WHAT'S WORKING?

A Study of the Intersection of Family, Friend, and Neighbor Networks and Early Childhood Mental Health Consultation

Lan T. Le, M.P.A.
Kelly Lavin, M.A.
Ana Katrina Aquino, B.A.
Eva Marie Shivers, J.D., Ph.D.
Deborah F. Perry, Ph.D.
Neal M. Horen, Ph.D.

GEORGETOWN UNIVERSITY
Center for Child and Human Development

DECEMBER 2018

Recommended Citation
Le, L. T., Lavin, K., Aquino, A. K., Shivers, E. M., Perry, D. F., & Horen, N. M. (2018). *What's Working? A Study of the Intersection of Family, Friend, and Neighbor Networks and Early Childhood Mental Health Consultation*. Washington, DC: Georgetown University Center for Child and Human Development.

Funding
This study was funded by the Robert Wood Johnson Foundation. We thank them for their support but acknowledge that the findings and implications discussed in this report are those of the authors alone, and do not necessarily reflect the opinion of the foundation.

Report available at https://gucchd.georgetown.edu

ACKNOWLEDGEMENTS

We are extremely grateful for the partnerships that enabled us to embark on this important study and gather takeaways in the hopes of better supporting our most essential caregivers. We would like to extend a special thank you to the following individuals for their time, insight, and generosity.

- Each of the site liaisons, Jordana Ash, Cassandra Coe, Mary Mackrain, Meghan Schmelzer, and Eva Marie Shivers, for making important connections and laying the foundation for successful site visits.
- To the program directors and organizational leaders and staff, Estela Garcia, Richard Garcia, Valerie Gonzales, Sheri Hannah-Ruh, Berta Hernandez, Karla Mancini, Erin Mooney, Sarah Ocampo-Schlesinger, Kenia Pinela, Janis Pottorff, Diana Romero Campbell, Rose Sneed, Alison Steier, and German Walteros, for graciously hosting us and sharing their invaluable insights and feedback.
- Each of the family, friend, and neighbor (FFN) and family child care (FCC) providers, mental health consultants, early childhood network providers, state and county administrators and leaders, and funders we spoke to across the four study sites for so candidly sharing their thoughts, perspectives, and experiences with us.
- Our Expert Workgroup members, Jordana Ash, Lee Beers, Helen Blank, Juliet Bromer, Mary Beth Bruder, Amanda Bryans, Cassandra Coe, Lynette Fraga, Kadija Johnston, Brenda Jones-Harden, Mary Mackrain, Kim Nall, Mary Ann Nemoto, Sarah Ocampo-Schlesinger, Jennifer Oppenheim, Toni Porter, Dawn Ramsburg, and Amy Susman-Stillman, for their tremendous expertise, thoughtful guidance, and helpful feedback.
- Our colleagues at the Georgetown University Center for Child and Human Development (GUCCHD), Amy Hunter and Toby Long, for being an integral part of the study team from the inception of the study to materials development, data collection, and review of preliminary findings.
- Maya Sandalow at GUCCHD for her substantial contributions around the national scan including outreach to participants during the data collection phase and data analysis and summarizing of the findings.
- Our administrative team at GUCCHD who supported the logistical and financial aspects of this study. In particular, MelKisha Knight for her administrative support of the study team and expert workgroup activities, and Brian Hosmer, Mariam Kherbouch, and Donna Deardorff for their administrative leadership and guidance.

- Charles Yang, formerly of Indigo Cultural Center, Inc. for his study team and administrative support.
- The Leonardtown Grants, LLC editing team, Dorothy McRae, Leslie Roeser, and Amanda McKinley, for their time and assistance copyediting the report drafts.
- Our project officer, Claire Gibbons, for her consummate support and guidance throughout this study, and the Robert Wood Johnson Foundation for funding this important, emerging area of study to better understand the needs of and supports for FFN child care providers.

TABLE OF CONTENTS

SECTION 1

OVERVIEW OF PROJECT

Family, friend, and neighbor (FFN) child care—also referred to as kith and kin care, relative care, informal care, home-based care, and license-exempt care—is one of the oldest and most common forms of child care. This child care setting is defined as any regular, non-parental care arrangement in the caregiver or child's home provided by relatives, friends, or neighbors. In this study, with funding from the Robert Wood Johnson Foundation, we endeavored to understand more about the FFN child care landscape to help determine which services and supports, and, in particular, mental health related services and supports, are most requested and needed by FFN child care providers to build their knowledge, skills, and self-efficacy to better attend to the social and emotional development of young children in their care and to ultimately improve quality of care and child and family outcomes.

In the United States, despite its prevalence—with up to 60% or almost 6 million children in FFN child care—(NSECE, 2015), little is known about the characteristics, quality, and evidence of successful programs that provide services and supports to FFN child care providers. By contextualizing the FFN landscape, we hoped to ground the work of programs committed to strengthening protective factors and serving and supporting FFN providers and families to positively influence child and caregiver well-being. During visits to the sites, we wanted to learn about the characteristics of FFN providers and families, including their backgrounds, experiences, and why they started providing care, and also understand who was choosing FFN care and why they were selecting it to provide a context for the delivery of programmatic services and supports.

FFN providers and families face a myriad of historic, systemic, and socio-economic barriers that may influence the care provided to young children. Lack of basic needs, intergenerational trauma, chronic fear and stress, and economic instability can make it extremely challenging to be an FFN provider. Moreover, FFN providers may be grappling with family-related stress, financial burdens, burnout, depression, and so on. Left unattended, this multitude of stressors can adversely affect provider-child interactions and lessen the quality of care. Although FFN providers are an essential and highly utilized part of the child care continuum and a critical resource in any family-supporting community, most providers feel undervalued, isolated, and remain in the shadows, unconnected to formal systems, receiving little to no support.

In particular, their mental health needs and emotional well-being are often neglected. Since the mental health of young children is intimately and inextricably linked to the well-being of their caregivers (National Research Council and Institute of Medicine, 2000; Center on the Developing Child, 2013), there is a need for strong developmental experiences and high quality parent/caregiver-child interactions in early childhood; the impact of unmet provider needs can have detrimental effects on children's long-term achievement and success. We wanted to learn about the mental health and other needs of

FFN providers to understand the effects of home-based caregiving on the mental and physical health of providers and family dynamics, and explore access to and utilization of programmatic services and supports for FFN providers to alleviate stressors and build capacity.

The literature on professional development for FFN child care providers is limited and there are no systemic efforts underway to support quality in FFN care. In fact, there is a lack of consensus about what quality of care looks like in FFN child care settings. Although FFN care more closely resembles parental care than center-based care (Porter et al., 2010b), many child care researchers continue to apply paradigms and frameworks to FFN care that have been developed for center-based care (Shivers & Farago, 2016). As a result, FFN child care is frequently rated as providing the lowest quality child care in comparative studies using global assessments of quality (e.g., Fuller, Kagan, Loeb, & Chang, 2004). Greater understanding about how quality of early childhood settings affects child outcomes has led to increased attention around quality at the state and federal levels and stimulated parents, researchers, and policymakers to ask more thoughtful and probing questions about what quality of care means across settings, including FFN care (Susman-Stillman & Banghart, 2011).

To ensure that all children receive high quality care in whatever setting their family has chosen for them, especially in FFN settings, increasing numbers of child and community advocates and policymakers argue that there is a need to examine and advance innovative strategies, such as Infant and Early Childhood Mental Health Consultation (IECMHC), that can potentially improve children's social and emotional outcomes as well as the overall quality of care (Annie E. Casey Foundation, 2006; Chase, 2008; Emarita, 2006; Kreader & Lawrence, 2006; Shivers, Farago, & Goubeaux, 2016). To this end, we selected four sites where there was or is a potential intersection between FFN child care and IECMHC. These sites were Arizona, Colorado, Michigan, and San Francisco, California. Respondents included unlicensed FFN providers, licensed family child care (FCC) providers, program directors, mental health consultants (MHCs), early childhood network providers (ECNPs), state and county administrators and other state leaders, and funders.

With few systemic efforts to improve and enhance FFN child care, this study aimed to understand the potential role that IECMHC, as an effective, prevention-based service, could play to meet the needs of FFN providers, children and their families. With no previous studies about how IECMHC is being used by FFN child care, we wanted to determine whether mental health consultation is a helpful approach for FFN settings in supporting young children's social and emotional development. IECMHC pairs a MHC with families and adults who work with infants and young children in the different settings where they learn and grow, such as child care, preschool, and at home, to build their capacity to strengthen and support the healthy social and emotional development of children early on (Center of Excellence for IECMHC, 2018[1]). Social and emotional health, or the ability to form strong relationships, solve problems, and express and manage emotions, is critical for early learning, school readiness, and lifelong success (Center of Excellence for IECMHC, 2018[2]).

However, IECMHC is often seen as more of a center-based intervention and early childhood MHCs are typically only sanctioned to work with licensed providers. This generally leaves FFN providers unable to access individualized consultation and reliant on ECNPs to play a supportive role to improve their capacity and enhance the quality of care. Including FFN support programs in the study enabled us to learn about how they support FFN providers and how they could interface with IECMHC programs to maximize resources and capacity for the betterment of the FFN provider community. Therefore,

[1,2] https://www.samhsa.gov/iecmhc

we explored the role that MHCs could play to support FFN providers, if and when available, and also explored the role of ECNPs as well as provider peers to incite change. ECNPs are often community members with education, training, and expertise in child care or child development who act as cultural brokers, coaches, mentors, and trainers, within community-based early childhood networks of supports, to provide an array of services and supports to FFN providers.

Organizational leaders intentionally and explicitly created FFN support programs and curricula to leverage the protective factors of culture, community, and social connections making ECNPs uniquely poised to reach out to, engage with, and support FFN providers. The idea of who delivers programmatic services and supports to FFN providers, namely ECNPs, has not been explored at all in the literature. As such, our study provides insight into the role of staff at the frontlines supporting FFN providers. The distinct yet synergetic roles of MHCs and ECNPs on behalf of FFN providers suggests that a more coordinated, comprehensive array of services and supports for FFN providers could be beneficial and argues for increased partnerships between IECMHC programs and early childhood networks of support. We hope our discovery of critical considerations for IECMHC programs who want to support FFN providers, an indispensable and often overlooked segment of child care providers, will contribute to the growing discourse and research about how to effectively meet the needs of FFN caregivers, and ultimately affect quality of care in FFN settings, where most infants and young children are learning and growing each day across the country.

The cross-site findings

- Contextualize the FFN child care landscape by:
  - Shedding light on the FFN landscape and family and provider characteristics, motivations, and perspectives,
  - Recognizing the intergenerational trauma, fear, and mistrust of systems experienced by vulnerable communities who most often utilize and provide FFN care,
  - Outlining the multitude of historic, systemic, and socioeconomic barriers experienced by FFN providers, with a focus on complex family dynamics and complicated payment and funding structures,
  - Acknowledging the lingering stigma around mental health and lack of accessible high quality mental health services and supports to address the needs of providers, children, and families,
  - Highlighting the mental health and other needs of providers and children in FFN care, which could be met through program services and supports, and
  - Conveying how FFN provider expertise, perception, intentionality, and self-efficacy can be positively affected by program offerings.
- Describe components of successful programs interfacing with FFN child care providers, from IECMHC programs to early childhood networks of support, by:
  - Assessing the extent to which services are available and accessible to FFN child care providers, including IECMHC and education and supports by early childhood network programs,
  - Acknowledging the importance of organizational leadership in the creation of culturally steeped, relationship-based approaches to serving and supporting FFN provider communities,
  - Citing the importance of protective factors, such as community, social connections, and culture to combat risk factors and barriers experienced by FFN providers,
  - Spotlighting the centrality of relationships and how relationship-based approaches are critical to effective delivery of services and supports for FFN providers, particularly around mental health,

- Laying out critical cultural and linguistic considerations, including the need for cultural brokers and the importance of hiring program staff that share a similar cultural and linguistic background, as well as embodying a stance of cultural humility, and/or curiosity, when designing and providing programmatic services and supports to FFN providers from marginalized racial, ethnic, and linguistic backgrounds,
- Recognizing the value of a mental health lens and how it can inform work with FFN and FCC providers,
- Describing the background, role, and responsibilities of provider peers, ECNPs, and MHCs to support the mental health and other needs of home-based providers and families,
- Describing the parallel process of supporting those who are supporting FFN providers with supports needed at multiple levels for FFN providers, children, families, ECNPs, and MHCs,
- Profiling the innovative programs visited across the four sites, and where they fall along a continuum of services addressing mental health in FFN care settings, and
- Highlighting reported and desired impacts at the provider, child, and family levels due to programmatic services and supports.

"[FFN providers] are the lynchpin cornerstone providers in their communities. These are the reasons that people are able to go to work."

—MI, ORGANIZATION LEADER

- Lay out lessons learned to help programs improve services and supports for FFN child care providers by:
  - Noting barriers on the program side to effective engagement of FFN providers in the continuum of services and supports, and
  - Highlighting components of successful models working with FFN providers to inform future efforts by programs, most especially around IECMHC, to support FFN providers and bolster quality of care in FFN child care settings.

SECTION 2

LITERATURE REVIEW

This section provides an overview of the research efforts to date related to family, friend, and neighbor (FFN) child care and Infant and Early Childhood Mental Health Consultation (IECMHC) to provide grounding and context for this study, and how the findings might contribute to the growing literature.

Introduction to Family, Friend, and Neighbor Child Care

"Kith and kin," "informal," "license-exempt," or "family, friend, and neighbor (FFN)" all are terms to describe one of the oldest and most common forms of child care. This type of care is defined as any regular, non-parental, non-custodial child care arrangement other than a licensed center, program, or family child care (FCC) home; thus, this form of child care usually includes relatives, friends, neighbors, and other adults caring for children in their homes (Brandon et al., 2002). With regard to home-based settings, FCC or family day care are terms commonly used for registered, licensed, or regulated home-based child care (Tonyan, Paulsell & Shivers, 2017). In contrast, FFN child care is often exempt from licensing or regulations and these home-based settings tend to be less formal than required by typical regulations governing FCC; therefore, this type of child care can also be called license-exempt or informal care (Tonyan, Paulsell & Shivers, 2017). FFN care also denotes the presence of prior relationships between providers and the children in their care. The distinction between FCC and FFN care can be blurry since varying state or county regulations may mean care that is regulated in one state may not be regulated in another state (Susman-Stillman & Banghart, 2008).

What is family, friend, and neighbor child care?

"Family, friend, and neighbor child care—also referred to as informal care, home-based care, kith and kin care, kin care, relative care, legally unlicensed, and license-exempt care—is more and more commonly recognized as home-based care—in the caregiver's or child's home—provided by caregivers who are relatives, friends, neighbors, or babysitters/nannies."

— SUSMAN-STILLMAN & BANGHART, 2008

The prevalence of FFN child care has been well documented by researchers over the past fifteen years. With millions of families across the United States relying on home-based care, scholars estimate that a third to one half of all children under five are in FFN child care arrangements (Boushey & Wright, 2004; Johnson, 2005; Maher & Joesch, 2005; NSECE, 2015; Porter et al., 2003; Snyder & Adelman, 2004; Snyder et al., 2005; Sonenstein et al., 2002). Results from the National Survey of Early Care and Education (NSECE) suggest that the number of young children in FFN settings may be even higher than earlier estimations—up to 60% depending on one's interpretation of provider categories used in the national survey (e.g., unlisted-paid; unlisted-unpaid) (NSECE, 2015). Due to the informal nature of this type of child care, it is difficult to track the exact numbers of children in these types of care

arrangements. Research indicates parents choose FFN care arrangements based on trust, safety, parent flexibility, accessibility, cost, a desire to maintain and strengthen family connections, and a belief that children receive more personal attention in FFN care (Anderson, Ramsburg, & Scott, 2005; Brandon, et al., 2002; Bromer, 2006; Brown-Lyons, et al., 2001; Li-Grining & Coley, 2006; Paulsell, et al., 2006; Porter, et al., 2010; Porter, 1998). While research on FFN care is still in the early phases, a number of studies have relied on surveys to increase understanding of the characteristics of FFN child care providers and the families that utilize FFN child care arrangements (Anderson, Ramsburg, & Scott, 2005; Layzer & Goodson, 2006; NSECE, 2015; Paulsell et al., 2006; Shivers, 2003; Shivers, Yang, & Farago, 2016a).

"The majority of parents using FFN care report that they are satisfied. They find FFN care to be the most flexible, affordable, accessible, and trustworthy."

— LI-GRINING & COLEY, 2006

Families across all socioeconomic groups rely on and use FFN care; however, families with low income are more likely to use FFN care arrangements (Susman-Stillman & Banghart, 2008). A few studies report that both single mothers (regardless of part- or full-time work status) and parents who work full-time (both single and married) may be more likely to use relative care (Snyder & Adelman, 2004; Capizzano, Tout & Adams, 2000; Brandon, et al., 2002; Susman-Stillman & Banghart, 2008). Parents of children with disabilities and other special needs may choose FFN care because of the difficulties associated with finding care for their children to be in (Brown-Lyons, et al., 2001). Patterns of FFN use differ by children's ages, with infants and toddlers being the most likely to be cared for by FFN providers, regardless of family income or structure, while preschoolers tend to use multiple care arrangements, including FFN care (Susman-Stillman & Banghart, 2008). The number of hours in FFN care also varies by children's ages. Among children of employed parents in FFN care, infants and toddlers are as likely as preschool-age children to be in full-time (thirty-five plus hours/week) relative care (Snyder & Adelman, 2004), while two-thirds to three-fourths of school-age children are in relative care for fifteen hours per week or less (Capizzano, Tout, & Adams, 2000; Snyder & Adelman, 2004). For ten-to-twelve-year-olds, this number is even smaller given the time they spend in self-care (Chase, et al., 2005).

"Infants and toddlers, regardless of family income or household structure, are predominantly cared for by family, friends, and neighbors."

— SUSMAN-STILLMAN & BANGHART, 2011

Scholars and policy makers are becoming more aware of the differences in families' use of FFN child care by race and ethnicity (Boushey & Wright, 2004; Snyder & Adelman, 2004):

- FFN care is especially prevalent among families of color and families with low income (Brandon, 2005; Porter et al., 2010b) due to its accessibility, inexpensive nature, and flexibility for providers to also hold other part-time employment (Susman-Stillman & Banghart, 2008).
- Some studies have found that Latino and African American families use home-based care more often than white families, although differences exist by the age of the children, as previously noted (Crosnoe, 2007; Liang, Fuller, & Singer, 2000; Magnuson & Waldfogel, 2005; Snyder & Adelman, 2004).
- Research also shows that some families, particularly those who are newcomers to the United States, want to use family members for care because they share the same culture, home language, values, and child-rearing practices (Fuller, Holloway, & Liang, 1996; Shivers, 2006; Yoshikawa, 2011).
- Research shows that FFN providers tend to match the culture and ethnicity of the children in their care (Layzer & Goodson, 2006; Shivers, 2004; Shivers, 2008a).

- Cultural and ethnic matches between providers and children are very important to parents and providers for the transmission of cultural knowledge, values, and practices (Anderson, Ramsburg, & Scott, 2005; Drake, Unti, Greenspoon, & Fawcett, 2004; Guzman, 1999; Howes & Shivers, 2006; Shivers, Howes, Wishard, & Ritchie, 2004; Shivers, Sanders, & Westbrook, 2011; Wishard, Shivers, Howes, & Ritchie, 2003).

Several major statewide surveys (Anderson, Ramsburg, & Scott, 2005; Brandon, et al., 2002; Chase, 2006; Shivers, Yang, & Farago, 2016a) have shown that relatives are the most common form of FFN care and that grandparents (most often grandmothers) are the most typical related caregiver. However, in some states, such as Arizona, aunts are the most common relative category. FFN providers also tend to live in close geographic proximity to the children in their care in both urban and rural areas (Susman-Stillman & Banghart, 2008). Further, FFN providers tend to have similar incomes to the families of the children in their care (Susman-Stillman & Banghart, 2008). Approximately half of home-based child care providers are located in moderate- or high-poverty density areas, and less than one-third of providers are paid for providing care (Tonyan, Paulsell & Shivers, 2017). The majority of FFN providers do not charge parents or charge only nominal amounts for care. However, parents are likely to provide nonmonetary support to the provider (e.g., bartering).

More specifically:

- Relative caregivers tend to provide care to support their families (Porter, 1998; Reschke & Walker, 2006) and as a result, tend to charge little or nothing (Brandon, et al., 2002; Chase, et al., 2005; 2006; Mulligan, et al., 2005), or accept the level of subsidy payment with no co-payment from parents.
- Non-relative caregivers are more likely to view child care as a way to generate income for the household; therefore, they are more likely to charge and/or receive alternative forms of payment (Susman-Stillman & Banghart, 2008).
- FFN providers who receive child care subsidies are more likely to provide care for more hours (essentially full-time), provide care across standard and non-standard hours, and express an interest in learning about licensure (Anderson, Ramsburg, & Scott, 2005; Chase, et al., 2006; Todd, et al., 2005; Susman-Stillman & Banghart, 2008).

FFN caregivers are most commonly relatives and most often grandmothers. They are usually located in close geographic proximity to the children in their care. They are often of the same ethnic background as the children in their care. They often have similar incomes to the families of the children in their care.

