offer classroom coaching every Thursday from 9:00 AM–11:30 AM  
Executive director to introduce MHCs to parent community at Back to School Night |
| **October** | MHCs to meet with each classroom team on the 2nd and 4th Thursday  
MHCs to observe children and offer classroom coaching every Thursday from 9:00 AM–11:30 AM  
MHCs to begin meeting with executive director and assistant to the director the 1st Thursday of each month for 1 hour.  
MHCs, ED, AD, and Lead Teachers Meeting to determine if referrals need to be made to Golden Gate Regional Center or the Ravenswood Unified School District. Ongoing as needed.  
MHPs schedule individual parent meetings as needed. |
| **November** | MHCs to meet with each classroom team on the 2nd and 4th Thursday.  
MHCs to observe children and offer classroom coaching every Thursday from 9:00 AM–11:30 AM  
MHCs to lead Parent Education Workshop: Managing Challenging Behaviors in the Home  
MHPs schedule individual parent meetings as needed.  
MHCs meet with ED and AD 1st Thursday of the Month |
| **December** | MHCs to meet with each classroom team on the 2nd and 4th Thursday.  
MHCs to observe children and offer classroom coaching every Thursday from 9:00 AM–11:30 AM  
MHCs meet with ED and AD 1st Thursday of the Month  
MHPs schedule individual parent meetings as needed.  
Full Staff Meeting All Classrooms Friday before Winter Break |
| **January** | MHCs to meet with each classroom team on the 2nd and 4th Thursday.  
MHCs to observe children and offer classroom coaching every Thursday from 9:00 AM–11:30 AM  
MHPs schedule individual parent meetings as needed |
<table>
<thead>
<tr>
<th>Month</th>
<th>Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>MHCs meet with ED and AD 1st Thursday of the month</td>
</tr>
<tr>
<td></td>
<td>MHCs to meet with each classroom team on the 2nd and 4th Thursday.</td>
</tr>
<tr>
<td></td>
<td>MHCs to observe children and offer classroom coaching every Thursday from 9:00 AM–11:30 AM</td>
</tr>
<tr>
<td></td>
<td>MHCs meet with ED and AD 1st Thursday of the Month</td>
</tr>
<tr>
<td></td>
<td>MHPs schedule individual parent meetings as needed.</td>
</tr>
<tr>
<td></td>
<td>MHCs to lead Parent Education Workshop: Community Resources-Legal Aid, Immigration, Low Income Housing, etc.</td>
</tr>
<tr>
<td>March</td>
<td>MHCs to meet with each classroom team on the 2nd and 4th Thursday.</td>
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<tr>
<td></td>
<td>MHCs to observe children and offer classroom coaching every Thursday from 9:00 AM–11:30 AM</td>
</tr>
<tr>
<td></td>
<td>MHPs schedule individual parent meetings as needed.</td>
</tr>
<tr>
<td></td>
<td>MHCs meet with ED and AD 1st Thursday of the Month</td>
</tr>
<tr>
<td>April</td>
<td>MHCs to meet with each classroom team on the 2nd and 4th Thursday.</td>
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<tr>
<td></td>
<td>MHC to observe children and offer classroom coaching every Thursday from 9:00 AM–11:30 AM</td>
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<tr>
<td></td>
<td>MHCs meet with ED and AD 1st Thursday of the month</td>
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<tr>
<td></td>
<td>MHPs schedule individual parent meetings as needed.</td>
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<tr>
<td></td>
<td>Full Staff Meeting All Classrooms, 3rd Friday of the month</td>
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<tr>
<td>May</td>
<td>MHCs to meet with each classroom team on the 2nd and 4th Thursday.</td>
</tr>
<tr>
<td></td>
<td>MHCs to observe children and offer classroom coaching every Thursday from 9:00 AM–11:30 AM</td>
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<tr>
<td></td>
<td>MHCs meet with ED and AD 1st Thursday of the Month</td>
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<tr>
<td></td>
<td>MHPs schedule individual parent meetings as needed.</td>
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<tr>
<td></td>
<td>MHCs to lead Parent Education Workshop: Technology and Children</td>
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<tr>
<td>June</td>
<td>MHCs to meet with each classroom team on the 2nd and 4th Thursday.</td>
</tr>
<tr>
<td></td>
<td>The final month of the year for MHCs to observe children and offer classroom coaching</td>
</tr>
<tr>
<td></td>
<td>MHCs meet with ED and AD 1st Thursday of the Month</td>
</tr>
<tr>
<td></td>
<td>MHPs schedule individual parent meetings as needed.</td>
</tr>
<tr>
<td></td>
<td>End of Year Survey sent out: Parent Feedback, Teacher Feedback</td>
</tr>
<tr>
<td>July</td>
<td>MHCs to have End of Year Wrap up meetings with individual classrooms 4th Thursday of the month</td>
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<tr>
<td></td>
<td>MHCs meet with ED 1st Thursday of the Month to review End of Year Surveys</td>
</tr>
</tbody>
</table>

**Staff Responsibilities**

**Administrative Staff**

The ED will be responsible for developing and reviewing the mental health consultation plan. Upon completion, the ED will present the plan to the board of directors for final approval. The ED will recruit, interview, and hire MHCs and will manage payment for services. The ED will create a monthly checklist and present it to MHCs and teaching staff. The ED will be the
primary liaison between CMLC and the MHCs and will ensure the MHCs and teachers follow
the protocol and timeline for implementation.