—SUSMAN-STILLMAN & BANGHART, 2008

In addition, Susman-Stillman and Banghart (2011) found that FFN providers have:

- Generally lower levels of education than those of licensed providers (a high school education compared to some college or a college degree);
- A range of experience caring for children, with some gained by virtue of their own parenting experiences, and some by caring for children of others;
- A remarkable degree of stability as the child's caregiver, ranging from twelve months or more;
- The desire to help the child's parent and child as the primary motivation for providing FFN care; and
- Other consistent and similar reasons for providing care include wanting to help the child grow and learn, fostering intergenerational ties, and staying home with their own children.

Recently, it has been noted that many of the features of FFN care more closely resemble parental care than center-based child care (Porter et al., 2010b). Yet, many child care researchers continue to apply paradigms and frameworks to FFN care that have been developed for center-based care (Shivers & Farago, 2016). As a result, FFN child care is frequently rated as providing the lowest quality child care

(in comparative studies using global assessments of quality; e.g., Fuller, Kagan, Loeb, & Chang, 2004). Some studies have argued that the uneven and low-quality child care found in FFN care settings may have an adverse impact on children's and families' development (Fuller, Kagan, Loeb, & Chang, 2004; Maher, 2007; Polakow, 2007; Porter et al., 2010b). Although it may be true that FFN providers are doing a poorer job of caring for children than providers in licensed settings, the field lacks a clear definition of quality in FFN settings, and across all child care settings, with measures likely missing important attributes of FFN care (Susman-Stillman & Banghart, 2011). Greater understanding about how quality of early childhood settings affects child outcomes has led to increased attention around quality at the state and federal levels and stimulated parents, researchers, and policymakers to ask more thoughtful and probing questions about what quality of care means across settings, including FFN care (Susman-Stillman & Banghart, 2011).

"One of the difficulties in rating quality of FFN care is that there is no consensus about how to define quality in FFN settings."

— SUSMAN-STILLMAN & BANGHART, 2008

Increasingly, a major message in the campaign of quality for each and every child is the recognition that it is of paramount importance to ensure that children can thrive and access high quality care in whatever setting their family has chosen for them (Kreader & Lawrence, 2006; Susman-Stillman & Banghart, 2011). Rather than viewing these concerns as an argument *against* greater support for FFN care, increasing numbers of child and community advocates and policy makers argue that there is a need to examine and advance strategies that can improve it, especially since FFN care will continue to play a significant role in the lives of children most marginalized and at risk of not being ready for school (Annie E. Casey Foundation, 2006; Chase, 2008; Emarita, 2006; Kreader & Lawrence, 2006). The support parents have for FFN care underscores the importance of understanding relatively low quality ratings compared to licensed settings and the need to come to consensus on how to define quality in FFN settings and increase supports for providers (Susman-Stillman & Banghart, 2011). Numerous studies have found that FFN providers are interested in training and support (Anderson, Ramsburg, & Scott, 2005; Brandon, et al., 2002; Chase, 2006; Shivers, 2008b) and more research is needed to understand how professional development opportunities can impact quality of care.

Quality in Family, Friend, and Neighbor Child Care Settings

Despite active discussions by researchers and policymakers about how to define and assess child care quality across the range of settings and within settings, there is little consensus. The first wave of research examining quality in FFN care looked at structural and process measures. A structural perspective emphasizes features of the settings that can be affected by state regulation and is often seen in studies examining quality of care in licensed child care centers and FCC homes (Smolensky & Gootman, 2003). These structural characteristics are focused on tangible aspects of settings, such as child-adult ratio, group size, physical environment, and caregiver education and training (Susman-Stillman & Banghart, 2011). Process characteristics, on the other hand, are focused on opportunities children have for social and cognitive stimulation and exploration, such as interactions with caregivers, other children, materials, and equipment (Susman-Stillman & Banghart, 2011).

Caregiver characteristics have also been studied as variables that affect quality, such as attitudes and perceptions about children and caregiving, and the stability of caregiving arrangements (Susman-Stillman & Banghart, 2011). These caregiver characteristics may also affect quality of care; however,

they are more difficult to regulate. Studies have demonstrated linkages between structural characteristics and process quality (NICHD, 1999; Kisker, et al., 1991) and associations between structural characteristics and process quality and child outcomes (Smolensky & Gootman, 2003). However, the samples for these studies have been licensed centers and FCC homes using measures designed for licensed settings. Although researchers extended this framework to unlicensed, home-based settings, as dialogue about quality evolved, other theories and measurements were deployed to look at quality in FFN care (Susman-Stillman & Banghart, 2011).

Howes' developmental framework places children's development within ethnic, cultural, historical, and social contexts of communities as well as within relationships with others (Howes, 2000; Howes, James, & Ritchie, 2003; Rogoff, 2003). The cultural communities of FFN providers are critical in understanding how FFN providers' beliefs about child care and practices with children reflect the impact of a community's adaptive culture or the group of goals, values, attitudes, and behaviors that set families and children of color apart from the dominant culture in which white middle-class standards are the norm (Shivers & Farago, 2016). In addition to considering the importance of sociocultural contexts when researching FFN child care practices and beliefs, Howes (2000) framework also places relationships at the cornerstone of children's development, and emphasizes the need to study the influence of strong relationships in FFN care (Shivers & Farago, 2016).

Current trends in FFN care literature and quality enhancement approaches are increasingly promoting the importance of taking into account the specific cultural community and diverse contexts in which children and providers are embedded (Powell, 2008; Porter & Vuong, 2008; Shivers et al., 2016). There are several specific studies that have addressed the importance of examining and exploring the cultural responsiveness of FFN professional development and quality initiative approaches (Kruse, 2012; Powell, 2008; Shivers et al., 2016). Not doing so can further marginalize low-income communities of color, which already struggle with the myriad consequences of historic, institutional, and systemic racism (Suarez-Orozco, Yoshikawa, & Tseng, 2015). In general, FFN outreach, training, and support programs are most effective when tailored for a specific cultural community (Powell, 2008) and administered or facilitated by members from the same cultural group (Shivers, Farago, & Goubeaux, 2016). There is a recent push in the IECMHC field to make culture and equity more central in its theory of change, model design(s), workforce development, etc. (Center of Excellence for IECMHC, 2016; Shivers, 2016). Other cultural considerations include addressing the under-utilization and mistrust of mental health services by non-white cultural communities (e.g., historical stigmatization of mental-health in the African American community) (Abdullah & Brown, 2011; Bailey, Milapkumar, Barker, Ali, & Jabeen, 2011).

Notably, a family support perspective has been used to conceptualize and measure quality in home-based settings (Bromer, et al., 2011; Kreader & Lawrence, 2006; Morgan, Elliott, Beaudette, & Azer, 2001; Todd, et al., 2005). Unlike developmental or regulatory frameworks, this perspective supports a family-centric view of FFN care as responsive to the needs and reflective of the strengths of families. In particular, the family-sensitive caregiving model postulates that when families feel supported—through positive relationships with providers and child care being provided when needed—the child care arrangements are more likely to remain stable and consistent lessening parental stress and supporting positive child outcomes (Susman-Stillman & Banghart, 2011). This strengths-based perspective may guide the development of new measures of quality as well as new services and supports for FFN providers and research efforts. For example, use of a parent education model of support may better suit the needs of FFN providers than the traditional professional development models (Susman-Stillman, 2003; Susman-Stillman & Banghart, 2011).

Increasing numbers of advocates, policy makers, and researchers have argued that in this era of scaling up Quality Rating and Improvement Systems (QRIS), while it is critical to expand financial support for formal quality child care programs and improve access for low-income families, it is also important to recognize that much can be gained by going where the children are, and increasing training and support for FFN providers (Adams, Zaslow, & Tout, 2007; Brandon, 2005; Chase, 2008; Michigan's Early Childhood Investment Corporation, 2015; Thomas, Boller, Jacobs Johnson, Young, & Hu., 2015; Weber, 2013). Even though there are many early education advocates who understand the importance of offering support, training, and education to FFN child care providers, there are very few examples of larger, public initiatives and investments in FFN support at the state and federal levels. Some notable examples include(d) Hawaii, Michigan, Minnesota, and Oregon. The majority of FFN quality improvement programs are funded at the community or regional level—often by private funds.

"There is a growing movement around the nation to offer support and education as one strategy to improve the quality of care offered by FFN providers. This movement is building upon the findings from reports of FFN providers describing their interest in learning how to best support children's development, as well as public interest in accountability and children's development."

— SUSMAN-STILLMAN & BANGHART, 2011

One of the major difficulties is identifying FFN providers who are amenable to education and support (Todd, et al., 2005; Chase, et al., 2005). With reports that between 10-30% of FFN providers express an interest in becoming licensed, efforts must appeal to a larger majority. Education and support must be developed for a wide range of interests, goals, and skill sets (Susman-Stillman & Banghart, 2011) with special consideration for the traditionally low level of education of FFN providers (Todd, et al., 2005).

Once engaged, FFN providers have identified the need for information in the following areas:

1. Health, safety, and nutrition;
2. Child development;
3. Business and financial issues;
4. Community resources and activities, particularly low-cost ones;
5. Stress management; and
6. Working with parents (Susman-Stillman, 2003; Todd, et al., 2005; Porter, 1998; Susman-Stillman & Banghart, 2011).

FFN providers have also expressed a preference for variety in topics and learning formats other than traditional learning formats already established for licensed providers (Susman-Stillman & Banghart, 2011). To date, the most common strategies used to increase quality in FFN child care settings include:

1. Training and material distribution;
2. Home visiting; and
3. Play-and-learn groups (Porter, Paulsell, Del Grosso, Avellar, Hass, Vuong, 2010; Weber, 2013).

Many programs use a combination of these approaches. Although stakeholders are always interested in how and to what extent these strategies improve quality of care and children's outcomes, there is still very little data on the effectiveness of many of these interventions (Porter et al, 2010; Weber, 2013).

A particular challenge for the policy community, related to the limitation of the existing research literature, is that while there appears to be both substantial need and potential demand for training and support for FFN caregivers, there is no robust evaluation literature documenting the conditions under which FFN caregivers will actually participate, the role of early childhood network providers (ECNPs)

in facilitating enhancements in quality, or the degree to which various training or support activities can improve the quality of their interactions with children (Brandon, 2005; Porter et al., 2010a). Gathering more data about this group of providers as well as the organizations delivering the professional development strategies is therefore a critical priority for the early childhood policy agenda throughout the country (Chase, 2008; Thomas et al., 2015; Weber, 2013).

Future research needs to focus on documenting effective outreach, curricular and program efforts as well as linking programs to improvements in quality of care. For example, Susman-Stillman and Banghart (2008) put forth the following questions:

- What kinds of outreach strategies are most effective in linking FFN providers to education and support?
- Do effective supports differ by relatives and non-relatives, or by cultural groups?
- How does participation in support or peer groups improve the quality of care provided by FFN caregivers?
- Does participation in community-based activities or family support programs improve the stability of FFN caregiving arrangements and children's opportunities for learning?

There are very few systemic or community-based efforts focused on the social and emotional learning of children in FFN care settings.

While there has been a surge of interest in programs and initiatives that focus on enhancing children's social and emotional learning in center-based child care, very few systemic or community-based efforts—focused heavily on children's social and emotional learning—have been made with children in FFN child care settings. A limited number of studies suggest that FFN providers show support for children's social and emotional development through the warmth, affection, and responsiveness of their interactions; however, there are missed opportunities to promote social skills, such as cooperative play, sharing, and emotional control (Layzer & Goodson, 2006; Tout & Zaslow, 2006). Studies have also been descriptive, not predictive of children's development, and have not focused on implications for unique groups, such as infants, children with special needs, and school-age children (Susman-Stillman & Banghart, 2011). There is a need for definitive research on how social and emotional development is being addressed in FFN settings given the large percentage of children in these arrangements.

Moving forward, it is important to more comprehensively describe the experiences and outcomes for children in FFN care. To ensure that all children receive high quality care in whatever setting their family has chosen for them, including FFN settings, increasing numbers of child and community advocates and policy makers argue that there is a need to examine and advance innovative strategies—like Infant and Early Childhood Mental Health Consultation (IECMHC)—that can potentially improve children's social and emotional outcomes as well as the overall quality of care (Annie E. Casey Foundation, 2006; Chase, 2008; Emarita, 2006; Kreader & Lawrence, 2006; Shivers, Farago, & Goubeaux, 2016). Despite the solid evidence for IECMHC in formal, licensed child care settings, such as Head Start and Early Head Start, little is known about the potential benefits for children in FFN care. Thus, the aims of this study were to better understand the FFN child care landscape, the needs of FFN providers to enable them to more effectively attend to children's social and emotional development, and the potential benefit of IECMHC programs as well as early childhood networks of support on caregiver well-being and quality of care.

There is a need to examine innovative strategies, such as IECMHC, to improve children's social and emotional outcomes and overall quality of care in FFN care settings.

Introduction to Infant and Early Childhood Mental Health Consultation

What is Early Childhood Mental Health Consultation?

Mental health consultation in early childhood settings is a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more caregivers, typically an early care and education provider and/or family member. Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age six and their families.

— ADAPTED FROM COHEN & KAUFMANN, 2000

IECMHC is an evidence-based approach that pairs mental health professionals with people who work with young children and their families in the different settings where children learn and grow, such as child care, preschool, and their home. According to the Center of Excellence for IECMHC[3], the aim of mental health consultation is to build adults' capacity to strengthen and support the healthy social and emotional development of children—early and before intervention is needed. Social and emotional health or the ability to form strong relationships, solve problems, and express and manage emotions, is critical for early learning, school readiness, and lifelong success (Center of Excellence for IECMHC, 2018[4]). Without it, young children are more likely to have difficulty experiencing or expressing emotions, which could lead to withdrawal and distancing, have trouble making friends or getting along with their peers, and/or display behavioral problems, such as hitting, using unkind words, or bullying, which can lead to difficulty with learning, suspension or expulsion, or later school dropout (Center of Excellence for IECMHC, 2018[5]).

IECMHC programs are integrated within the communities they serve. Mental health consultants (MHCs) are highly trained licensed or license-eligible professionals with specialized knowledge in childhood development, the effects of stress and trauma on families, and the impacts of adult mental illness on developing children (Center of Excellence for IECMHC, 2018[6]). MHCs often provide community trainings on social-emotional topics and connect families and early care and education providers to community-based services and supports. IECMHC involves the collaborative relationship between a professional consultant who has mental health expertise and a child care professional. By its very definition, it is a service provided to the child care provider—not a therapeutic service delivered directly to the child or family (Brennan et al., 2008). It is not about fixing kids nor is it therapy. IECMHC equips caregivers to facilitate children's healthy growth and development by:

- Starting with the premise that all relationships matter in a child's life and working to promote both strong relationships and supportive environments for children, both of which are key to brain-building; and
- Focusing on building the capacity of adults in children's lives, so children are supported in all settings (Center of Excellence for IECMHC, 2018[7]).

"IECMHC builds the capacity of child care providers and parents to understand the powerful influence of their relationships and interactions on young children's development."

— THE RAINE GROUP, 2014

Research indicates that children's well-being is improved and mental health problems may be prevented through skilled observations, individualized strategies, and early identification of children with challenging behavior that places them at risk for negative experiences in preschool and beyond (RAINE Group, 2014). Throughout the country, states continue to explore innovations for enhancing the quality of early care and education for young children. These efforts are largely motivated by a growing body of research

[3,4,5,6,7] https://www.samhsa.gov/iecmhc

that uses longitudinal studies to prove how high quality early care and education experiences help to prepare children for school and provide them with the social and emotional skills required to be successful even beyond the early years (e.g., Pianta, Hamre, & Allen, 2012; Lamb, 1998; Mashburn et al., 2008; NICHD ECCRN, 2005). Unfortunately, when young children experience mental health problems they are likely to miss out on important learning opportunities (Gilliam, 2005; Perry, Dunne, McFadden, & Campbell, 2008). IECMHC has gained prominence as an effective, efficient, evidence-based strategy for promoting children's social and emotional competence and mental health, addressing challenging child behavior, and enhancing the quality of care in early childhood settings (e.g., Brennan, Bradley, Allen, & Perry, 2008; Hepburn, Perry, Shivers, & Gilliam, 2013).

As defined by ZERO TO THREE[8], infant and early childhood mental health refers to a young child's developing capacities to:

- Experience, regulate, and express emotions in socially acceptable ways;
- Form close and secure adult and peer relationships; and
- Explore the environment and learn.

All of this is done in the context of family, community, and culture.

The positive impacts of IECMHC on children and families, teachers, and child care programs have been well established in large-scale evaluations of IECMHC programs in many states. Findings from rigorous studies (e.g., randomized control experiments, quasi-experimental, and mixed-methods studies) indicate that access to IECMHC reduces serious problems that undermine school readiness in American children (Hepburn, Perry, Shivers, & Gilliam, 2013). The body of evidence to date suggests that IECMHC has a positive impact on program, staff, and child outcomes, including but not limited to: teacher sensitivity, teacher-child relationships, children's externalizing and internalizing behavior, enhanced overall emotional climate in classrooms, and reduced child expulsion (For excellent reviews, see: Brennan, Bradley, Allen, & Perry, 2008; Hepburn, Perry, Shivers, & Gilliam, 2013; Perry, Allen, Brennan, & Bradley, 2010). The federal government, in fact, has issued several policy briefs highlighting IECMHC as an effective strategy for reducing child expulsion in general, and expulsion for boys of color specifically (U.S. Dept. of Education & U.S. Dept. of HHS, 2014). The evidence base for the effectiveness of IECMHC in promoting positive social and emotional outcomes for young children and reducing the risk of negative outcomes has been the impetus for many states to invest in IECMHC programs and systems.

Duran, Hepburn, Irvine, Kaufmann, Anthony, Horen, & Perry (2009) of the Georgetown University Center for Child and Human Development (GUCCHD) extracted the core, common elements of effective IECMHC across six IECMHC programs in six states. **Figure 1** is a visual representation of the findings, highlighting the relationship between the core program components and positive outcomes at the child, family, staff, and program levels.

This framework suggests that there are five factors that are important in the design of effective IECMHC programs.

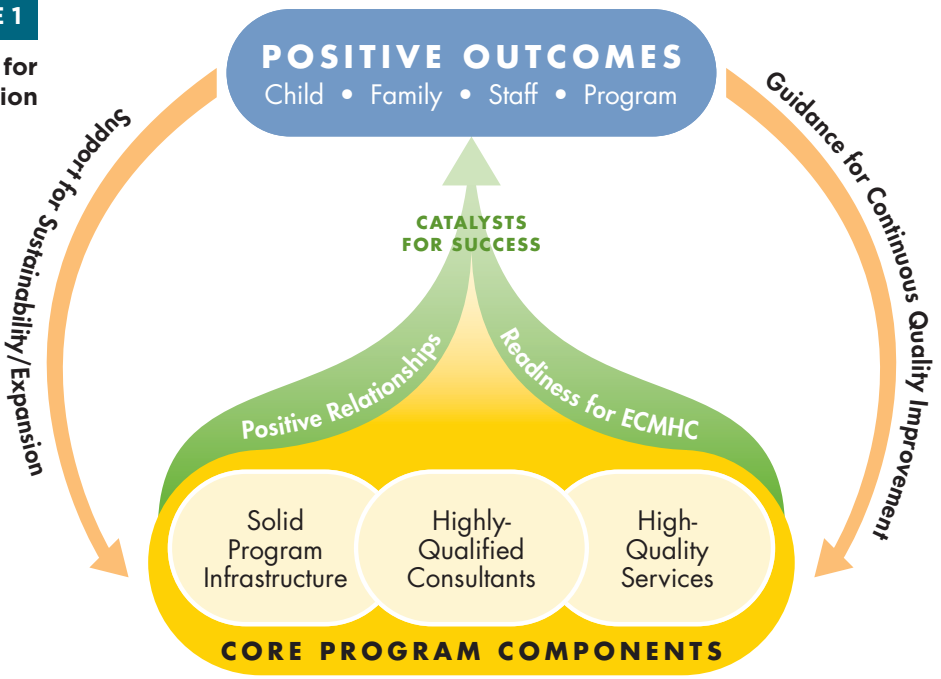
First, three core components must be in place:

1. Solid program infrastructure, such as strong leadership, clear model design, strategic partnerships, and evaluation;
2. Highly qualified MHCs; and
3. High quality services.

[8] https://www.zerotothree.org

FIGURE 1

Conceptual Framework for IEMCHC Theory of Action



Two other elements that are catalysts for success are:

1. Quality of the relationships between and among consultants and consultees; and
2. Readiness of families and early childhood education providers/programs for IECMHC.

In addition, the diagram underscores the importance of using evaluation findings and outcome data to guide program enhancements, such as continuous quality improvement processes, and to educate funders and other stakeholders about the program's impact in promoting sustainability and/or expansion. It is important to understand whether these core constructs and core components are applicable in FFN care settings.

Intersection of Family, Friend, and Neighbor Child Care and Infant and Early Childhood Mental Health Consultation

Despite the evidence for impacts at the child, teacher, and classroom level from evaluations of IECMHC in formal, center-based child care settings, little is known about the potential benefits of IECMHC for providers, children and their families in FFN child care arrangements. There are notable, distinct features of FFN child care arrangements and the profiles of FFN providers themselves, outlined below, that provide a compelling case for why IEMCHC might be beneficial for caregiver well-being and children's social and emotional development, as well as for program staff who work directly with FFN providers, such as ECNPs. These factors led us to study the intersection between FFN child care and IECMHC to understand if mental health consultation could be beneficial for FFN providers and the staff supporting them, and to better understand the congruous work of IECMHC programs and early childhood networks of support on behalf of FFN providers, children and their families.