The assistant to the director (AD) will ensure all meetings are scheduled and will secure
classroom coverage when needed. The AD will be the primary contact with parents, will make
introductions between MHCs and parents, and will schedule meetings. The AD will ensure all
paperwork is completed to include parent intake forms, permission forms, referrals to outside
agencies, among other related documents.

**Teaching Staff**

The teaching staff are responsible for attending all MHC meetings. The teaching staff
will keep the MHCs informed of all concerns related to children and their families. The teaching
staff will assist the AD in connecting families with the MHCs and will help with any
communication between the parties. Teaching staff are responsible for completing any
paperwork related to assessments, Ages and Stages Questionnaires (ASQs), referrals, and IEPs.
The teaching staff will work with the MHCs to develop their individual path for professional
development.

**Mental Health Consultants**

The MHCs will work closely with all key personnel to ensure that mental health
intervention and support is delivered to all children and families at CMLC who are in need of the
service. The MHCs will work with staff to support the healthy development of CMLC children.
Their focus will be improving the knowledge and skills of CMLC staff in addressing and
managing difficult behaviors and emotions. The MHCs will assist staff in the development of
behavior management techniques and an intervention plan for families in crises. Additionally,
MHCs will offer comprehensive support to the families of CMLC children. This comprehensive
support will include referrals for parental MHPs; domestic violence referrals; and resources for immigration, legal, food, and housing needs.

**Monitoring and Data Collection**

The ED will work with MHCs and staff to monitor progress of goals identified in the intervention program. During monthly meetings, the ED will check in with MHCs to review their work each month. The ED will maintain confidential data regarding children and families receiving services, along with the professional development plans of individual teachers and teaching teams.

In June 2024, an end-of-the-year survey will be given to all parents and teaching staff. Teachers will use Google forms to complete their surveys, whereas the parent community will be given hard-copy surveys to turn in anonymously. This survey will identify strengths and areas needing improvement of the 1st year of implementation of the mental health intervention program at CMLC. Parents and staff will be given an opportunity to offer suggestions as to how the program can improve in future years. The ED and MHPs will discuss the results of the survey in July at their final meeting of the school year. The results will be used to revise and develop the plan for the following school year. The ED will present the end-of-year survey and revised plan to the board of directors by the ED in August 2025.

**Barriers and Challenges**

One barrier to this plan is time restraints in the school day. Administrative staff will have to ensure adequate time is given to teaching staff to meet with MHCs as part of the mentoring and onsite coaching aspect. CMLC is currently struggling with high rates of staff turnover, and these teacher shortages have affected most schools in California (Skale et al., 2020). Skale et al. (2020) found that staff turnover is one challenging factor in implementing mental health
intervention programs for young children. CMLC has not been able to hire a floating teacher who would be able to support classrooms in shadowing children with challenging behaviors, nor in providing classroom coverage for teachers to meet with the MHCs. Although onsite coaching will be helpful to overall classroom management, it does require the MHCs to be able to engage directly with teaching staff during classroom time, which may cause challenges in the teachers’ ability to supervise the classroom overall. A strong mental health intervention program can assist in preventing high rates of staff turnover from teacher stress and burnout as more teachers feel supported by the program.

**Conclusion**

The introduction of an evidence-based early intervention program is needed to support the mental wellness of the children and families at CMLC. The goal of this program is to recognize symptoms early and proactively support students before symptoms become more chronic and impact their later schooling. Providing this service free of charge to enrolled families gives parents access to mental health support and care they may not otherwise have been able to afford. Teaching staff will be given the tools and technical assistance they need to provide onsite classroom interventions in a safe and familiar environment for their students. CMLC will be able to coordinate full family support onsite and through referrals for those needing outside specialized services. Bekar et al. (2017) found although risk factors such as poverty and unattended social–emotional problems have a strong negative influence on a child’s later functioning, school-based interventions proved to be significantly helpful to different types of children. This program will support the community of CMLC by addressing student and family stress and trauma. The plan will take a multilevel, prevention-oriented approach that benefits the children of CMLC by building the capacity of the staff and program to support the overall
development of all children and work effectively with children experiencing mental health and social–emotional behavioral challenges.
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