- The **centrality of provider-child relationships and family-provider relationships** in FFN child care is a strong base from which IECMHC programs can leverage and maximize positive outcomes. A summary of these strengths include:
  - FFN caregivers are often attachment figures for the children in their care (Kontos, Howes, Shinn, & Galinsky, 1995; Shivers, 2008a; Shivers & Farago, 2016; Susman-Stillman & Banghart, 2011; Weber, 2013).
  - Emotional investment in the child(ren) is a primary motivation for FFN providers to providing child care (Bromer, 2006; Porter et al., 2010b; Shivers, 2012; Shivers, Yang, & Farago, 2016a).
  - There is a salience of the provider-child-parent triad, with strong continuity of relationships with family (Bromer, 2006; Henly & Bromer, 2009; Susman-Stillman & Banghart, 2011).
  - FFN child care settings typically have small provider-to-child ratios (a typical marker of structural quality) (Herbst, 2008; NSECE, 2015; Paulsell et al., 2006; Shivers, Yang, & Farago, 2016a).
  - When FFN providers are surveyed about their training needs and desires, positive discipline and challenging behavior usually tops the lists (Anderson, Ramsburg, & Scott, 2005; Shivers, 2008b).

- A large percentage of FFN providers are **caring for children with special physical, emotional, behavioral, or developmental needs**.
  - Anecdotally, FFN providers have shared that they often find themselves taking care of those young children who have been expelled or "kicked-out" of multiple child care programs (Ward et al., 2006).
  - They are also more likely to care for those young children whose parents are not able to find an appropriate and affordable therapeutic and inclusive child care program (Chaudry, Pedroza, Sandstrom, Danziger, Grosz, Scott, & Ting, 2011; Ward et al., 2006).
  - FFN caregivers express a great desire for more training and information about how to help children with special needs and where to find resources that they can share with the child's family (Brandon, et al., 2002; Shivers, 2008b; Shivers & Wills, 2001).

- An IECMHC approach is well-suited to **bridge the gap between family support and regulated early care and education** (O'Donnell et al., 2006; Hoffmann & Conway Perrin, 2009).
  - Some researchers argue that FFN care often falls through the cracks because the placement of FFN care on the child care continuum highlights the unfortunate "silos" in our early childhood system.
  - FFN care is located at the nexus of the parental/family support field and the early care and education field (O'Donnell et al., 2006; Hoffman & Conway Perrin, 2009; Wilder & Bruner, 2012). Consequently, improvement strategies commonly involve opening access to materials, training, and/or technical assistance to improve the quality of FFN care or opening access to family support services to enhance overall family health and child development.
  - There are few intervention approaches with FFN care that truly embrace models from both fields of family support and early care and education.

- Supporting the **resiliency of FFN caregivers** is a common attribute of effective FFN training and support programs.
  - Whether an intentional or unintentional part of a program design, many FFN programs that support training, outreach, resources, and/or support to FFN child care providers discover that the support FFN caregivers receive as individuals is a powerful motivator that keeps providers engaged in the program, facilitates more emotional availability with the children in their care, and leads to other positive outcomes.

SECTION 3

THEORETICAL FRAMEWORKS

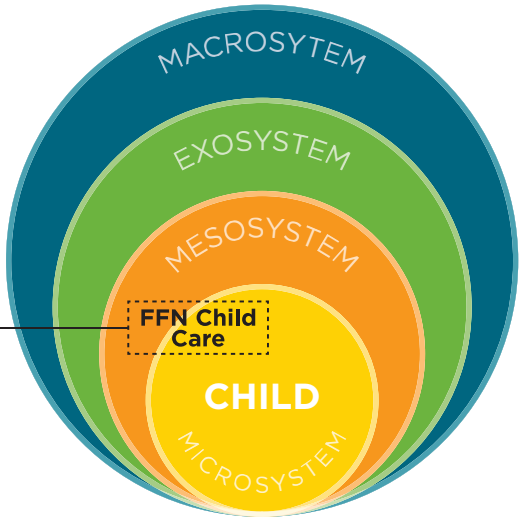
This section highlights the theoretical frameworks pivotal in guiding the study development and analysis.

In order to examine the interconnectedness of multiple layers within the nexus of FFN child care and IECMHC, this study—specifically the analysis—was guided by a broad theoretical framework that places children's development within the context of their care environments, family systems, and further, within ethnic, social class, and policy contexts. The methodology, analysis, and interpretation were all influenced to greater and lesser extents by particular components of multiple theories and constructs that make up the broader theoretical framework.

- We first drew from **Ecocultural/Ecological Theory** (Bronfenbrenner, 1979; Gallimore & Goldenberg, 1993; Lerner, 1986; 1991), in which individual development is nested within the broader "sociocultural system," and from more recent work that interprets the development of all children within a cultural context (Garcia Coll, Lamberty, Jenkins, McAdoo, Crnic, Wasik, & Garcia, 1996; Johnson & ECCRN, 2003).
  - We think that a child served in an FFN care setting is exposed to a complex array of influences at the micro- and meso-levels (Aquino, et al., 2018). FFN providers can be found either within the microsystem, as relative providers, or at the mesosystem, as friends or neighbors. **Figure 2** displays where FFN child care falls within Bronfenbrenner's ecological theory (Aquino, et al., 2018).

FIGURE 2

Bronfenbrenner's Ecological Systems Applied to FFN Child Care



FFN Care in a Child's Ecological Frame

A child served in an FFN care setting is exposed to a complex array of influences at the micro- and meso-levels. FFN providers can be found either within the microsystem (as relative providers) or at the mesosystem (as friends or neighbors).

- **Garcia-Coll's Integrative Model** helped us organize information about how more distal ecological factors, such as social position and culture, impinge on the more proximate contexts of early development (family, early care and education settings) for ethnic minority children.
  - Pervasive racism, prejudice, and discrimination in the United States have resulted in families of color developing an adaptive culture (Garcia Coll et al., 1996).
  - According to Garcia Coll (1996), expression of adaptive culture emerges in socialization practices or "ways of doing things" with children—including selection of child care arrangements that reflect families' goals, values, attitudes, and align with urgent realities such as cost and convenience.
  - Selection and usage of FFN child care, arguably an adaptive response of many marginalized families to their experiences with racism, prejudice, and wide disparities regarding access to resources, have led to the creation of a "system" outside of the dominant culture (e.g., white, middle-class).

- The third theoretical framework which heavily influenced this study was the **Howes Developmental Framework**. This framework is largely applied to early care and education settings and is influenced by socio-cultural theory as well as attachment theory.
  - Howes' Developmental Framework places children's development within ethnic, cultural, historical, and social contexts of communities, as well as within relationships with others (Howes, 2000; Howes et al., 2003; Rogoff, 2003).
  - Howes posits that providers' beliefs about child care and practices with children reflect the impact of their community's adaptive culture—a group of goals, values, attitudes, and behaviors that set families and children of color apart from the dominant culture (predominantly white, middle-class).
  - For a more robust exploration of how the Howes Model applies to FFN child care see Shivers & Farago, 2016.

- Key constructs from **Infant Mental Health** were also instructive in this study. Some of the key constructs which guided our understanding of the data included:
  - **Attachment Theory** is the dominant theory used in the study of infant and toddler behavior and in the fields of infant mental health, treatment of children, and related fields (Ainsworth et al., 1978; Bowlby, 1969/1982; Bretherton, 1985; Pianta, Steinberg, & Rollins, 1995).
  - The **Transactional Model** is focused on how children and contexts shape each other. It has become central to understanding the interplay of nature and nurture in explaining the development of positive and negative outcomes for children (Lazarus, 1966; Lazarus & Folkman, 1984).
  - Relatedly, the **IECMHC Theory of Action Framework** also guided our design, methodology, analysis, and interpretation (Duran et al., 2009), and **parallel process**[9] provided a framework for thinking about how to support those who support FFN providers (Heffron, 2013).
  - In examining the mental health needs of FFN providers, we used the attachments frameworks as well as the **Family Stress Model** (Lavin, et al., 2018) that posits that caregivers' psychological distress mediates the relationship between economic disadvantage in families and children at risk for negative psychological outcomes (McCloyd, 1990).

[9] https://mi-aimh.org/endorsement/endorsement-exam/reflection/parallel-process

- Another important theoretical lens that was very useful in exploring our data included the constructs and theories involved with **human, cultural, and navigational capital** (Vesely et al., 2012).
  - Understanding and exploring FFN providers' awareness and use of community resources provides valuable insights that can shape current and future services that align with broader early childhood goals.
  - Colleen Vesely and colleagues (2012) use findings from a qualitative study with immigrant mothers to posit that high quality early childhood programs can build various types of "capital" necessary for parenting in a new host community.
    - The various types of capital they describe are: 1) *human capital* (e.g., personal characteristics, skills, and capabilities that influence financial well-being such as education, language skills, documentation status, etc.); 2) *social capital* (e.g., benefits and resources caregivers receive through social relationships such as informational support, logistical support, and emotional support); and 3) *navigational capital* (e.g., abilities and strategies needed to maneuver systems and institutions that are generally less accessible to marginalized communities such as early intervention services, enrolling in preschool programs and kindergarten, health care enrollment, counseling and mental health services, etc.).
  - Based on our reading of the literature and deep knowledge of FFN providers, we argue that providing thoughtful, well organized, supported community resources to FFN providers and well as training and support increases their human, social, and navigational capital (O'Donnell et al., 2006; Vesely et al., 2012; Vesely & Ginsberg, 2011).

- We also utilized the **Unified Theory of Behavior Change (UTB)** (Jaccard, Dodge & Dittus, 2002; Jaccard, Litardo & Wan, 1999) to frame the process of change.
  - This theoretical framework is based on the idea that individuals' actions can be predicted by factors affecting their readiness or "behavioral intentions" to carry them out and by more immediate determinants, which affect the conversion of intentions to action.
  - Within the UTB framework, behavioral intentions are enhanced by positive perceptions of the goals and the actions required to achieve them, including the behavioral beliefs (both advantages and disadvantages) and associated emotional valence. Behavioral intentions are also thought to be influenced by the normative beliefs of important others about pursuing the targeted goals and the social image that this might convey.
  - Also, in the UTB framework, intentions are linked to feelings of empowerment or self-efficacy, beliefs that one can overcome obstacles standing in the way of achieving goals. Even though a behavior may have a positive expected and normative value, the individual may not perform a behavior if he or she thinks it cannot be done. Encouraging factors include a belief that the targeted goal is legitimate and worthwhile, attainment is possible, and significant others support the effort (Hamilton et al., 2003).
  - By taking into account these critical components of behavior change, MHCs and ECNPs could better support practice and behavior change.

- Finally, a **systems integration lens** was also applied to our design, methodology, analysis, and interpretation (Coffman, 2007).
  - FFN child care has typically been viewed as an informal type of child care, as a family social support system, or as both. Some researchers argue that FFN care often falls through the cracks because its placement on the child care continuum highlights the unfortunate "silos" in the early childhood system.
  - FFN care is located at the nexus of the parental/family support field and the early care and education field (O'Donnell et al., 2006; Hoffman & Conway Perrin, 2009; Wilder & Bruner, 2012). Consequently, improvement strategies commonly involve *either* opening access to materials, training, and/or technical assistance to improve the quality of FFN care *or* opening access to family support services to enhance overall family health and child development.
  - There are few intervention approaches with FFN care that truly embrace models from both fields of family support and early care and education.

SECTION 4

STUDY BACKGROUND AND OBJECTIVES

This section provides an overview of the rationale and drivers behind the project. It also describes the principal objectives from the outset of the project and how the research questions evolved to focus on the mental health related needs of FFN child care providers, children and their families.

Project Rationale

Research has clearly confirmed the importance of nurturing and responsive relationships and high quality early childhood education in supporting young children's development. With almost six million children in FFN care (NSECE, 2015), it is critical to determine the needs of FFN child care providers in providing nurturing and responsive relationships and supporting young children's social and emotional development. Work over the last two decades has demonstrated the effectiveness of IECMHC in early childhood settings to support the ability of early care and education providers and/or family members to support the healthy social and emotional development of young children. IECMHC has been implemented in Head Start, Early Head Start, child care, home visiting, and primary care and has been found to have positive outcomes related to children, staff, families, and programs (Hepburn, Perry, Shivers, & Gilliam, 2013).

- Child level outcomes of IECMHC include improvements in children's social skills, secure attachments and resilience, school readiness, and reductions in children's challenging behavior.
- Family level outcomes include reduced stress, fewer missed days of work, and better teacher-parent relationships.
- Program level outcomes include reductions in child expulsions, reduced staff stress, reduced staff turnover, improvements in identifying mental health concerns, increased developmental screening and follow-up, and improvements in the organizational culture.
- Home visiting programs have seen improvements in family engagement and retention rates.

Despite the large percentage of children in FFN child care settings, there is no definitive research on how social and emotional development is being addressed in FFN child care settings or the extent to which IECMHC is being used in FFN child care settings to build the capacity of FFN child care providers. The research to date on IECMHC has been conducted almost exclusively in formal, licensed child care settings. IECMHC has the potential of offering increased effective assistance to a larger number of young children, their families, and the caregivers who care for them. A scan of the literature shows FFN child care providers currently receive very little support. Therefore, we wanted

to determine the extent to which IECMHC is available in FFN child care settings, and if/when available, whether IECMHC could be a viable and helpful approach in these home-based settings. If possible, we also wanted to describe the components of effective IECMHC programs for and on behalf of FFN providers.

Principal Objectives

To guide the project, we convened a national Expert Workgroup of individuals with expertise in FFN child care and those familiar with IECMHC. The Expert Workgroup assisted with different phases of the study from materials development to site selection to review of preliminary findings.

The principal objectives of this project are:

1. To understand the needs of FFN child care providers in supporting young children's social and emotional development through a mental health lens;
2. To determine the extent to which FFN child care providers have access to supportive services, such as IECMHC, or other training and educational opportunities through early childhood networks of support; and
3. To describe a continuum of services and supports available to FFN child care providers that may include IECMHC models.

Research Questions

The research questions for this report evolved from the principal objectives of the project. The questions focused more explicitly on the mental health needs of FFN child care providers and how programmatic services and supports—both IECMHC programs and early childhood networks of support—are configured and delivered to meet these needs.

1. What are the unique mental health and other needs of FFN child care providers?
   a. What are the implications of unmet caregiver needs for the children in FFN child care settings?
2. To what extent are the mental health and other needs of FFN child care providers currently being addressed?
   a. What strategies seem to have the most impact?
   b. To what extent are mental health consultants playing a role?
   c. To what extent are early childhood network providers playing a role?

Hypotheses

Based on our initial knowledge of various quality enhancement and/or family support strategies or approaches being used by programs for FFN child care providers, we went into this study hypothesizing that we would likely discover an array of social and emotional learning strategies for FFN providers. These efforts, which might include IECMHC, could represent a continuum of services and supports to address the mental health and other needs of FFN providers, children and their families.

SECTION 5

METHODOLOGY

This section provides an overview of the study design, role of the national Expert Workgroup, description of the major study components, and a summary of the multi-phased data analysis process.

Study Design

The current study was informed by one conducted previously by GUCCHD that sought to examine effective, center-based early childhood mental health consultation programs (Duran et al., 2009). The current study therefore mirrors methodology with considerable adaptations to and consideration of the FFN child care landscape. In order to address the aforementioned research questions, the study team utilized a mixed-methods approach to synthesize extant data with new data collection and analysis. The study team convened an array of experts in the fields of mental health consultation, FFN child care, and research and evaluation to provide consultation and guidance throughout the study process and ensure thorough consideration of important factors in the planning, implementation, and analysis of the study.

To gain a better understanding of the extent to which mental health services and supports, namely IECMHC, were reaching FFN child providers nationally, an online scan was distributed to the Children's Mental Health Directors and Child Care Administrators in all 50 states, the District of Columbia, and territories, to learn about their service array. In addition, primary data were collected from a small sample of mental health consultation programs and early childhood network sites that demonstrated either current or previous engagement with FFN child care providers. With four sites selected, where there was or is an intersection between FFN care and IECMHC, the study team conducted multi-day visits (ranging from two to five days) to each site and gathered various resources and measures to better understand the programs and their models. The study team conducted semi-structured key informant interviews and focus groups with a mix of respondent types, both onsite and virtually following the site visits. Each of these study components is described in detail below.

National Expert Workgroup

In addition to the study team, a small group of experts were engaged in this project (see Acknowledgements for a listing of workgroup members). Specifically, this study tapped their expertise to:

- recommend notable IECMHC programs and other early childhood programs serving FFN providers for site visit consideration;

- review and provide feedback on the interview and focus group protocols, FFN survey, and national scan; and
- convene regularly as an advisory group to discuss each phase of the study as well as implications of the study.

Following an in-person kickoff meeting to introduce the study, refine objectives, frame the project, and discuss potential sites, virtual discussions occurred monthly to finalize the research questions, decide on a final cohort of sites, solicit feedback on materials, and report on preliminary learnings from site visits. Throughout the study development, data collection, and data analysis phases, feedback and recommendations were received online through virtual webinars as well as short surveys and email correspondence. This highly engaged group of experts provided critical guidance and feedback throughout the duration of the project. Once the sites were selected, from the Expert Workgroup, there was one site lead for each site who helped tremendously with site visit planning and logistics.

After each site visit, the study team met with the Expert Workgroup to review the visit, highlighting the itinerary of programs visited, who was interviewed, and what initial takeaways were observed. Once all sites were visited, the study team spent time analyzing qualitative data from the interview and focus group transcripts until the findings were ready for review by the site leads. The site leads engaged in member checking of the cross-site results to ensure accuracy and clarity of the findings.

National Scan

In order to attain a broader understanding of how states have been providing mental health services to populations of FFN providers, this study collected national data through a web-based survey tool in Qualtrics, a powerful online survey platform. An electronic invitation was emailed to leaders in the planning, delivery, and coordination of child care and/or early childhood mental health services and supports for children, namely the Children's Mental Health Directors and Child Care Administrators in each state and territory, to respond for their state or jurisdiction. The national scan was the first of its type: an attempt to provide a snapshot of both FFN care and IECMHC programs across the nation, as an essential first step in better meeting the needs of children and families in these child care arrangements. Twenty-five responses were received from the child care side and twenty-one responses from the mental health side. Eleven states completed both sections of the scan.

Site Visits

This section describes the site selection process and site visit preparations including development of the study protocols as well as the multi-phase data analysis process of the descriptive information.

Site Selection

Data for this study were primarily collected through visits to four sites. As mentioned above, the study team solicited recommendations from experts in the field through an online survey, as well as follow-up meetings to discuss and select sites. In addition to consulting national experts, the study team also referred back to the Duran et al. (2009) study for mental health consultation programs previously visited, taking advantage of familiarity with the programs and established connections with their leaders. Outreach was done to speak to leaders from recommended sites to determine fit for the study specifications and interest in participating.

The goal of site selection was to assemble a diverse mixture of early childhood mental health consultation programs and/or early childhood programs that effectively engage (or used to engage) with FFN child care providers. Although a sample size of six sites was originally proposed, in vetting the potential sites, four sites seemed to most aptly fit the selection criteria. The decision was made to focus in-depth on these four sites where we might learn the most about the potential intersection of FFN care and IECMHC. After this multi-level selection process, in close consultation with the Expert Workgroup, the sites chosen for inclusion in this study were Arizona, Colorado, Michigan, and the city of San Francisco, California. It is important to note that although the four sites selected for this study represent a diverse mix of programs interfacing with FFN providers, they are not nationally representative of all efforts and initiatives seeking to serve and support FFN populations.

Interview and Focus Group Protocols

Once the four sites were notified of their selection and agreed to participate, study team members (two per site) began working with site leads who were familiar with the mental health consultation programs and/or the early childhood network programs within their site. These site leads assisted in the coordination and scheduling of interviews and focus groups with various programs and their participants. Semi-structured interview protocols were developed to learn from the following groups of participants:

- FFN (and FCC) child care providers
- IECMHC program staff (e.g., MHCs) and ECNPs
- IECMHC program directors, state administrators, and other leaders

The protocol for the FFN providers was also translated into Spanish and Cantonese, per the site leads' request. In addition, site leads were asked to identify any other individuals who might help the study team gain a better understanding of mental health services within the FFN landscape and study protocols were slightly amended, as needed, to speak to these individuals.

The study team conducted on-site interviews and focus groups between April to May 2017, with follow-up virtual interviews and focus groups occurring through July 2017. Respondents included FFN providers, FCC providers, MHCs, ECNPs, other program staff (e.g., family resource center staff), IECMHC program directors or administrators, program directors, leaders, and staff of early childhood networks of support, state and county administrators, and funders. Forty-one interviews and focus groups were conducted across the four sites. We spoke to a total of 147 participants.

Each interview or focus group lasted between one to two hours. Apart from the FFN and FCC providers, interviews with all other participants were mostly conducted in English (with the exception of one ECNP program wherein a translator was used to conduct the focus group). Interviews and focus groups were audio-recorded, and took place mostly in shared spaces such as conference rooms, libraries, and lounge areas. A few individual interviews took place in the participant's home or office.

At each site, the study team was able to convene at least one focus group of FFN providers to learn from and understand their experiences working with programs and services. FFN providers in these focus groups also completed an on-site FFN survey that was created to gather information on each provider's particular child care arrangement and practices. Due to a logistical challenge, the FFN survey was not completed in one of the four sites.

Focus groups and surveys with FFN providers were completed in either English or Spanish. One site was also able to put the study team in touch with FCC providers receiving mental health consultation. Individual interviews took place in the providers' homes, and the study team was able to observe the child care environment. These interviews were conducted in either Spanish or Cantonese by members of the study team, with support from local staff and translators. Both FFN and FCC providers received $25 gift cards for meeting with the study team members and providing their time and insight for the study.

The study team also gathered supporting data and materials to learn more about programs' designs, practices, and services when engaging with FFN child care providers. These materials supported and supplemented learnings from the site visits and are available upon request.

Following the site visits, audio files of the interviews and focus groups were sent to outside transcription services to be transcribed. When applicable, audio files and transcriptions were also professionally translated to English for consistent coding and analysis. These documents were uploaded to ATLAS.ti, a qualitative data analysis and research software program, resulting in a total of forty-one transcripts of interviews and focus groups for analysis.

Data Analysis

A multi-phase, rigorous data analysis process was used to examine the qualitative data gathered from the four site visits. Due to the semi-structured nature of the interview protocols, qualitative content analysis followed the method of Weiss, using a framework approach, a flexible tool that can be adapted for use with many qualitative approaches that aim to generate themes (Weiss, 1994), instead of a purely grounded theory method. This approach enabled the study team to develop detailed site descriptions, integrate multiple perspectives, describe services and supports for FFN and FCC providers, including IECMHC, when available, and describe cross-site findings clustered around themes.

To prepare for the data analysis process, the study team debriefed major takeaways with the site visit team and listened to audio recordings from the site visits to inform the development of a codebook. After a series of discussions and revisions, a codebook was created with fifty-seven codes in ten code families focusing on the FFN/FCC landscape, FFN/FCC provider needs, program descriptions, relationships, special topics such as cultural considerations, perspective on mental health, and children's social and emotional development, challenges, facilitators, recommendations, and coding questions and thoughts (see Appendix A). The structured codebook consisted of four parts: names of the code families, names of the codes, definitions of the codes, and examples. The codes embodied the assumptions underlying the analysis. Utilizing a dynamic, team-based approach to develop the codebook helped the study team members come to consensus around the meaning of different codes and led to a more comprehensive "map" for exploring the data (MacQueen et al., 1998).

Once transcripts of the interviews and focus groups were produced, the textual data were imported into ATLAS.ti (version 7.5.7) for coding. One study team member had primary responsibility for building the hermeneutic unit (HU) in ATLAS. The HU contained the research questions, primary documents (categorized by primary document families—by respondent type and site), and codes (categorized by code families and with definitions). Three study team members each independently test coded the same primary document and discussed their coding process to help ensure inter-rater reliability. The team then came together to do a segment-by-segment review of the coding to see where there were consistencies and inconsistencies and discussed and resolved those (MacQueen et al., 1998). Once

high intercoder agreement was reached, the primary documents were divided up by respondent type and assigned to the team members for systematic coding of the textual data. When the team-based coding was complete, the three HU's were merged to create a final, master HU for analysis.

The study team engaged in thematic analysis by identifying analytic categories or themes within each code, discussing how emerging themes linked together or differed by site or respondent type, using the connections between the themes to build theoretical models and an analysis framework, and integrating the related themes to answer the research questions and describe the role IECMHC could play to support the needs of FFN child care providers to support the social and emotional development of children in their care. Although described below as phases, the data analysis process was not discrete but rather iterative and interactive with each phase circling back to as well as informing the next phase to more fully describe the major takeaways.

Phase 1: Analysis of Major Codes

The study team began the analysis process by coding or categorizing the quotations to start the process of abstracting or reducing the qualitative data. Memos or running notes were also written during coding to capture important and interesting concepts that were emerging from the data. The memos ran the gamut from theoretical commentaries to placeholders for follow-up. It was a way for the team members to keep a running list of their questions, thoughts, and hypotheses while coding. Once coding concluded, query reports were run in ATLAS.ti so each of the team members could analyze the clustering of similar and interrelated ideas and concepts to identify emerging themes. These themes were discussed during weekly meetings and provided a basis for an analysis framework of major findings. In discussing takeaways from major codes, relationships and interactions seemed to play a critical role; therefore, the next phase of analysis focused on these different and important levels of interaction.

Phase 2: Analysis of Interaction Levels

In this next phase of analysis, the study team focused on interactions between groups and how these interactions may have facilitated or mediated the use of IECMHC or early childhood networks of support. **Figure 3** depicts the critical stakeholders within IECMHC and FFN child care and the various interactions across these groups. This phase sought to describe what happened within the context of these relationships and what is needed to improve services and supports for FFN providers to enhance the social and emotional development of children and improve the quality of care in FFN settings.

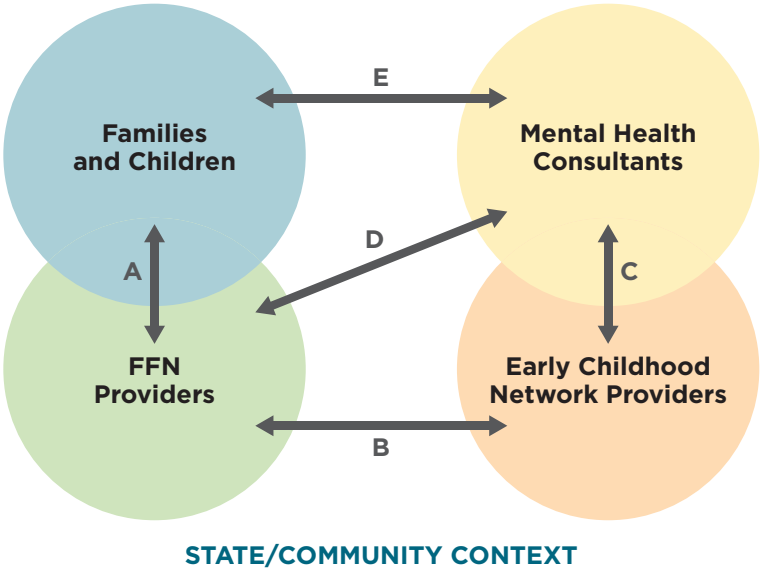
The interaction levels are:

- **Interaction Level A: Families and Children ↔ FFN Providers** describes interactions and dynamics between children and their parents and FFN providers.
- **Interaction Level B: Early Childhood Network Providers ↔ FFN Providers** highlights interactions, services, and supports provided by ECNPs and needed by FFN providers.
- **Interaction Level C: Early Childhood Network Providers ↔ Mental Health Consultants** profiles interactions, services, and supports provided by MHCs to ECNPs and needs of ECNPs for IECMHC.
- **Interaction Level D: FFN Providers ↔ Mental Health Consultants** focuses on interactions between MHCs and FFN providers directly or a potential need for these interactions.
- **Interaction Level E: Families and Children ↔ Mental Health Consultants** looks at the potential role for MHCs to work directly with children/families in FFN care.

The takeaways from each of these interaction levels reinforced and augmented emergent themes.

FIGURE 3

Levels of Interaction



Phase 3: Site-Specific and Respondent Informed Analysis

In this phase of analysis, study team members created network maps in ATLAS.ti showing overlaps in quotations amongst codes and ran frequencies, distributions, and counts to determine how often codes were used by site and respondent type. These analyses helped the team determine which codes were most and least prevalent in which sites and by respondent type. For each site, the most prevalent and relevant codes were analyzed. This analytic phase enabled the team to better describe the unique features and practices of each of the four sites and discuss strong, recurring themes with cross-site applicability. It also confirmed that the majority of themes emerged from multiple stakeholders and shed light on more unusual perspectives.

Phase 4: Integrative Analysis

The final phase of analysis focused on integration with the development of thematic narratives from related codes. The process of organizing, combining, and overlaying the related themes uncovered during each phase enabled the team to tell a more cohesive story about the mental health and other needs of FFN providers and how programmatic offerings meet these needs. The review of emergent themes from each of the phases allowed for the creation of an analysis framework highlighting the major findings across sites.

Limitations

Limitations discussed in this section are related to study design, data collection, and analysis as well as application of the study findings.

The four study sites were identified with the assistance of the Expert Workgroup with members having tremendous knowledge, expertise, and experience in the child care, mental health, and research and evaluation fields. In discussing potential sites, we learned that there are few sites where IECMHC programs intersect with FFN care. Therefore, we also visited programs where IECMHC was previously provided to FFN providers and where IECMHC is primarily provided to home-based, licensed FCC providers. These circumstances made it difficult to identify the effective components of IECMHC for and on behalf of FFN providers exclusively. In addition, we learned from early childhood programs who offer frontline support to FFN providers to improve quality of care. These conversations enhanced our understanding of the needs of FFN providers and how ECNPs work to meet those needs. Although we believe the lessons learned have widespread applicability for program design and implementation, each of these sites has its own nuances, contexts, and structures and each state, site, or community needs to take its own landscape into consideration when trying to apply learnings. It is also important to note that the FFN programs we visited are exemplary in design and have evaluation data demonstrating the success and effectiveness of their training and supports on provider and child outcomes. These programs are not representative of most programming available to FFN providers.

With regard to methodology, the research team analyzed a subset of codes to inform the results for this report. Given the enormity of the data with approximately 2,500 minutes of audio recordings and a large number of codes with most ATLAS.ti query reports with coded quotations in the triple digits in terms of page length, it was not feasible within the timeframe allotted to analyze every code. After the site visits, however, the site visit teams debriefed major takeaways, and this was a first step in developing an analysis framework. In addition, each research team member listened to audio recordings from sites prior to coding to inform the creation of a comprehensive codebook and elicit themes. The co-principal investigator also reviewed the thematic summaries for all phases of analysis to develop an expanded analysis framework. Therefore, we believe the results capture cross-site findings with major themes that emerged to tell a cohesive story, and the intensive four phase analysis process also uncovered site-specific learnings in key areas to showcase lessons learned working with FFN and FCC providers. The rich data collected from the sites can be further analyzed for peer reviewed journal articles to add to what has been shared in this summative report.

The study findings which emanated from work with FFN and FCC providers offers insight into the mental health and other needs of these providers who are connected to a formal system and taking advantage of programmatic offerings. Many other FFN providers remain unconnected to services and supports. As such, the point of leverage are the FFN providers who are connected to a formal system or who choose to enroll in the child care subsidy. There are opportunities to enhance their knowledge, skills, and capacity through program linkages. For FFN providers who remain in the shadows, there may be a place for the dissemination of high quality materials and resources; however, it is difficult to track whether these materials and resources are reaching FFN providers and making a difference. How to support FFN providers who are unconnected remains a huge dilemma. It requires leadership from child-serving agencies and community-based organizations to collaboratively think about potential ways to creatively interface with a larger number of FFN providers and the young children and families who select and rely on this child care arrangement.

Key Terms and Acronyms

For a list of important terminology and acronyms used throughout the report, please see Appendix B.

SECTION 6

NATIONAL SCAN FINDINGS

This section highlights select findings from the web-based national scan.

GUCCHD sent an online survey to all states and territories to explore the intersection of Infant and Early Childhood Mental Health Consultation (IECMHC) and family, friend, and neighbor (FFN) child care settings. This scan aimed to help the field understand the needs of FFN child care providers in supporting young children's social and emotional development, including the role that mental health consultation can play. The scan was sent to both the Child Care Administrator and Children's Mental Health Director in each state in order to have both of their perspectives.

Twenty-five Child Care Administrators and twenty-one Mental Health Directors or their designees from a total of thirty-five states and territories completed the scan (see **Table 1** below). And a brief summary of the relevant findings are reported here.

TABLE 1: Breakdown of Respondents

Child Care Administrators/Leaders (n=25)	Mental Health Directors/Leaders (n=21)	Both (n=11)
1. Alabama	1. Arizona*	1. Arizona
2. American Samoa	2. Arkansas	2. Colorado
3. Arizona*	3. California	3. Connecticut
4. Colorado*	4. Colorado*	4. Florida
5. Connecticut*	5. Connecticut*	5. Kentucky
6. Florida*	6. District of Columbia	6. Maryland
7. Georgia	7. Delaware	7. Missouri
8. Guam	8. Florida*	8. New York State
9. Indiana	9. Illinois	9. Ohio
10. Iowa	10. Kentucky*	10. Pennsylvania
11. Kansas	11. Louisiana	11. Utah
12. Kentucky*	12. Maryland*	
13. Maryland*	13. Michigan	
14. Massachusetts	14. Minnesota	
15. Missouri*	15. Missouri*	
16. Nebraska	16. New York*	
17. New Hampshire	17. Ohio*	
18. New Mexico	18. Oklahoma	
19. New York*	19. Pennsylvania*	
20. North Carolina	20. Utah*	
21. Ohio*	21. Wisconsin	
22. Oregon		
23. Pennsylvania*		
24. Utah*		
25. Virginia		

* = Child Care Administrator/Leader and Mental Health Director/Leader response from that state

For the purposes of the scan, FFN care was defined:

> "Family, friend, and neighbor" child care is one of the oldest and most common forms of child care. Other terms often used for this type of arrangement are "kith and kin," "informal," or "license-exempt." This type of care is usually defined as any regular, non-parental (non-custodial) child care arrangement in the provider's home other than licensed family child care; thus, this form of child care usually includes relatives, friends, neighbors, and other adults caring for children in their homes (Susman-Stillman &Banghart, 2011; Brandon et al., 2002).

State Child Care Administrators or their designees were asked to reflect on the definition of FFN care that was provided in the survey. While many states indicated that this definition was representative of FFN care in their state, some states noted that care may also take place in the child's home. A wide variety of terms were used to refer to this population of child care providers including: Out-of-Home Relative Child Care Provider, In-Home Relative Child Care Provider, Home-Based Provider, and Exempt Provider.

Data collection methods to describe the prevalence and characteristics of FFN care varied widely, and many states reported that they collected no data at all. Fewer than half of the responding states were able to report data on the percentage of children in FFN care, and the vast majority of these states only collect data through their subsidy program. Several states were using innovative methods to quantify the use of FFN care, including estimation techniques and the administration of a household survey. For example, one state reported that they conduct a household survey of a random sample that included child care questions to estimate the percent of children in FFN care. Several other states attempt to back into an estimate of the number of children in unregulated care by taking the total population of children birth to five who have primary caregivers who are both working outside the home, and then subtracting the number of children enrolled in licensed/regulated settings and/or receiving subsidy payments. Very few states were able to estimate the number of FFN providers in their state, their strengths and needs, or the characteristics of the families they serve.

In more than half of the responding states, FFN providers are offered child care payments for providing care to families eligible for Temporary Assistance for Needy Families (TANF) or Child Care and Development Block Grant (CCDBG) funding. Payments varied widely, but many were very low, with the maximum offered at $43/day, per child. Many states place restrictions and regulations on FFN providers to participate in the subsidy system, including: 1) restrictions on number of children in care, 2) restrictions on hours of care, 3) restrictions on where non-relatives can provide care, 4) criminal background checks, 5) annual home inspections, and 6) mandatory training.

Preservice annual training for FFN providers to receive subsidy payments ranged from ten to fifteen hours, and one state outlined specific classes required rather than hours (e.g., Introduction to Health and Safety, Department of Human Services Orientation, First Aid/cardiopulmonary resuscitation (CPR), Recognizing and Reporting Child Abuse and Neglect. Less than half of the responding states require ongoing training for license-exempt FFN providers, ranging from two hours per year to sixteen hours per year. A handful of states mandate mental health or social-emotional topics for preservice training. These topics included social and emotional development, development of social skills, basic child development, and modules related to working with families experiencing homelessness.

Many states have implemented changes to their license-exempt requirements as a result of the 2014 CCDBG regulations. Respondents indicated that these new regulations could lead to a reduction in the number of FFN providers who participate in the subsidy program. For example, in several states unrelated caregivers can no longer be in-home providers without certification. Other states indicated that a reduction in FFN providers who can get the subsidy could lead to families being more likely to select licensed child care. One state predicted that they will initially lose providers due to the new requirements, especially providers who are not comfortable with technology or those who are not comfortable with home visits, but that with proper messaging, the pool of FFN providers will eventually increase. Another state noted they have seen a reduction in FFN providers, but they are unsure if this is due to an actual decline or a cleanup of the data system.

Most states indicated that some kind of professional development services were accessible to FFN providers. The most common resources and supports available were: 1) face-to-face training, 2) written materials, and 3) online training. Four states reported that one-on-one consultation with a mental health professional was available for FFN providers; and one additional state will soon offer this support. Several states added additional supports, including child care resource and referral technical assistance, online resources, CALM guidelines for unregistered providers, Inclusion Services through the Department of Health, one-on-one with an Inclusion Specialist, and a special professional development program for relatives.

For the purposes of the scan, IECMHC was defined:

> "IECMHC is a prevention-based service that pairs a mental health consultant (MHC) with families and adults who work with infants and young children in the different settings where they learn and grow, such as child care, preschool, and their home. The aim is to build adults' capacity to strengthen and support the healthy social and emotional development of children—early and before treatment is needed. IECMHC improves children's lives by supporting their social, emotional, and behavioral health and development." (Center for Excellence for IECMHC, 2018[10])

Of the twenty-one state and territory respondents from the Children's Mental Health Directors perspective, twenty confirmed that IECMHC services—consistent with this definition—are available in their state (see list). The majority of state mental health respondents pointed to suspension and expulsion data as contextual factors that influenced the development or expansion of IECMHC efforts. Several states highlighted the lack of access to mental health services for young children and the needs of early childhood providers for supports to address infant and toddler social-emotional issues. Several states also noted data on school readiness, the new CCDBG requirements, and the availability of different funding opportunities to initiate or expand IECMHC. One state singled out the need to reduce implicit bias in child care and increase child care staff retention.

Among the twenty states that indicated they do have IECMHC, eleven of these states reported that services are available statewide; for the remainder, IECMHC is only available in certain jurisdictions. Among the states with IECMHC in certain jurisdictions, some local programs set their own eligibility criteria and others establish criteria at the state level. In most states, young children 0-5 are eligible for IECMHC services, and in five states these services are available for school-age children as well.

States reporting IECMHC services using the definition provided:

1. Arizona
2. Arkansas
3. California
4. Colorado
5. Connecticut
6. District of Columbia
7. Delaware
8. Florida
9. Illinois
10. Kentucky
11. Louisiana
12. Maryland
13. Michigan
14. Minnesota
15. New York
16. Ohio
17. Oklahoma
18. Pennsylvania
19. Utah
20. Wisconsin

[10] https://www.samhsa.gov/iecmhc

Many states reported several types of funding were supporting their IECMHC programs. The most frequently identified sources of funding included: 1) Federal Project Grants, 2) State General Funds, and 3) Federal Block Grants. States coordinate across a range of programs and agencies. Fourteen state respondents were able to report on how much funding is allocated to support their IECMHC system, and six states did not know the total amount. Many states allocated funding to support the salaries and fringe benefits for the MHCs; other costs covered included training and technical assistance, reflective supervision, and evaluation.

Of the fifteen states that specify qualifications for IECMHC, fourteen require a master's degree or higher in Mental Health or Early Childhood Education. Half of the responding states reported having bilingual MHCs, however the majority of those states admitted that the consultant workforce is not reflective of the workforce they serve or that they are unsure how reflective the consultant workforce is. Common supports to early childhood MHCs include in-service training, supervision, peer networking sessions, and technical assistance. In-service training topics identified include infant mental health, trauma-informed care, implicit bias, cultural equity, sensory issues, and autism. Several states offer Center on the Social and Emotional Foundations for Early Learning (CSEFEL) training and several involve their infant mental health association in training their consultants.

Of note, only four responding states offered IECMHC for all child care providers, including unlicensed, FFN caregivers, and an additional two states have had IECMHC available for FFN providers in the past. For those that do not offer IECMHC for FFN providers, the most common barriers included: 1) lack of funding, 2) challenges in recruiting FFN providers, and 3) need to understand the unique needs of FFN providers and train consultants in these areas.

SECTION 7

DESCRIPTION OF STUDY SITES

This section provides brief descriptions of each of the four study sites including information about the study participants, organizational and program overviews, and services and supports for FFN child care providers.

Arizona

Study Participants: During the site visit to Arizona, a total of twelve interviews and focus groups were conducted. The study team spoke with twenty-two FFN providers, three program directors or managers, five early childhood network specialists, three MHCs, two state administrators/funders, and two state leaders.

Arizona Kith and Kin Project

The Arizona Kith and Kin Project is a program of the Association for Supportive Child Care (ASCC), a nonprofit child care agency that was founded in 1976 to improve the quality of care for Arizona's children, and is funded by First Things First and Valley of the Sun United Way. ASCC oversees and coordinates the Arizona Kith and Kin Project as well as other early childhood programs. The program provides ongoing early childhood training and support to FFN caregivers. The goals of the program are to 1) improve the quality of child care through training; 2) increase caregivers' knowledge and understanding of early child development; and 3) increase caregivers' knowledge and understanding of health and safety issues to provide safe child care.

To read more about the Association for Supportive Child Care, please visit their website: www.asccaz.org

The Arizona Kith and Kin Project is a fourteen-week, two-hours-a-week support group training series for Spanish- and English-speaking and refugee caregivers, with most training-support sessions offered in Spanish. The training-support sessions are held at various community partner locations, such as Head Start centers, faith-based organizations, public libraries, elementary schools, and local community centers that have an adjoining space for child care. The effectiveness of the Arizona Kith and Kin Project has been extensively evaluated and shown to significantly improve FFN child care providers' practices, their relationships with the children in their care, and increase their understanding of child development. In addition, the evaluation found improvements in providers' literacy practices as well as improved literacy for the children in their care.

A more in-depth description of the Arizona Kith and Kin Project as well as evaluation briefs can be found at: www.familyfriendandneighbor.org/research.html

Smart Support

Arizona's IECMHC program is known as Smart Support. Smart Support officially launched its services to early care and education programs in April 2010. The Smart Support program receives its funding from First Things First, the agency that oversees the disbursement of the voter-approved tax revenue on tobacco products to support a comprehensive early childhood system in Arizona. The agency serving as the administrative home for Smart Support is Southwest Human Development, Arizona's largest nonprofit dedicated to supporting early childhood development.

To read more about Southwest Human Development, please visit their website: www.swhd.org

Smart Support services are provided without cost to Arizona Department of Health Services licensed child care centers and Department of Economic Security regulated family care providers. Smart Support's mission is to provide high quality mental health consultation to early care and education providers, keeping two main goals in mind. The first is to improve the overall quality of early care and education settings so that they are better able to support the social and emotional development of all children in their care. The second goal is to increase the capacity of early care providers to address the mental health needs and challenging behaviors that place individual children at risk for negative outcomes in the early years of life and beyond. Evaluation research on the effectiveness of Smart Support has demonstrated positive outcomes for teachers, classrooms, and students' mental health and well-being.

For a copy of the evaluation report, go to: http://indigoculturalcenter.org/products-and-reports

In 2012, Smart Support piloted a small project to offer indirect mental health consultation to the largest FFN program in the state—The Arizona Kith and Kin Project. That is, the MHCs provided IECMHC to the early childhood specialists within the Arizona Kith and Kin Project. These were the specialists who worked directly with the FFN child care providers. Smart Support provided large group trainings to the specialists, and also provided one-on-one in person or phone consultation for one hour each week. This pilot project only lasted one year. In 2018, following this study, Smart Support began providing indirect IECMHC to the Arizona Kith and Kin Project again, but with a slightly different approach that includes some co-facilitation of groups for FFN providers by MHCs and the early childhood specialists.

To learn more about Smart Support, visit their website: www.swhd.org/training/smart-support

Colorado

Study Participants: While in Colorado, a total of eight interviews and focus groups were conducted. The study team spoke with a total of seven FFN providers, thirty-three ECNPs, MHCs, and program directors, and ten state-level administrators from the Office of Early Childhood.

The Colorado Statewide Parent Coalition

The Colorado Statewide Parent Coalition (CSPC) provides advocacy and training for parents and child care providers to be meaningfully engaged in children's educational success. With equity in mind, CSPC aims to serve all historically under-represented children and their families to ensure access to equitable educational opportunities. They have developed a number of curricula aimed at these goals, one of which is the Providers Advancing School Outcomes (PASO) program.

The PASO training program provides professional development to Latino FFN providers to promote school readiness for children birth to five years old. The PASO program in Colorado follows a community-based model aimed at closing the achievement gap between Latino and non-Latino children before they enter kindergarten. Trainers (known as "tias") engage FFN providers in an intensive, early childhood education program, aligning their curriculum with Child Development Associate (CDA) credentialing.

There are annual cohorts of twenty-plus FFN providers in each low-income Latino service area. PASO is an intensive 120 hour, thirty session early childhood education program. The trainings address environment/safety concerns, health, early childhood literacy and numeracy, social skills, family support, and other early childhood education services. There is also an in-home coaching component with three home visits throughout the fifteen weeks and ongoing support by tias to help FFN providers implement and understand learnings from PASO.

For more information, visit their website: http://coparentcoalition.org

Cultivando

Cultivando is a leadership, advocacy, and capacity-building organization in Denver, Colorado, that works in collaboration with community leaders and partners. The organization seeks to provide culturally relevant trainings, build collaboration and advocacy around equity, inclusion, and other self-identified community issues. Their work includes culturally-relevant trainings, building collaboration and advocacy around equity, inclusion, high quality educational, healthy eating, active living (HEAL), and other self-identified community issues, with a focus on building the capacity and supporting the voice of community leaders to bring about sustainable change. All of their trainings are offered in Spanish and developed by and for the Latino community, honoring the inherent strength and knowledge that exists within the community. In addition, their programs are focused on building health equity and community capacity for positive policy and systems change.

Cultivando's work is rooted in the Promotora Model. Promotoras are highly skilled community leaders characterized by *servicio de corazón* or "service from the heart." Cultivando built a leadership curriculum in 2016 and 2017 to train and support Spanish-speaking emerging community leaders in cultivating their internal leadership, emotional health and self-care, collaboration, and understanding local systems in order to make positive change for their community. Cultivando works to train and support promotoras in an effort to bring about sustainable change.

More information can be found on their website: www.cultivando.org

Mile High United Way

Mile High United Way (MHUW) is the birthplace of the international movement, and a leader within United Way Worldwide. Located in Denver, Colorado, this nonprofit organization seeks to build the capacity of communities through professional development, service provision, and partnerships with other community organizations and programs. In an effort to coordinate and deliver services to underserved children and families, MHUW works with numerous local partners to promote healthy outcomes and create lasting impact in their communities.

As a leader in Colorado for FFN advocacy, MHUW hosted a mix of ECNPs, representing programs and institutions such as Denver Public Schools, Early Childhood Councils from different counties in Colorado, and local family resource centers. All participants spoke of their knowledge and

understanding of FFN providers, the needs of children and families in their communities, and the extent to which their services reached this specific population of child care providers.

More information on Mile High United Way and their partners can be found on their website: https://unitedwaydenver.org

North Range Behavioral Health

North Range Behavioral Health (NRBH) is a community mental health center in Weld County that supports people who face mental, behavioral, and addiction challenges. They offer an array of services such as crisis support, medical services, counseling, peer programs, as well as population-specific programs for teens, adults, children and families.

NRBH offers early childhood prevention programs that provide a strong start for a child and nurture emotional and mental well-being. Expert staff in the Family Connects program at NRBH work with parents and other caregivers to evaluate young children who are exhibiting behavioral challenges, and provide support in many ways, one of which is through early childhood social-emotional development consultation. The mission of Family Connects is to increase the capacity of families, caregivers, and professionals to support the developmental, behavioral, wellness, learning and literacy needs of young children to enhance school readiness and build healthy relationships. Alongside IECMHC, Family Connects implements four other primary evidence-based programs in their wraparound services with participants: Home Instruction for Parents of Preschool Youngsters (HIPPY), Incredible Years®, Parents as Teachers (PAT)® home visiting, and the SafeCare® parent-training and case management.

More information can be found on their website: www.northrange.org

United Way of Weld County

The mission of United Way of Weld County is to improve lives by mobilizing the caring power of their community. The organization fights for the health, education, and financial stability of every person in their community. Their programs are focused on Early Education, Youth Development, Household Stability, and Seniors and Aging with projects and partners for each program area.

To learn more about United Way of Weld County, visit their website: www.unitedway-weld.org

In 2007, HB 1062 identified a statewide need to increase and sustain quality, accessibility, capacity, and affordability of early childhood services for all families. In response, the PASO Institute, as developed by CSPC, was offered as an early learning and development effort at United Way of Weld County to address the achievement gap between Latino and non-Latino children by helping providers create high quality care environments, exposing providers and parents to the need for quality early childhood care and education, to better prepare Latino children for school success.

More information about United Way of Weld County's PASO can be found on their website: www.unitedway-weld.org/what-we-do/education/promises-for-children/providers-advancing-school-outcomes

Valley Settlement

Funded by the W.K. Kellogg Foundation, Valley Settlement started out as a project under the Manaus Fund that sought to understand the experiences of immigrant families in Roaring Fork Valley. Through interviews with more than 200 families conducted in 2011, the organization learned about barriers that immigrants faced settling in their community. Findings revealed immigrants' feelings of isolation, as they were unconnected to schools, services, jobs, and opportunities. There were additional barriers such as fear, poor public transportation, and a lack of understanding or warm welcome from schools that further isolated this already marginalized population. Their findings suggested that there were no organizations in the community systematically reaching out to welcome and engage immigrant families with young children.

In response to these findings, early childhood and adult education programs were conceived, and further funding from the W.K. Kellogg Foundation, alongside other foundations, regional governments, and donors allowed for the infrastructure necessary to implement seven programs simultaneously in twelve targeted neighborhoods. By the end of 2016, Valley Settlement had become a stand-alone 501c3 nonprofit organization, continuing to engage immigrant families in their local schools and community.

Valley Settlement's early childhood education programs serve a population of young children who would otherwise have no preschool experience prior to entering kindergarten, putting them at high risk for poor school achievement. The programs are based on the philosophy that the family is the child's first teacher. The goal is to increase school readiness through child-centered, bilingual programming, rich in language and social and emotional development experiences.

For more information, visit their website: www.valleysettlement.org

Michigan

Study Participants: During the site visit in Michigan, a total of ten interviews and focus groups were conducted. The study team spoke with twelve FFN providers, fourteen Social-Emotional Consultants (SECs) and Quality Improvement Consultants (QICs), and seven state leaders.

The Child Care Expulsion Prevention Program

"In the late 1990's, a needs assessment conducted by the Michigan Department of Community Health led to the development of the Child Care Expulsion Prevention (CCEP) as a means to prevent child care expulsion and increase children's socio-emotional success" (Carlson et al. 2012). The CCEP programs, operated through community mental health organizations, provided a model of IECMHC for parents and child care providers caring for children ages 0-5 who were experiencing behavioral or emotional challenges putting them at risk for expulsion from child care. The aims of CCEP were to reduce expulsions, improve the quality of child care, and increase the number of parents and providers who successfully nurture the social-emotional development of infants, toddlers, and preschoolers. Sixteen CCEP projects served thirty-one Michigan counties with funding from the Michigan Department of Human Services (DHS). The projects were administered by the Michigan Department of Community Health in collaboration with the Michigan Community Coordinated Child Care (4C) Association.

The Child Care Development Block Grant funds earmarked for infant/toddler quality were used to start the CCEP work. With Michigan being one of three states with the highest rates of birth-to-three-year-olds in relative care, funding was given with the caveat that attention be focused on children, birth through three, in all types of subsidized care and in relative care. Services and supports were offered

in center-based settings and family and group homes, and then with relative-enrolled, relative, and daycare aides. Approximately 20% of the providers were relative and daycare aides, therefore, specialized outreach was done to connect more with the relative and daycare aides where most of the young children were in care. In the IECMHC model, the consultant was a master's-prepared, infant-mental-health-endorsed mental health clinician through the local community mental health agency and would connect directly to providers and families requesting services.

More specifically, services offered included child/family-centered consultation for children at-risk of or experiencing challenging behaviors, with observations of the child at home and at child care, functional assessment of the child's behavior, an individualized plan of service developed by a parent-driven team, and intervention such as coaching and supporting parents and providers to learn new ways to interact with the child within the home and child care settings, modifying the physical environment, connecting the family to community resources, and so on. Additionally, programmatic consultation was offered with relationship-based coaching and individualized training for administrators, staff and parents, strategies and curricula to promote social-emotional competence, quality improvement activities, strategies to improve communication and relationship quality among administrators, staff and parents, and support to promote the mental health of child care staff and families.

In 2009, the project changed dramatically when DHS had to comply with more federal requirements on how earmarked funds can be spent. This meant that preschool children could no longer be served and 50% of the provision had to be relative and daycare aides. The model changed to accommodate these new requirements. The consultants came together and created a layered level of services through which they provided community coffee clubs and embedded themselves into every play group and community event where relative providers might be; it was a successful strategy. The numbers of relative providers reached started to grow. However, CCEP came to an end in 2010 when DHS had a change in their budget. This loss of funding affected forty-four MHCs.

Race to the Top—Early Learning Challenge

The Race to the Top Early Learning Challenge (RTT-ELC) funding was seen as an opportunity to revitalize the CCEP work. The RTT-ELC is a federal initiative that provides state grants to ensure that greater numbers of children with high needs are able to access high quality early learning and development programs, and that these programs are embedded within an integrated state system of programs and supports for young children. Michigan was awarded $51.7 million to improve early learning programs over a period of four years from January 2014 to December 2017. State agencies responsible for the implementation of grant projects and activities are the Michigan Department of Education (MDE), Michigan Department of Health and Human Services, and Center for Educational Performance and Information within the Michigan Department of Technology, Management, and Budget. MDE is the lead agency and the MDE Office of Great Start leads the implementation, management, and cross-partner collaboration efforts of the grant. Additionally, the Early Childhood Investment Corporation and Michigan Association for the Education of Young Children are participating partner organizations and have significant responsibility for implementing numerous grant activities.

With Michigan's RTT-ELC, there is a continued focus on social-emotional development, in addition to a new emphasis on health and safety as well as family support. Thirteen full-time equivalent (FTE) SECs are deployed in eighteen counties with an aim to scale across all of Michigan's counties. This time around, there is also a strong emphasis on health equity and working to eliminate racial and ethnic disparities. The intentionality around using the CCEP evidence-based model as well as the state's Project LAUNCH grant to inform this next iteration was critical to laying a strong foundation for the work with child care providers. As with the CCEP model, consultants are master's-prepared, infant-mental-health-endorsed, clinically trained and experienced (minimum of three to five years of providing home-based clinical family work under the supervision of a licensed, endorsed clinical director/manager), and receive ongoing reflective supervision. They are supported to do the CCEP evaluated intervention model, which includes family/child centered consultation and programmatic consultation. For RTT-ELC, the populations prioritized are providers within the Quality Rating Improvement System (QRIS) and family/group home providers. The consultants are also collaborating with family/physical health coaches. Referrals come in through the QRIS system instead of the mental health center directly.

Beyond IECMHC, the other RTT-ELC projects that provide services and supports for home-based providers, including FFN providers, and families include:

- The *Increasing Great Start to Quality (GSQ) Project* is developing and implementing effective strategies for improving the quality of early learning environments, across provider types, through increased participation in GSQ. QICs provide training and consultation through GSQ to unlicensed providers to support quality improvement. Regional QICs offer outreach and individualized technical assistance to home-based providers.
- The *Supporting Healthy Minds and Bodies Project* is working to increase the availability of high quality early learning programs that meet the physical and social-emotional health needs of young children by aligning GSQ program standards with nationally recognized physical and social-emotional health standards; developing training and technical assistance materials and supports that promote healthy habits for families and providers, as well as developmental screening and referral procedures; and providing SECs and Health Consultants to support home-based providers meeting the social-emotional and physical health needs of young children.
- The *Developing Early Childhood Educators Project* is focused on ensuring that early childhood educators have the skills needed to be successful. This project includes home-based providers and expands opportunities for home-based providers to earn a degree and increase the supply of staff qualified to teach in Michigan's Great Start to Readiness Program.
- The *Increasing Family Engagement Project* seeks to increase family access to resources designed to promote the physical, social, and emotional health of children by incorporating the Strengthening Families Protective Factors into the GSQ program standards, placing Family Engagement Consultants in communities to support parents and providers, assisting families and providers in understanding and adopting protective factors into daily practice, and so on.

To learn more about Michigan's RTT-ELC grant, please visit: https://www.michigan.gov/mde/0,4615,7-140-63533_71176---,00.html

San Francisco

Study Participants: During the site visit in San Francisco, a total of eleven interviews and focus groups were conducted. The study team spoke with fourteen FCC and FFN providers, six program leaders and staff, three MHCs, and four state and county administrators and funders.

The Early Intervention and School-Based Program at Instituto Familiar de la Raza

Instituto Familiar de la Raza (IFR) grew out of an absence of mental health services in the Mission District of San Francisco in the late 1970s. With the lack of representation of Latino service providers, few inclusionary practices or culturally based interventions in mental health institutions, a group of Chicano, Latino, and Indigena communities mobilized to meet the great need to build responsive, self-determined community institutions. This group worked to conceptualize a new framework incorporating community-based practices relevant to the racial and ethnic communities being served and the issues they were grappling with from chronic mental health illnesses to life stressors such as intergenerational conflicts and historical trauma. In 1978, this group became the founding members of IFR, the first integrated community-based mental health clinic in San Francisco, whose mission is to promote and enhance the health and well-being of Chicanos/Latinos and multicultural/multiracial children and their families. Presently, in providing a continuum of health and wellness programs for children, youth, adults, and families, IFR's teams work in a collaborative and integrated manner to support prevention efforts, mental health needs, and health concerns.

For more information about IFR, visit their website: http://ifrsf.org

After an informal "charla" (support group) from the community organically formed with the organization's guidance in the late 1980s, IFR began to offer IECMHC to impact the natural support systems in their communities. As pioneers launching the use of IECMHC in the 1990s decades before others across the country, IFR partnered with natural child care support systems, like home-based and FFN care providers, as well as teachers in center-based settings, to build the capacity of and strengthen the well-being of these child care providers and positively impact the social-emotional development of children. Currently, the Early Intervention and School-Based Program provides mental health consultation services to child care providers of children ages 0-14 years. Focused on promotion, early intervention and building community resiliency, the Early Intervention team offers services that address the unique developmental, behavioral, and social-emotional needs of children and their families by enhancing supportive relationships, embracing the families' world view, and fostering positive learning environments.

The Early Intervention team currently provides mental health consultation services to early learning sites, and school-based mental health consultation services to the San Francisco Unified School District elementary and middle schools. As part of San Francisco's Early Childhood Mental Health Initiative, the Early Intervention Program partners with early childhood programs, family resource centers, and FCC providers to deliver an array of services including mental health consultations for teachers and care providers, program consultations to administrators and teachers, child observations, parent consultations, case management, and therapeutic services. A support group of Latino FCC providers, which is open to all providers including FFN providers, is an especially impactful peer support group and can be an avenue for obtaining formal consultation. With the county funding stipulation that providers need to be licensed to receive formal IECMHC, the support group is less of a mix of provider types now and consists primarily of licensed FCC providers.

To learn more about the work of the Early Intervention and School-Based Program, please visit: http://ifrsf.org/programs/early-intervention-and-school-based-program

Casa Corazón at Instituto Familiar de la Raza

Casa Corazón offers family programs within IFR to ensure that families receive a continuum of services and supports to enhance resilience. The Family Resource Center staff provide case management, parent education, and early intervention services. More specifically, family resource specialists facilitate parenting classes, parent leadership and education workshops, parent support groups such as Las Comadres art therapy class, Hijas de la Luna, or Daughters of the Moon dance therapy class, and Cirdulo de Padres, a support group for fathers, parent-child activities such as a parent-child interactive activities, children's group, family night, kiddie play group hour, and additional family support services such as individual consultation, information and referrals, case management and family advocacy, and mental health services to families as well as FCC and FFN child care providers. FFN providers can also gain access to IECMHC through the Family Resource Center.

To learn more about Casa Corazon, please visit: http://ifrsf.org/programs/casacorazon

The Fu Yau Project

Since 1999, the Fu Yau Project has provided prevention and early intervention mental health services to the family resource centers and child care community that cares for children, ages 0-5 years old. The Fu Yau Project strives to provide high-quality clinical, cultural, and linguistically appropriate services. More specifically, IECMHC is provided to center-based and FCC providers in San Francisco who are in the Asian-Pacific Islander community. The Richmond Area Multi-Services (RAMS) is the parent agency that holds the Fu Yau Project, which started out with school district programs, a number of private nonprofit child care programs, and then a handful of FCC providers. Over the years, the project has been able to expand, especially as the demographics have changed in different neighborhoods, by offering services beyond Chinatown in the Richmond and Sunset areas that are predominantly made up of Chinese immigrants. The project has expanded into areas that had been historically more Latino or African American with Chinese immigrant families moving into these neighborhoods.

The Fu Yau Project is now one of the largest in the San Francisco Early Childhood Mental Health Consultation Initiative. The Fu Yau Project is funded through the San Francisco Department of Public Health Behavioral Health Services–Child, Youth, and Family–System of Care, Early Childhood Mental Health Consultation Initiative with funding from the San Francisco Human Services Agency, San Francisco Department of Children, Youth and Their Families, San Francisco Families and Children Commission, Preschool for All, and Mental Health Services Act. The Fu Yau Project currently provides services at more than fifty child care centers, family resource centers, and home-based services, which are located in thirteen San Francisco neighborhoods. In addition, it is one of five agencies serving the 250 FCC providers in the newly created Family Child Care Quality Network. The program's current client demographics include the following: 99% are low-income families with limited resources, and over 80% of the families are of Asian and Pacific Islander ethnicity, many of whom are from China and have limited or no English-speaking ability.

Services include on-site program and child observation, clinical consultation with child care staff and families, on-site intervention with individual and with groups of children, parenting classes and support groups, and in-service training for the child care staff relating to child development and mental health-related issues. The support group for FCC providers meets twice a month. The support group also reaches out to providers who do not get monthly home visits. It provides an opportunity for the providers, including FFN providers, to receive mental health support and create greater connections with other providers in the community. The staff includes a child psychiatrist, a licensed and license-

tracked clinical psychologist, clinical social workers, and marriage and family therapists. The staff members appropriately reflect the unique language skills and cultural competence needed to provide services for the children, families, and teaching staff of the child care programs.

To learn more about the work of the Fu Yau Project, please visit: www.ramsinc.org/fy.html

SECTION 8

CROSS-SITE ANALYSIS

This section describes findings and takeaways from our in-depth analysis of the descriptive interview and focus group data. The major themes contribute to a greater understanding of the FFN child care landscape and highlight important takeaways and considerations for programs committed to serving and supporting FFN child care providers.

Contextualizing the Family, Friend, and Neighbor Child Care Landscape

Prior to sharing findings from our cross-site analysis highlighting elements of successful programs serving FFN child care providers, it is important to contextualize the FFN child care landscape and the many varied factors that influence and affect FFN child care providers, young children and their families. Although the communities across the four sites vary in terms of their racial, ethnic and linguistic makeup, geographical influences, economic prosperity, social-political context, and community priorities, there are commonalities in terms of their beliefs, perceptions, needs, stressors, and challenges. We will start by describing characteristics of the families and providers, then share more information about their perspectives and motivations, including why they chose and provide FFN care. We will reiterate why FFN care continues to be seen as the most natural, trustworthy, culturally and linguistically responsive, adaptable, and affordable setting to care for young children.

We will explore the impact of historic, systemic, and socio-economic barriers and environmental factors on FFN child care providers and families, such as intergenerational trauma, chronic fear and stress, discrimination, and poverty, and examine the effect of stigma on their perception and use of mental health services and engagement with programmatic services and supports. We will reflect on difficult family dynamics and other stressors, such as payment concerns and funding structures. We will discuss the mental health and other needs of FFN providers, young children and their families and the impact unmet needs can have on them. By describing the multifaceted, complex world in which FFN providers deliver child care, we hope to ground the work of programs dedicated to strengthening protective factors to promote well-being, and serving and supporting FFN providers, children and their families to enhance mental health and social and emotional development, to ultimately improve quality of care, early learning, and school readiness.

Characteristics, Considerations, and Perspectives of Families

Participants across the four sites confirmed that, similar to national trends, FFN child care arrangements are most often used by families who tend to be low-income, communities of color, and communities that tend to be marginalized, such as immigrant and undocumented families where English is the secondary language. Our findings also affirm research indicating that trust, safety, parent flexibility, accessibility, cost, a desire to maintain and strengthen family connections, and a belief that children receive more personal attention in FFN care (Anderson, et al., 2005; Brandon, et al., 2002; Bromer, 2006; Brown-Lyons, et al., 2001; Li-Grining & Coley, 2006; Paulsell, et al., 2006; Porter, et al., 2010; Porter, 1998) are some of the primary reasons why families choose FFN care. We learned that, due to the cycle of intergenerational trauma, high levels of trauma-exposure, and chronic fear and stress experienced by children, families, and providers in these vulnerable communities, parents oftentimes look to trusted caretakers in their lives for support. Family members, such as grandparents or aunts, who are the most typical related providers, or close friends or neighbors from similar racial and ethnic backgrounds, give parents the feeling that their children are in the best hands possible so they can focus on financially providing for their families. Participants reported feelings of fear and mistrust when interacting with systems, and the need for a "safety net" of support. FFN child care arrangements seem to help alleviate parents' fears about their children getting hurt, mistreated, or abused while in care. They could more instinctively trust that their children are being genuinely cared for each day by their own family, friends, or neighbors.

> *"If we're looking at high risk populations, there's really not much higher risk than you can get than these folks who are often in the shadows, and really isolated, really unsupported, many, many high risk factors."* — MI, STATE LEADER

> *"A lot of families that we work with choose FFN providers for lots of reasons. Having providers that speak your language, having providers that understand your family and your culture and will give your children affection in a way that doesn't happen in licensed care."* — CO, ECNP

FFN child care is seen as a natural support system where children are cared for in a safe and loving environment and in a culturally and linguistically responsive way with FFN providers having similar values and child care practices. We found that the cultural and linguistic match is pivotal with both parties better able to understand culturally steeped and normative child rearing practices, communicate with one another in the same language, and honor important traditions and customs. This affirms previous research showing cultural and ethnic matches between providers and children are very important to parents, who prefer providers for the transmission of cultural knowledge, values, and practices (Anderson, Ramsburg, & Scott, 2005; Drake, Unti, Greenspoon, & Fawcett, 2004; Guzman, 1999; Howes & Shivers, 2006; Shivers, Howes, Wishard, & Ritchie, 2004; Shivers, Sanders, & Westbrook, 2011; Wishard, Shivers, Howes, & Ritchie, 2003). Additionally, we learned that families who use FFN care are most often dealing with many life stressors and tend to work nontraditional or multiple jobs with off-shift hours (second or third shifts) or rotating shifts, or are in school. These circumstances require flexible child care arrangements that include evening, overnight, weekend, and/or sick care as well as long hours. These considerations make it extremely difficult to rely on and/or afford center-based care. In sum, the study sites described FFN care as an "authentic" child care system that grew naturally, organically, and exponentially, especially in communities with lower socio-economic status and communities of color in need of a culturally responsive, trustworthy, flexible, and cost-effective way to care for their children.

> *"The most important piece of FFNs, I think it's the culture for Latino people. Even for me, it's really hard to take my daughters to day care or to licensed care because of the language. I want to grow my daughters up with Spanish. It's more confident/trusting if you use a friend or your mom or somebody. Time, it's easier if you use a FFN provider. You move your schedule. It's more flexible. Especially for Latinos, if they work in construction, they work on the field, so their shifts are so long so FFN is cheaper, easy to handle."* — CO, MIXED FOCUS GROUP OF MHCS AND ECNPS

Characteristics, Motivations, and Self-Perceptions of Family, Friend, and Neighbor Child Care Providers

A number of studies have relied on surveys to increase understanding of the characteristics of FFN child care providers and the families that utilize FFN child care arrangements (Anderson, Ramsburg, & Scott, 2005; Layzer & Goodson, 2006; NSECE, 2015; Paulsell et al., 2006; Shivers, 2003; Shivers, Yang, & Farago, 2016a). In this vein, we distributed an FFN survey in three of the four sites (n=43) to learn more about the characteristics of the FFN providers in our study cohort. Overall, FFN providers across the sites who participated in our focus groups tended to be from Hispanic racial and ethnic backgrounds (primarily Mexican heritage), between the ages of thirty to fifty years old, with a middle school/junior high, high school, or some college education, are married, and do not work outside the house. The majority are related to the children in their care (primarily foster mothers/mothers, aunts, and grandmothers). About 40% of respondents have had special training in caring for children and about 25% have worked in a center-based child care program or preschool before. Most providers report providing care for sixteen to twenty years and the next most frequent time range was one to five years. Approximately a third provide full-time care of at least six hours per day, 20% report services that vary from day-to-day or week-to-week, and 18% providing part-day care of less than six hours. Some providers also offered night care, overnight care, weekend care, and sick care. Most providers, though, reported stable schedules from week-to-week.

In addition, from the FFN survey, we learned most providers tend to take care of between one to three children and children five years of age and under. In terms of the age range of the children, a third of providers' report taking care of preschool age children between twenty-five to forty-eight months, 30% report taking care of school age children, 26% report taking care of toddlers between twelve to twenty-four months, and 20% report taking care of infants under twelve months of age. Approximately 12% of providers' report taking care of children with physical, emotional, or learning disabilities, including language delays, behavioral, or emotional concerns, physical or gross motor delays, feeding concerns, autism, inadequate self-help skills, special medical needs, sensory integration disorder, and attention deficit/hyperactivity disorder. Most providers report being paid for taking care of children; however, most do not receive payment from the government for individual children. Many providers have a set rate while others stated that it depends on the family's income and ability to pay. Most providers were unlicensed but are considering becoming a licensed FCC provider. Although these self-reported provider characteristics may not be reflective of FFN providers in general, they offer a snapshot of the FFN provider communities in these sites and could be used to better tailor service delivery.

During the interviews and focus groups, FFN child care providers across the four sites reported a range of experience from lived experience taking care of their own children to education and specialized training in early childhood, child development, child care, and/or children's social-emotional development. Of note, a number of FFN providers who immigrated from other counties find that their degrees are not recognized in the United States. Given limited English proficiency, informally caring for young children became an appealing and attainable livelihood. There was also a comfort level caring for children from the same or similar cultural and linguistic backgrounds. Word-of-mouth in close-knit

The vast majority of FFN providers expressed a desire to help and support their families and this primary motivation of the familial relationship was usually the point of entry into FFN care.

communities oftentimes led to referrals to FFN providers. The vast majority of FFN providers, though, expressed a desire to help and support their families and this primary motivation of the familial relationship was usually the point of entry into FFN care. Grandmothers and aunts, most often, became the natural choice for parents, and given their existing attachments to the children, they willingly accepted the responsibility to help their families. This finding affirms that the desire to help the child's parent and child are the primary motivation for providing FFN care (Shivers et al., 2015(b); Susman-Stillman & Banghart, 2011).

Across the sites, FFN providers also expressed a special interest in giving children the emotional attention they need, teaching them, listening to them, and engaging in developmentally appropriate activities with them, so they do not feel alone, but feel loved and part of a family, make progress when they are struggling, can flourish in their development, and be prepared for school. By attending to the unmet needs of the children in their care, FFN providers are working to create the most nurturing environments for children to learn, grow, and thrive. A genuine interest in children and supporting their healthy social and emotional development gives providers a sense of purpose. We learned that financial compensation is not a primary motivating factor for the majority of FFN providers across the sites. Where it is a factor, such as when the provider is already struggling financially, it can be a point of contention between parents and providers, and state-instituted payment systems can be extremely challenging.

> *"First of all to support my own family, my daughter, in her role as a mom and above all things, make the child be part of a family. Because if the child is outside of the family circle—mom, dad—maybe seeing there is a family around him…that they don't feel alone and away from home. That we can see how they grow up and develop their abilities and that they grow up with role models…"* — AZ, FFN PROVIDER

Many of the FFN providers did not self-identify as FFN providers per se and thought of themselves, for example, as a grandmother taking care of her grandchild to help her daughter. Since most of the providers across the four sites reported being related to the children in their care, the relationship is seen as familial and not often within the confines of the child care arrangement. As such, this self-perception can make programmatic outreach and recruitment of so called "FFN providers" much more difficult. These providers may want support, but the formal title delineating who is being recruited for services and supports may not resonate. Interestingly, participants used multiple, varied terms during the interviews and focus groups to describe the continuum of child care from informal, unregulated child care providers (e.g., FFN providers) to formal, regulated child care providers (e.g., center-based providers). Although these terms are helpful in describing the types of child care providers and the evolving terminology circulating in the field, FFN providers tend not to think of themselves as part of the conventional child care field and their self-perceptions matter for program outreach and engagement.

> *"Even if you ask, "Do you offer child care?" "No, I just stay at home with my granddaughters." They don't think of themselves as FFN. They're just helping somebody…They just say, "I'm not a child care provider."* — CO, MIXED FOCUS GROUP OF MHCS AND ECNPS

> *"PASO (Providers Advancing Student Outcomes) really was looking at those family, friend, and neighbor providers who maybe didn't know they were family, friend, and neighbor providers to help them [with] workforce development, not just licensing."* — CO, MIXED FOCUS GROUP OF MHCS AND ECNPS

Loosely, the terms used by the study participants in the focus groups and interviews to describe the continuum of child care providers includes:

- grandparents,
- grandmothers,
- relatives,
- relative providers,
- family members,
- aunts,
- friends,
- neighbors,
- legal babysitters,
- community child care providers,
- FFN providers,
- FFN caregivers,
- kith and kin providers,
- informal child care providers,
- unlicensed informal care providers,
- license-exempt child care providers,
- unlicensed subsidized providers,
- uncertified relative providers,
- qualified providers,
- qualified exempt providers,
- home care providers,
- licensed home care providers,
- family child care home providers,
- home-based care providers,
- regulated child care providers,
- center-based care providers,
- certified or licensed providers,
- and child care center providers.

Family, Friend, and Neighbor Experts and Quality of Care

In seeking to understand the FFN child care landscape, it became clear that there is a tension around the professionalization of FFN care. There is a subset of FFN providers who want to become more "professional" by getting licensed, becoming a home-based business, and engaging in more professional development in order to become a teacher at a local early care and education center. For example, in San Francisco, we spoke to licensed FCC providers who shared their journeys toward licensure and how programmatic services and supports, especially IECMHC, are pivotal. These providers were extremely proud to be licensed and expressed pride in the work and dedication it took to achieve this accreditation. Many FFN providers though simply want to help their families and perhaps add some money to the household income. Therefore, increased professionalism can also include accessing needed networks of support, attending trainings and workshops to enhance knowledge and capacity, and gathering advice for how to handle concerns with children. Expertise can be greatly bolstered by training and educational opportunities regardless of whether those activities are linked to the goal of licensure. There seems to be a need to conceptualize and support a continuum of services and supports that would be available to FFN providers, including, but not limited to, moving them along the professional development continuum. Within this continuum, there is the potential for IECMHC to play a role for FFN providers, given its effectiveness for other early care and education providers and families.

> *"There are some that are just not interested in becoming licensed. They just want to watch their relative children, but even in watching their relative children, they can get access to resources and needs."* — CO, STATE ADMINISTRATOR

For a number of FFN child care providers, there is no motivation or desire to get formally licensed. They want to offer the best child care possible, but they may prefer or have to stay unlicensed for different reasons. They may be ineligible for licensing due to legal status or other personal or household constraints such as a family member with a felony record living in the house. The costs associated with going through the licensing process, paperwork and documentation, and/or the time commitment may be deterrents as well. Others may be too stressed or overextended. That leaves a subgroup where licensing will never be the goal or an option. Even if FFN providers are hesitant to get licensed, many

are extremely eager for more training and support opportunities, which connect them to the formal system. Since we spoke to providers who are connected to the system, the desire to improve was resoundingly present whether they had their sights set on getting licensed or not. Through linkages to programmatic services and supports, there are opportunities to impact FFN providers' sense of self as a child care expert, and ultimately the quality of care provided.

> *"It's just expensive to go through that licensing process."* — CO, MIXED FOCUS GROUP OF MHCS AND ECNPS

> *"The big problem is trying to professionalize these women. Professional ain't better than nonprofessional."* — SF, MENTAL HEALTH DIRECTOR

A key finding is that FFN providers are able to develop a sense of self as a child care/development expert without being licensed. Exploring ways to increase the quality of FFN care can be done without imposing added regulations on FFN providers. In fact, increased regulations and requirements for license-exempt providers, as a result of the 2016 Child Care and Development Block Grant (CCDBG) regulations[11], may present more barriers for FFN providers and may have an unintended consequence of driving them back into the shadows. It is important to balance the need for regulations to ensure the safety of children and what is feasible and realistic for FFN providers to accomplish with support. In lieu of looking at FFN providers as "other" and what they are not, it is more helpful to invoke a strengths-based approach and focus on the positive impact that FFN providers can have on the lives of the children in their care and work to support their efforts in more accessible and coordinated ways. The four sites demonstrate that MHCs, ECNPs, and peers can be powerful support systems for FFN and FCC providers by providing an array of culturally relevant services and supports to bolster capacity and attending to the mental well-being of providers who are often isolated, undervalued, and stressed.

> *"We are not trying to create licensed child care providers out of people who do not want to be them. We are trying to improve the quality of care, regardless of where children are."* — MI, ORGANIZATION LEADER

"Family child care providers who intentionally seek out opportunities to learn more about child care and education are also those people who create the most nurturing and educational environments. These are intentional providers who offer warmer and higher quality child care" (Galinsky, 1994). Intentionality, or how a child care provider views their role in children's lives, their motivations for providing care, how they organize their day, and so on are important factors in determining a high quality child setting and could be factors in whether or not they pursue additional training and support—including technical assistance for licensing/regulations (Kontos, Howes, Shinn, & Galinsky, 1995). When FFN providers see a shift acknowledging that what they are doing really matters for the children beyond providing care while the parents work, it can be a pivotal moment. Further, when FFN providers feel a sense of greater self-efficacy or belief in their ability to complete tasks and reach goals, this self-affirming, can-do attitude can propel them to more fully engage in services and supports. Programs can support FFN intentionality and self-efficacy by increasing capacity, providing tools for greater self-reflection, helping providers take pride in their work, seeing the value of their work, seeing themselves as experts, and assisting with the formulation of goals and action steps. Each of the sites studied supported provider intentionality and self-efficacy in complementary ways to augment caregiver well-being and children's social and emotional health.

[11] https://www.acf.hhs.gov/occ/ccdf-reauthorization

> *"Oh, what I do really matters for this child beyond just providing custodial care while the parents work. Oh wow, OK." That is the first thing to shift."* — AZ, ORGANIZATION LEADER

> *"...a barrier that very few of them consider themselves professionals and lack of either confidence or validation or both when it comes to just the invaluable importance that they have in these infant-toddler relationships[s] and how crucial they are in their development, specifically around emotion. What I've noticed too, and what I've heard is, when providers hear and get that validation, that can be a game changer for them...when they start to realize, "Oh, I do play a really valuable role in these little one's lives, in these families' lives."* — MI, SEC

Mistrust of Systems and the Need for Cultural Brokers

Given the difficulty with self-identification as FFN child care providers and anxieties around formal institutions, in the sites we visited, the FFN support networks were well-established community-based organizations with outreach via cultural brokers to settings frequented by FFN providers and the young children they serve. Due to the mistrust and fear inherent and present in communities that have been marginalized, collaboration with trusted programs that have been vetted by the community is essential. Therefore, a key finding is the importance of partnering with trusted community entities, such as community centers, community-based organizations, family resource centers, faith-based organizations, Head Start programs, schools, libraries, and nonprofits as an entrée into identifying, recruiting, and engaging with FFN providers and families to deliver programmatic services and supports, such as training, peer supports, and IECMHC. Utilizing a community-centric approach indicates that the protective factors of community and social connections are valued and leverages them to promote health and well-being and minimize risk factors.

> *"The whole concept of cultural broker really helped a lot...because if you have a person that looks like you and talks like you, etc., it's easier to bring people to the table."*
> — CO, MIXED FOCUS GROUP OF PROGRAM LEADERS AND TIAS

Another key finding involved an exploration of FFN providers' interactions with larger systems and the implications for enhancing human and cultural capital (Shivers, Yang, & Farago, 2016b; Vesely, Ewaida, & Kearney, 2012). Complicating FFN provider outreach, recruitment, and engagement are multiple fears that are important to acknowledge and allay. These fears include concerns that utilizing program services and supports may bring families to the attention of child-serving systems, such as Child Welfare. Providers and parents worry that child rearing practices, which may be historically rooted and culturally normative, may place them in a vulnerable position in the United States where they may not be viewed as acceptable. Programs designed to support FFN providers may be seen as part of the "system" and providers and families are afraid of being tracked, monitored, or reported. The onus is on FFN support networks to acknowledge these fears, listen without judgment, and work to assure providers and families that they only want to provide support and are not there to get them in trouble. There are also deep-seated fears for some around legal status. On one end, FFN providers may be afraid to get involved in programs because they worry their immigration status will be exposed and it will have a detrimental impact. On the other end, potential funders and program collaborators may be unsure and/or concerned about working with providers who are undocumented and how this might affect funding. Given these fears, early childhood networks of support are uniquely situated to outreach, engage, and provide culturally and linguistically appropriate services and supports that are tailor-made to address the needs of providers and families in their particular communities.

> *"It even extends out to our partnerships in the community. We're very strategic when we're trying to plan on delivering the training and support for the family, friend, and neighbor community. We collaborate with different agencies, at Head Starts or community centers. We try to tap into those communities and go into the agency to deliver. In that way, we're able to gain trust. If they're already trusting Head Start or they trust the community center that they're coming to, then they know we're not some random agency or program coming through to deliver this information to them."*
> — AZ, EARLY CHILDHOOD SPECIALIST

Participants spoke about the grassroots approach taken by early childhood networks of support and how program offerings grew due to personalized outreach at strategic locations, word-of-mouth, going door-to-door, and being visible throughout the community. There was also mention of staff dedicated to marketing and communications, use of social media, and fliers and advertisements to recruit FFN providers. Once connected, program staff often circle back to increase awareness of and access to relevant and valuable community resources to support providers and their efforts to provide the best care possible to young children. Program staff also realize that within Maslow's hierarchy of needs (Maslow, 1943), FFN providers and families must attend to basic needs, such as food, water, warmth, and rest, before they can attend to psychological and self-fulfillment needs. Quality of care cannot be enhanced if the most minimal of needs are not being adequately met. As such, program staff directly provide or make linkages to community resources to help with any unfulfilled basic needs to better enable FFN providers and families to partake of services and supports.

> *"...the difficulty is the traditional format of recruiting licensed providers or child care center staff doesn't work for our [FFN providers]. It is really hitting the ground through word of mouth."* — CO, ECNP

> *"We've learned that it's word of mouth. That is how the program has really grown. People tell their friend or somebody else down the street, "Oh I go to this great meeting. I get away from the kids. I learn what to do with them." The word of mouth has really spread for this program...Our most successful partnerships to get started were with Head Start, because they were already working with the families."*
> — AZ, FORMER PROGRAM DIRECTOR

Barriers Experienced by Providers

In addition to the historic, systemic, and socio-economic barriers faced by FFN child care providers and families that cause tremendous stress, such as lack of basic needs, chronic fear, legal status, discrimination, linguistic hurdles, disparities in access and health outcomes, traumatic experiences, violence, poverty, and economic instability, there are barriers specific to FFN care that make it especially difficult to be an FFN provider. These challenges run the gamut from complex family dynamics and difficult interactions with parents to financial hardships and low payment systems to stigma and an unfavorable view of mental health and use of services and supports. There is also a lack of access to services and supports specifically for FFN providers, including IECMHC, which is often seen as more of a center-based intervention and less of a home-based strategy and mostly only sanctioned for licensed providers excluding unlicensed, FFN providers. Policy and funding restrictions need to be addressed to broaden access and availability. There needs to be recognition at the state level that with the majority of children in FFN care, caregiver health and well-being are essential to high quality child care and need to be prioritized through increased training and educational opportunities. For FFN providers who are already in the shadows feeling alone and unsupported, lack of access to needed individualized services, most especially mental health-related supports, can impact the provision and quality of child care for some of the most vulnerable children. Participants at each of the four sites we visited articulated barriers to FFN care, and most of these difficulties are highlighted as context for program design and delivery. We highlight three key findings about barriers below.

Family System Dynamics

Although most families prefer a relative to care for their young children, FFN child care providers also report that complicated family dynamics often add to the stress of working with young children (Anderson et al., 2005; Bromer & Henley, 2004; Porter, Rice, & Mabon, 2003). In our study, we discovered many examples of these specific challenges. Providers sometimes worried that parents were slow to acknowledge developmental delays, behavior problems, or social-emotional issues with their children, making it more difficult to intervene early. Further, providers discussed boundary issues with parents' not being considerate or cognizant of space, time, and payment concerns. FFN providers may also not have enough emotional reserve or support to care for parents who may be going through divorce, custody battles, immigration issues, and so on. The stresses of taking care of both the child and the parent can take a huge emotional toll on providers, who are already overburdened.

> *"Oftentimes [grandparents] come up to me and say, "Oh, my God. I've already tried talking with my daughter. It's so frustrating. We just see things so differently around how to talk to the child or how to even discipline him."* — SF, MHC

Complex family dynamics also made it difficult for FFN child care providers to express social-emotional health and child development concerns to parents and families. Providers expressed discomfort and/or hesitancy presenting concerns to parents due to lack of background knowledge, credibility, or a fear that the parents would be defensive or offended about the topic. As a way to avoid exacerbating family tensions, FFN providers often asked ECNPs to bring any concerns to the family's attention or act as their ally in joint conversations. Generally, program staff will explain to parents the importance of early intervention, reiterate the need for referrals or assessments, if needed, and urge the child's parents to put the child's welfare above all other concerns. This tactic of involving program staff in interactions with parents tends to bring a greater level of legitimacy and urgency to the issues and may mitigate some complicated family dynamics. The partnership between all parties to assure the best outcomes for young children is extremely affirming.

> *"Sometimes I need a little bit of help...The child needs help and if we can provide the help early, it's better than later. I'll usually recommend to the parents, if a child needs help, it's better to give it now than later."* — SF, FCC PROVIDER

Payment and Funding Structures

Barriers with regard to payment and funding for FFN care and related services and supports involve the family dynamic as well as federal regulations, state policies and structures, and contractual stipulations. Subsidy payments tend to go directly to parents who may not pay providers, which may cause stress and strife in families. Subsidy payments also tend to be extremely low, which does not incentivize providers to engage with the system to become a license-exempt subsidized provider or participate in a state's Quality Rating Improvement System (QRIS). QRIS is a systemic approach to assess, improve, and communicate the level of quality in early and school-age care and education programs (National Center on Early Childhood Quality Assurance[12]). Lack of adequate compensation can put further pressure on providers and families who may already be struggling financially. Further, funding is a challenge as some programs' funding may be lacking, unstable, or in competition with other programs. Limited funding trickles down to limited services for FFN providers, children, and families who are already receiving little to no support. In fact, early childhood MHCs are typically only sanctioned in grants, contracts, Standards of Practice, and so on to work with licensed providers, leaving FFN providers unable to

[12] https://qrisguide.acf.hhs.gov

access more individualized consultation. These multiple challenges are most aptly described within the state specific context.

For example, in Michigan, in 2005, there were approximately 65,000 unlicensed FFN providers and they were primarily receiving the child care subsidy. Then, in 2010, there was a legislative requirement to add an orientation training and start criminal background checks for eligibility for the subsidy. More specifically, FFN providers can be enrolled by the state in the subsidy program if they complete an application, take a seven-hour orientation class covering health and safety topics, first aid, and cardiopulmonary resuscitation (CPR), agree to background checks, and complete a phone interview, all of which can be tremendously burdensome on providers who are already overextended. That year, 18,000 unlicensed providers were trained and met the requirement. Now, the state is down to no more than 7,000 unlicensed providers. Such a dramatic shift could leave sizeable gaps in care for the families most in need. This dilemma reiterates the need to balance safety measures to protect children and feasibility considerations on the FFN provider side. It also has implications at the program level for supporting FFN providers.

Additionally, in Michigan, due to tax law, the payment structure for subsidy payments goes to the parents and it is their responsibility to pay the FFN provider. In 2005, a technical assistance memo was issued by the federal government to the state declaring that payments must be made in this manner or a fine would be incurred. Therefore, the choice was either two-party payments with checks having both the provider and parent names or direct payments to the parents. Since the majority of banks will only accept two-party checks if one of the individuals has a bank account and both parties must be present to sign the check, the state weighed these less-than-ideal options and chose to pay parents. The practical ramification of this decision is that due to complex family dynamics, payments to providers oftentimes do not happen, making money a point of contention. For FFN providers, this can leave them with the financial burden of caring for children without compensation, and also paying their bills. With family, it is not a business relationship; therefore, payment for "services" can get muddy.

> *"...the payment structure causes pretty significant strife in some families. If you have a tenuous relationship with your daughter who you're providing child care for 90 hours a week, and then she does not pay you, you might decide that being in this program where you have to get online, and figure out how to bill, and all of these things, is not worth not getting paid."* —MI, QIC

In Michigan, FFN providers who are eligible for the subsidy and complete the orientation training and satisfy the additional requirements make $1.35/hour. After an additional ten hours of training, there is a $.0.50/hour increase to $1.85/hour. If providers have at least one child under six, then the raise after an additional ten hours of training is $2.20/hour. The minimally low payment rates set by the Michigan state legislature, in an attempt to move FFN providers along the continuum to licensure, is detrimental to the most vulnerable providers and families. Providers dealing with financial burdens, life stressors, and complex family dynamics can experience decreased mental wellness. Lack of adequate financial compensation could adversely impact the number of FFN providers offering care or coming out of the shadows to seek resources and support to better care for themselves and the children in their care. A lack of FFN providers to serve families with nontraditional jobs and hours could also leave a huge gap in care for some of the most vulnerable children. Without re-examination and re-structuring to acknowledge and adequately compensate FFN providers for their critical role in the child care continuum, providers will continue to operate at a deficit. Unless reimbursements are recalibrated, families with the highest need may not be able to afford high quality care. In Michigan, a current proposal to increase rates for all provider types based on the market rate for family homes is a first step in the right direction.

There is also a tremendous need for infant and toddler care in Michigan. Funds are earmarked for school age children, three to five years old, with free preschool and free child care through the Great Start to Readiness Program. However, this leaves very few slots for infants and toddlers, 0-3 years old. There is also a shortage of qualified providers for infant and toddler care. A participant shared that FFN providers do not want to care for infants because of the risk of sudden infant death syndrome (SIDS) and safe sleep concerns. These, along with other concerns, have led to a gap in child care providers across counties and ongoing conversations are occurring to try to fill the need. An increased subsidy for infant and toddler care beyond the small incentive currently in effect may be a way to incentivize more providers, as would more trainings and support to address concerns specific to infant and toddler care such as SIDS, infant safe sleep practices, developmental milestones, and so on.

Further compounding the FFN landscape in Michigan is the Flint water crisis, where "due to insufficient water treatment, lead leached from the lead water pipes into the drinking water exposing more than 100,000 residents."[13] This devastating event exacerbated feelings of mistrust and made providers and families even more hesitant to get involved in services and supports thinking, *"I don't want a professional coming into my home. I don't know that I can trust them."* (MI, Social-Emotional Consultant). Due to the water crisis, if parents have a child three years of age or younger who was exposed, they qualify for up to twenty hours of free child care whether they still live in Flint, or not. For the child care subsidy to be utilized, however, the child care still needs to be in Flint. This financial stipulation further complicates child care considerations for families that may have providers outside the city limits but are still dealing with the health and psychological toll of lead exposure. Programmatic supports to help alleviate some concerns for providers and families include buying water cooler towers and getting hoop house vouchers for access to fresh food. Despite these services and supports, the parameters around use of the child care subsidy may put additional stress on families already grappling with a public health emergency.

> *"As soon as that broke—as soon as people acknowledged it was real—we asked whether or not we can distribute water coolers through basic health and safety, and it was an immediate yes. I think that that was probably one of the reasons those cohorts have people who have stayed there longest, because there is an immediate need and it was immediately met."* — MI, ORGANIZATION LEADER

In San Francisco, there is an inability to provide individualized, one-on-one consultation to unlicensed FFN child care providers due to funding barriers. Because of a contract stipulation, in-depth consultation can only be provided to licensed FCC providers leaving license-exempt FFN providers without access to these beneficial supports. Previously, Instituto Familiar de la Raza's (IFR) support groups could be an avenue for obtaining formal IECMHC. Although the support groups remain open to a mix of licensed and unlicensed providers, FCC providers are the primary attendees now with very few FFN providers attending and participating. Given this constraint, San Francisco has been innovative in developing mental health consultation services through other portals such as Family Resource Centers (FRCs) where many FFN providers attend programming. At IFR, for instance, FRC staff at Casa Corazón can identify FFN providers who need individualized consultation and provide a warm hand off to link FFN providers to IECMHC. The strategic partnership between these ECNPs and MHCs to ensure an avenue for FFN providers to access consultative supports is a creative workaround in San Francisco that could be a model for other communities, states, and jurisdictions.

[13] https://en.wikipedia.org/wiki/Flint_water_crisis

> *"The Early Childhood Mental Health Consultants' initiative, they changed our contracts so that we could only provide more indepth consultation to licensed family child care providers. Our charla that you saw used to have much more of a mix. We said, "We, we'll do that, but you know what? We're not disinviting anyone."...the charla itself, it needs to be a community. We're not gonna close our doors on people."* — SF, PROGRAM DIRECTOR

Additionally, in San Francisco, as in many states, they acknowledged struggling with quality improvement efforts for licensed and unlicensed providers. They have not done as much quality improvement work as they would want with the FCC sector though they want home-based providers to participate and stay engaged with programming to improve quality of care in these settings. On the upside, San Francisco uniquely has a lot of funding going to FCC providers, there are networks of support for FCC providers, and they are a part of the formal QRIS. So, they are primed to engage in more quality improvement efforts with FCC providers. This critical alignment between priorities and funding could provide a call to action for San Francisco as well as other communities and states to better engage with unlicensed FFN providers around quality improvement efforts and what that might entail. Lessons learned from quality improvement projects with FCC providers could help inform what quality of care could look like in FFN settings.

In Colorado, the Providers Advancing Student Outcomes (PASO) training program did not have an ongoing source of financial support in the beginning. They creatively and successfully used bridge funding and leveraged progress into additional funding to grow their cohorts and replicate the program. They also applied for grants from different types of entities, such as the Statewide Strategic Use Fund, a social innovation fund from Mile High United Way, and foundation funds. The strategic blending and braiding of funds is a strong lesson learned for other sites looking to refine, grow, and evaluate their programs. Further, in Colorado, a split in funding for the early learning initiative and mental health consultation services has created a burden for programs to continue providing IECMHC. Given that Colorado is a local control state with local leaders possessing a great amount of authority over how to reach goals and implement programs, most mental health consultation programs grew on their own. This has led to multiple service delivery models used in multiple sites across the state, which can lead to inconsistency and lack of continuity. Importantly, in Colorado, Cultivando learned during home visits with approximately sixty FFN providers that none of the providers was being paid more than $1.00/hour for a child. Providers who took care of children upwards of fourteen to sixteen hours a day tended to earn no more than $10-$12/day for that child. Despite the minimal amount, providers oftentimes were not paid and would continue to provide care with no financial compensation.

In Arizona, FFN child care providers are also getting paid very little. According to a study by Indigo Cultural Center, Inc. (Shivers et al., 2016b), in a sample of 4,500 providers who were surveyed, the average amount they received every week was $16 from the child care subsidy, given to them by the parents. As previously stated, parents may not pay providers making payments a point of contention in families. Further, 1.8% of the providers in this study reported receiving public child care subsidies. This indicates that there is an extremely small percentage of families using their child care subsidy for their license-exempt providers. This underscores that most FFN providers are not part of any system. It is all through private arrangements. *"They are getting paid very little, and there's a lot of bartering that does go on."* (AZ, Organization Leader). Unfortunately, this is echoed across the country and highlights the need for a closer look at the structure and impact of subsidies and whether they are meeting their intended goal of subsidizing families most in need (Shivers et al., 2016b).

Additionally, in Arizona, First Things First[14] is an important public funding source, created by the tobacco tax, dedicated exclusively to early childhood and supporting the healthy development and learning of Arizona's young children from birth to age five. With a focus on early childhood systems building, there are twenty-eight regional councils each having a budget and local control. Their job is to respond to regional needs and select strategies from an array of early childhood strategies in three areas, which include children's health, early learning, and family support and literacy. First Things First is the largest investment in the country right now for FFN care with over $3 million for the state, including the tribal regions. First Things First also funds Smart Support—Arizona's IECMHC program. IECMHC is seen as a preventive health strategy funded regionally, and funding from First Things First is leveraged with a Preschool Development Grant through the Department of Education with a collective pool of over $4 million.

There has been an increase in First Things First IECMHC funding being expanded to diverse settings other than center-based child care (e.g., home visitation programs), and now First Things First is again interested in extending IECMHC to FFN care. For a region to fund IECMHC for FFN providers, they must also fund IECMHC for centers and sites so there are staff available to be deployed. For regions with no investment in consultation but an interest in FFN care, they are not permitted at this time to fund IECMHC for only FFN settings. This is a systems barrier that will require thinking through with partners. In FY 2018 and FY 2019, Pinal County and Phoenix South Regions invested in IECMHC for FFN care and there is growing interest by other councils. First Things First's Standards of Practice, however, did not initially allow for direct consultation in FFN settings. IECMHC was expected, instead, to be targeted toward FFN/early childhood specialists and trainers. Thus, the indirect model piloted by Smart Support and the Arizona Kith and Kin Project was initiated. However, following further discussions after our site visit, First Thing's First's Standards of Practice were amended to allow for MHCs to provide IECMHC directly to FFN providers. Such a policy change with language modifications and restructured funding represents expanded views of IECMHC models. With funds to back this newly articulated commitment, it will be exciting to see how the intersection of IECMHC with FFN care continues to evolve in Arizona.

> *"We will adjust our Standards of Practice to what we know works and what we know other people are doing. As we collectively as a nation figure out what mental health consultation should look like for FFN and home visitation, that's where you see our Standards of Practice grow, develop, evolve."*
> — AZ, STATE ADMINISTRATOR

Stigma and Perspectives on Mental Health

The National Alliance on Mental Illness (2017) reports a myriad of reasons why marginalized communities have limited access to quality mental health care. A commonly cited reason includes cultural stigma that is steeped in a history of discrimination, bias, and other systemic barriers (Bussing & Gary, 2012). In our study, we similarly found that negative experiences with systems and being subject to racial and ethnic discrimination are barriers that keep many FFN child care providers and families from wanting to access needed mental health and other services and supports. Participants across the four sites also described an unfavorable view of mental health in general, which likely impedes candid conversations about the need for and use of mental health services and supports. Stigma is associated with the words mental health. Stigma is associated with use of mental health services. With mental health being a taboo word, outreach efforts focused on improving the mental health and well-being of FFN providers and families must be strategic in their messaging. Word choice

[14] https://www.firstthingsfirst.org

and perception matter in terms of engaging providers and families who may be averse to discussing mental health concerns and/or accepting mental health services.

> *"Mental health is one of those taboo things. We need to not use that word with families…I think that shifting that to say, "You deserve to care for yourself," and self-care, and really acknowledging that they have a lot to offer and they need support as well."* — CO, ECNP

For example, in Michigan, their cadre of MHCs are called Social-Emotional Consultants (SECs). This was deliberate naming to encourage openness and receptiveness. It was purposeful non-use of the words, mental health, to avoid stigma. Consultants working with FFN and other home-based providers, such as Quality Improvement Consultants (QICs) and Family Engagement Consultants (FECs), use the words social-emotional health in lieu of mental health to more comfortably draw in providers and families. They explain that they are providing resources and supports to caregivers so they are better able to take care of themselves and effectively engage with families to meet the many needs of children in their care. By framing mental health support as "education" and/or "self-care," sites reported greater opportunities for ECNP program staff to stay connected to providers, children, and families to address any underlying mental health-related issues.

> *"You must make them feel comfortable, right? I don't use mental health when talking to most of the parents. I don't want to say it like too serious. We tell them the consultant is a specialist, who has a related special education background and can help with the children's behaviors and emotions. The purpose is to help the kids and you guys. We introduce them to the family in this way."* — SF, FCC PROVIDER

Similarly, FFN providers experience difficulty communicating concerns about children's mental and behavioral health to parents due to stigma. Children may not get the services they need early, compounding issues in the future. Oftentimes, parents' inability to hear or talk about their children's behavior stems from fear of having their children labeled or diagnosed with mental health concerns or even being taken away from them. This being so, the effort to engage families acknowledges those fears and utilizes supportive language to allay concerns and mediate help. Program staff, particularly MHCs and ECNPs, support providers to broach these difficult topics with parents and work to elicit needed referrals and assessments for children and families to identify and treat any problems.

> *"Culturally, I think seeking out psicólogo is, "Whatever, that's not me. I don't have problems. I'm not crazy." There's a lot of stigma to that word mental or mental health. They just don't want to be associated with having a problem. Who does?"* — SF, MHC

Unlike a health condition for which it is acceptable to go to a doctor, a mental health condition cannot always be openly spoken about or treated. Participants talked about cultural myths that perpetuate the perception that mental health concerns are not illnesses and those with mental health issues are simply "crazy." With many providers and families neglecting their mental well-being and not attending to issues that may escalate, there is a tremendous need for safe, easily accessible, and affordable mental health related services and supports. As a counterpoint to these cultural and societal fallacies, San Francisco has taken a culturally driven, strengths-based approach to discussing mental health and emotional well-being to overcome taboos, stigma, fear, and prejudice. IFR has chosen to focus on resiliency and inherent strengths instead of the historic focus on pathology and the need to fix pathology.

IFR utilizes a cultural frame for the services and supports they provide. They believe that culture provides a set of values by which communities are able to maintain healthy relationships. Culture regulates the capacity to maintain wellness at the individual, family, and community levels when

spirituality, mental, and physical health are recognized. IFR is working to change perceptions around mental health in this culturally informed manner. Staff hold both the "cargas" burdens and "regalos" gifts of the individual, family, and community, acknowledging that "cargas" come from past, present, and future history. With understanding of historical and intergenerational stories, and provision of cultural affirmation, healing can occur. Their insistence on cultural matches between MHCs and FCC providers may be one reason why they have been successful in combating fears and engaging providers and families who are hesitant or nervous. The trusting relationships formed with the program staff or "comadres" leaves providers and families feeling safe and able to access much needed services and supports to improve their mental well-being, better attend to children's social and emotional health, and ultimately enhance quality of care and child and family outcomes.

Mental Health Concerns of Providers

Since FFN child care providers and families have experienced the negative impacts of historic, systemic, cultural and ethnic, and socio-economic barriers, programs dedicated to supporting them must first focus on building relationships and trust to mitigate some of these barriers. Then everyone will be in a better position to identify and begin to address risk factors and mental health needs. While mental health-related services and supports may be much needed, they are largely unsupported for the FFN provider community. By understanding the distinct needs of FFN providers, programs can better target their offerings, materials, and resources to create focused professional development opportunities to meet these needs. This is also an argument for piloting of IECMHC in FFN care settings, which is basically nonexistent. During the site visits, we learned that on the provider side, mental health needs are systemic and personal. Though this list is not exhaustive of all the stressors experienced by FFN providers, it provides insight into the extenuating and complicated needs of many FFN providers.

In particular, the mental health needs of FFN child care providers are related to:

- family-related stress,
- primary trauma,
- secondary trauma (from helping children and family members who may have been traumatized or are suffering),
- financial burdens,
- immigration-related stress,
- lack of stress management skills,
- poor self-care,
- burnout,
- limited developmental knowledge and child rearing strategies to address challenging behaviors,
- low self-efficacy (FFNs do not realize the important role they may play in children's development or believe they can accomplish change),
- social isolation,
- depression, and
- anxiety.

> *"That workforce development support…It's contributing to the burnout because there's not that distinct separation between home and work. It's all together. The emotions that are tied just get a lot messier or can get a lot messier when you have one space holding both of those experiences for you."* — MI, SEC

We also learned about needs specific to the healthy social and emotional development and mental well-being of children in FFN care settings. According to the Center of Excellence in IECMHC[15], social and emotional health—the ability to form strong relationships, solve problems, and express and manage emotions—is critical for school readiness and lifelong success. "Without it, young children are more likely to have difficulty experiencing or showing emotions, which may lead to withdrawal from social activities and maintaining distance from others, have trouble making friends and getting along with others, and have behavior problems, such as biting, hitting, using unkind words, or bullying—behaviors that often lead to difficulty with learning, suspension or expulsion, and later school dropout" (Center of Excellence for IECMHC, 2018[16]). Visits to the sites affirmed the presence of these developmental issues and challenging behaviors for children in FFN settings that requires increased prevention and early intervention efforts.

The child development and mental health concerns for children in FFN child care include:

- delayed developmental milestones,
- language delays,
- speech concerns,
- witnessing violence,
- trauma-related behaviors,
- withdrawing and isolating behaviors,
- self-regulation difficulties,
- aggressive behaviors (e.g., biting, hitting, throwing),
- expulsion from day care centers, and
- early signs of mental health and developmental disorders (e.g., attention-deficit/hyperactivity disorder, autism, post-traumatic stress disorder).

> *"I don't know how you help, for example, children who are here undocumented, who are being cared for by providers that are here undocumented and all of the echoes of that experience which are constant. How do you develop with a feeling of constant anxiety or threat?"* — AZ PROGRAM DIRECTOR

As previously mentioned, one of the major themes that surfaced was the FFN and family members' resistance to hearing child development/mental health concerns. As in the transtheoretical model stages of change and motivational interviewing frameworks (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992), there is an emphasis on allowing the parent or provider to initiate their own readiness to change instead of superimposing change or intervention upon them (DiClemente & Velasquez, 2002). FFN providers and/or MHCs or ECNPs often utilize creative approaches to present their social-emotional or child development concerns to parents and families. Through their awareness of the negative impacts of stigma, they are able to implicitly inform FFN providers and/or families about available resources to help them learn about red flags in child development and understand the importance of early intervention. The hope is that by gaining child development knowledge, FFN providers and families will identify any developmental issues with their children and seek out or accept referrals to obtain any needed assessments or supports.

[15,16] https://www.samhsa.gov/iecmhc

Elements of Successful Program Models Serving Family, Friend, and Neighbor Child Care Providers

Given the complex landscape within which FFN child care providers, children, and families live, work, and play, programs serving FFN providers are acutely aware of the impact of these contextual factors and have developed training and educational opportunities to alleviate stressors, increase protective factors, and strengthen intentionality and self-efficacy to improve caregiver well-being and quality of care. Embracing an equity lens, if we want all young children to be socially and emotionally healthy and grow and learn in high quality environments, then an array of services and supports must be developed and accessible to all child care providers, most especially FFN providers who care for the majority of young children and receive little to no support. In this section, we will describe elements of successful program models serving FFN providers and families, and how these components are anchored by leadership, embedded into the organizational culture, and used as guideposts by staff to effectively deliver program offerings.

The protective factors of community, social connections, and culture are exemplified by early childhood networks of support with professional trained coaches and mentors that can help mitigate some of the aforementioned risk factors that can negatively impact health and well-being. These FFN support programs work to impart knowledge and skills and change attitudes, perceptions, and behaviors. Training and support have had a demonstrated impact on intentionality and self-efficacy, enabling FFN providers to see the value of their caregiver role, and strengthening their belief in their ability to complete tasks and reach goals. Within a theory of change, if FFN providers are strongly attached to community resources and culturally and linguistically relevant programmatic supports to bolster their personal growth and augment their professional development, then they will transmit those learnings to children in their care and their families. By strengthening the protective factors of community, social connections, and culture, programs are surrounding providers with a safety net of support. Affecting provider perception, intentionality, and capacity thereby affects higher level desired outcomes, such as improved caregiver well-being, children's social and emotional health, quality of care, early learning, and school readiness. The FFN provider and family-serving programs that seem to be the most successful at accomplishing these changes tend to focus on certain levers of change. These levers are supported by leadership-driven organizations and activated through relationships, including peer relationships and community connections, cultural and linguistic relevancy, and capacity building and self-efficacy.

> *"We know FFNs are out there. We're all working really hard on trying to provide the best program that fits FFNs."* — CO, PROGRAM LEADER

The four sites all attended to critical relationships between the FFN and FCC providers, children, families, MHCs, ECNPs, and other program staff. With increased emphasis on the importance of process elements of quality, our study findings affirm the importance of this shift with relationships being a critical driver of change. Successful outreach, recruitment, and engagement are predicated on strong relationships between providers and program staff. We will describe how within the confines of these safe and trusting relationships, providers are better able to gain valuable knowledge and skills to improve child care and attend to their mental well-being. We will also discuss the need to create opportunities for connection that are culturally and linguistically appropriate. Whether through cultural brokers, by culturally matching, or being culturally humble and curious, we learned that FFN providers are much more comfortable and invested in receiving ongoing services and supports when their race, ethnicity, culture, and language were taken into consideration. Such provider engagement is absolutely critical to move the needle in informal child care settings.

Further, employing a mental health lens, FFN providers are not able to take the best care of children when they are dealing with a multitude of stressors, burned out, and unable to attend to their mental well-being. In this situation, services and supports for FFN providers and families must have a mental health component even if it is not characterized that way. We will describe how culturally mediated peer support models are critically important due to the intrinsic understanding and empathy between peers and the willingness and ability to help, given similar backgrounds and experiences. Then we will discuss the unique role of ECNPs as trained, experienced, and culturally steeped supports dedicated to strengthening provider capacity and encouraging self-care. Given the minimal intersection between FFN care and IECMHC, we will speculate on the role that MHCs could potentially play to directly or indirectly support FFN providers, given dialogue with sites. We will draw on takeaways from mental health consultation work with FCC providers, and suggestions for how to improve indirect mental health consultation models to better support ECNPs as well as providers.

How Relationships Can Incite Change

In visiting the four sites, we found that relationships exist at many different interaction levels, are a critical vehicle for change, and can facilitate tangible outcomes. Strong relationships between FFN and FCC providers and MHCs and ECNPs, including early childhood network specialists, trainers, "promotoras," "tias," coaches, family resource specialists, specialized consultants, such as SECs, QICs, FECs, and physical health consultants, and other program staff, can lead to greater use of needed services and supports to strengthen the capacity and mental well-being of providers. Given the stigma attached to mental health and the limited access to and use of mental health services, trusting relationships with program staff can also facilitate the use of mental health services and supports by providers and families. The partnership created between the providers, families, and support staff can create a safe space to acknowledge sensitive and oftentimes traumatic issues, and begin to work through those issues to elicit better outcomes.

> *"Our communities, especially our most vulnerable communities, are traumatized. Some of us in this room are traumatized, so how do we, as professionals, create content that is comprehensive enough to be able to support everybody and all of their baggage that they're bringing to then support the children…just acknowledging that they're real people that have real experiences that need to be addressed in order for them to come to this next phase of wanting to grow and learn."* — CO, ECNP

In San Francisco, IFR provides opportunities for providers and families to connect with program staff, such as MHCs and FRC staff, and peers to support their complex needs in a nonjudgmental way. The value of being in relationships with people to offer healing guides how IFR approaches their organizational calling. To help accomplish this healing, mirroring is used to build and cultivate relationships with the vast majority of staff reflecting the cultural and linguistic makeup of the providers and families served. By making cultural match a reality and thinking of themselves as "comadres," IFR staff are able to offer the most culturally and linguistically relevant services and supports for providers and families. Moreover, IFR's perspective that all staff contribute to the healing of its community members, and that informal supports can be offered regardless of job title or role, puts relationship-building at the center of all interactions to best meet the needs of providers and families. All staff in some respect become ambassadors for the well-being of those served, and by building community and fostering trust, they set the stage for change. When strong relationships are built, programmatic success is more likely to happen due to provider engagement and retention in program offerings. Thus, culture and relationships are central to trauma, recovery, and healing.

> *"Your primary focus and how you train people, and what your organization values in your approach, has always got to go back to the relationship. When you attend to the relationship…change occurs. That's where the healing begins."* — SF, PROGRAM DIRECTOR

FFN support programs also hone in on relationship to promote provider engagement and retention. In Colorado, the PASO training program provides professional development in early childhood education to Latino FFN providers to promote school readiness for children birth to five years old, and to prevent the achievement gap between Latino and non-Latino children before they enter kindergarten. ECNPs, trainers, or coaches known as "tias," or aunt in Spanish, engage FFN providers in an intensive, early childhood education program, aligning their curriculum with the Child Development Associate (CDA) certification, a national credentialing program. Commitment and sustained engagement are needed to successfully complete PASO's program. Alongside the formal trainings that provide a space for peers to support one another and share learning experiences, the informal approaches PASO uses to facilitate relationships include activities such as community dinners and holiday celebrations that engage the families of the FFN providers. PASO acknowledges that their program is intensive and may take time away from providers' families; knowing this, and providing opportunities to gather and thank families for the provider's commitment, are gracious gestures that PASO does in order to build relationships not just with the FFN providers, but with their families as well.

> *"The Tias are really the heart of the program. It's that relationship they have with their providers. It's their training…They get everybody involved, everybody has a voice…If the Tias come and say, "Hey, will you come to this event?" or, "We need you," they will show up because of that relationship they have."* — CO, MIXED FOCUS GROUP OF PROGRAM LEADERS AND TIAS

In reflecting upon the power of relationships to incite change, intentionally culturally tailored programs that leverage peer dynamics are the most treasured and influential. Training support groups for FFN providers offer emotional benefits and capacity-building opportunities that are not available in other formats. Providers acknowledged the importance of peer supports in helping them normalize and validate their experiences caring for children and providing them with opportunities to exchange wisdom and insight. The trusting relationships built among these providers enables them to safely vent, share struggles and frustrations, and hear firsthand what has worked for other providers, who often come from the same cultural and linguistic background, may have gone through similar, relatable life experiences, and more intrinsically understand their stressors and struggles. These connections reaffirm the importance of being in-community and how willing providers are to help one another without judgment, reservation, or expectation. In this sense, culturally mediated peer supports are unparalleled and especially impactful.

Further, strong relationships between providers and families can impact outcomes for children. As noted, oftentimes the biggest struggle with making progress in children's lives is building relationships with the parents. Parents may not be very involved in child rearing and take their providers for granted. When home-based providers can learn to openly, honestly, and directly communicate observations and concerns to parents and receive advice or referrals from program staff to attend to the developmental and social-emotional needs of children in their care, then the benefits for the children are irreplaceable. Although there is a tremendous respect for the knowledge and expertise that ECNPs and MHCs bring, especially when it comes to interacting with parents and families, it is important to cultivate strong caregiver-parent interactions. ECNPs, MHCs, and other staff can act as critical connectors between providers and parents to help promote change for the betterment of children and their families.

The Need for Culturally and Linguistically Responsive Services and Supports

In addition to holding relationships at the fore, programs that work most effectively with FFN providers focus on cultural and linguistic considerations to best serve FFN child care providers. Culturally and linguistically responsive services and supports are the vehicle for an intentional, community-informed, equity focused frame. Since culture seems to be inherent in why families choose FFN care and why FFN providers take care of children—to support their family, friends, or neighbors in the most natural and culturally appropriate setting for raising young children—the development and delivery of program offerings are the direct result of the desire and commitment of organizational leaders to use a culturally driven, in-community approach to meet the needs of FFN providers. In visiting the study sites, we found that the most effective programs partnered with cultural brokers, as trusted entrees into the community, and employed a strong cultural lens and/or engaged in hiring specialists and other program staff who were culturally and linguistically matched with the communities they serve in order to deliver effective, culturally tailored training and education. By collaborating with trusted cultural brokers who act as a bridge, the reach to FFN providers was greatly enhanced. Culturally and linguistically matched specialists who were attuned to the providers, as well as cultural tailoring and translation of materials, resources, and supports helped improve buy-in from and retention of FFN providers. If not bilingual and bicultural, program staff were, at the very least culturally aware, sensitive, and responsive to the multifaceted needs of FFN providers.

In San Francisco, IFR was founded upon and is guided by a cultural frame. The organization is propelled by the values of social relationships and social justice as well as a commitment to being in-community, using a family- and neighborhood-centric lens, and being culturally responsive to the needs of the communities of color they serve. IFR's wide array of services and supports are culturally and linguistically informed and staffed by MHCs and ECNPs who are overwhelmingly a cultural and linguistic match for providers and families. IFR's commitment to having a bicultural and bilingual staff and developing a strong Latino mental health workforce is quite notable and exceptional. With a focus on overcoming historical trauma, providing new, enhanced perspectives on child care practices, strengthening attachment through a cultural frame, and encouraging behavior change through capacity building, MHCs, FRC staff, and other program staff are providing scaffolding for home-based providers and families to better support their mental well-being and children's social-emotional health.

> *"All of the staff are bicultural and bilingual…There's a deep commitment Instituto has to developing a professional network of Latino mental health providers."* — SF, PROGRAM DIRECTOR

Using a holistic approach that integrates conventional, traditional, and contemporary practices, IFR's approach to community well-being is grounded in a cultural field and culturally-informed practices are embedded in all the services and supports they provide. Culture is not an add-on but is foundational to the services and supports. Clinical practice is seen through the field of culture. Further, staff are very cognizant of the socio-political context of their clients, in particular how the effects of immigration may make some people feel unwelcome and unsafe. The programs work to reassure providers and families that they do not need to hide and can utilize programmatic services and supports and other trusted community resources to help take care of their basic needs, physical health, and mental well-being. IFR's effective outreach to and service of home-based providers and families in their community is a direct result of dedicated leadership and the cultural considerations that are embedded into the very fabric and makeup of the organization and embodied in its staff. Culture is their compass and they use "many medicines" to provide care and support to providers and families in their community.

> *"We're very intentional that we are thinking all the time, "Does this practice relate to the community that is being served?"* — SF, ORGANIZATION DIRECTOR

The purpose of the PASO training program in Colorado is to create an equitable, replicable, community-based model for providing professional development in early childhood education to Latino FFN providers to promote school readiness and close the achievement gap between Latino and non-Latino children before they enter kindergarten. PASO offers training and coaching to FFN providers to help them convert their homes into learning centers for young children. The curriculum was developed in Spanish, and specifically targets Latino FFN providers. Participants of the program expressed that because the program is "meant for them"—in that it is in their language and participants and staff share similar cultural backgrounds—it made them want to be more involved and engaged. With tias who are professionally trained in early care and education, FFN providers have a culturally matched ally building their capacity and skills. Among other important attributes, tias, like other ECNPs, are hired because of their ability to truly relate to providers. This intentional and explicit use of culture as a point of connection better enables programs to engage and connect with FFN providers.

> *"One of the factors that really makes a difference with the tias and the community is the cultural relevance. They understand our culture, the language, and these issues that the parents or the providers are facing."* — CO, PROGRAM DIRECTOR

In Colorado, there are not a sufficient number of bilingual and bicultural MHCs to meet the needs of the child care community across the state. The IECMHC workforce also is not reflective of the population of providers, young children, and families in the state. More specifically, there are two bilingual mental health specialists, who serve as state-funded MHCs, and the specialist program could benefit from having more MHCs who are at minimum bilingual and ideally bicultural. It is challenging to find qualified individuals who understand early childhood and child development. To try to find a Spanish-speaking consultant who might be from the same culture as the child care providers makes it even more complicated. Like other states and communities grappling with capacity issues, Colorado is trying to figure out how to deploy its limited mental health expertise and deliver culturally relevant services and supports to providers. The early childhood networks of support within the state provide examples of how to optimize a cultural frame in service delivery. Increased partnerships between FFN and IECMHC programs could lead to a wider array of services and supports to meet the mental health and other needs of FFN providers in culturally informed ways.

In Arizona, for the Arizona Kith and Kin Project specialists, who act in an ECNP role, it was not just about being bilingual but being bicultural and culturally sensitive to understand the experiences of and attend to the needs of FFN child care providers. This approach was used for their ongoing work with the Latino community but also refugee groups in Phoenix. The early childhood specialists work to understand where providers are coming from and their country of origin first. Emotionally heavy topics such as domestic abuse, spanking, and biting children back can surface, so specialists cannot be fearful of tackling the cultural aspects of these issues to incite change. Here again, culture is the root from which trusting relationships grow. The specialists utilize the training support groups as opportunities to tap into shared struggles, facilitate connections, and encourage change in a culturally respectful manner. Again, this ability of specialists to truly relate to FFN providers is paramount. Leadership from the Arizona Kith and Kin Project intentionally and explicitly ground their work in culture, making it central to how they hire specialists, how they collaborate with other community organizations, and how they design and keep evolving their programs to better serve FFN providers.

> *"We can't just come in and say, "Oh, by the way, you need to put your baby in a crib." You can't do that because they will shut down and turn off your message. We've had to adjust depending on where we are, who the population is, what their cultural background is, their belief system."*
> — AZ, PROGRAM DIRECTOR

In Michigan, state and program leaders and staff are having frank and honest conversations about the importance of being an ally, building safe spaces for conversations, and leaning in when others might be leaning back, when it comes to cultural incongruences between MHCs and child care providers. With consultants being primarily white, middle class women, the cultural and linguistic match with providers is not present with mostly Latino and African American providers in the counties. There is an acknowledgement of the cultural and linguistic differences as well as economic dissimilarities and the lack of shared life experiences and how those considerations can impact interactions. With the RTT-ELC grant in Michigan, there is a strong emphasis on health equity and working to eliminate racial and ethnic disparities in health and mental health outcomes. More specifically, the MHCs joined the other RTT-ELC specialized consultants for a day-and-a-half training on cultural equity facilitated by Dr. Eva Marie Shivers of the Indigo Cultural Center, Inc. The conversations focused on incorporating a racial equity lens in the day-to-day work and addressed topics such as implicit bias, systemic inequity, and identity, power, and privilege. The consultants are also receiving ongoing reflective supervision, so they can continue to feel supported, and model reflective capacity in their work with home-based providers, including FFN providers. The work in Michigan showcases that even if cultural matches do not always exist, consultants can be culturally curious, increase their capacity to use a racial equity frame in their work, and use a mental health lens to engage with and provide services and supports for child care providers, including FFN providers.

> *"It really is more than race and ethnicity on many levels around just learning each provider, learning each family, learning each kid and each story, and honoring their individual experience…The overarching theme is that we want to be aware and help facilitate those conversations in a very thoughtful way, integrated throughout this entire process."* — MI, SEC

The Value of a Mental Health Lens

Across the four sites, programs offer relationship-based, culturally and linguistically informed, and individualized services and supports to FFN child care providers so they can strengthen their knowledge and skills, see their value, and engage in greater self-care to better attend to the social and emotional health of children in their care. Formal activities that promote provider engagement, enhance provider capacity, and attend to children's unmet needs, such as trainings, peer support groups, home visits, consultation opportunities, and referrals for assessments or to community resources, as well as informal activities that promote gathering and belonging, such as field trips, engagement events, community dinners, or holiday celebrations, are all avenues for support facilitated primarily by ECNPs for FFN providers, and sporadically by MHCs for FCC providers. With an increasing focus on self-care and wellness through education and fellowship opportunities, FFN support programs are beginning to place greater value on mental health and acknowledging the importance of caregiver well-being on children's social and emotional health and, ultimately, quality of care. We found that this intentional focus on self-care and wellness is an important and growing strength of early childhood programs designed to support FFN providers. Ensuring that all young children have a strong social and emotional foundation for early learning must take into account the mental health and well-being of FFN providers, who are critically influential in the early years for the majority of young children across the country, and receive little to no support.

Additionally, by offering culturally mediated peer support models, programs are leveraging the protective factors of culture, community, and social connections to evoke change. Peer support groups provide a welcome, consistent opportunity for providers to interact, get advice, and feel supported by program staff as well as their provider peers. We will highlight the importance of peer-to-peer supports within a cultural frame. We will also describe and reflect on the role of ECNPs as well as MHCs, if and when applicable, in support of FFN providers. We began to see that when ECNPs and MHCs are grounded in a set of core principles, guiding framework, and methodology that integrates the importance of child development, attachment, and healthy relationships, they may be in the best position to fulfill their distinct yet symbiotic roles in support of home-based providers. In this regard, the study sites varied in terms of their intentionality; however, growing recognition of the need to collaborate on behalf of the mental well-being of FFN providers is promising.

We will highlight how MHCs have worked to support FCC providers, which could be a rallying call for expanding IECMHC to include FFN providers. When a mental health lens is coupled with reflective practice and intentional self-care, this creates a ripple effect whereby program staff can help providers and families, and providers and families, in turn, can then help their children. We will also describe an indirect model of consultation focused on supporting the ECNPs who work directly with FFN providers. The intense work of supporting FFN providers requires a parallel process of support for ECNPs to alleviate stress and burn out. With limited capacity, IECMHC programs are challenged about how to best deploy the specialized MHC expertise that is available. MHCs can work closely with ECNPs to help alleviate secondary trauma from taking on the burdens of FFN providers and families. Given the multitude of stressors faced by home-based providers, optimizing peer supports and increasing partnerships between ECNPs and MHCs could lead to more comprehensive networks of support for FFN providers.

The Importance of Culturally Mediated Peer Support Models

Peer relationships are one of the most prevalent support resources FFN community members seek out. The availability of and access to peer supports and mutually beneficial peer relationships is critical to the health and mental wellness of home-based child care providers and staff at the frontlines supporting them. Across the sites, culturally mediated training support groups for FFN and FCC providers, often facilitated by ECNPs, MHCs, or other specialized support staff, provide a much welcome opportunity for providers to get away, vent, share their stresses and concerns, hear what other providers are grappling with, hear about strategies that have worked for others that may be promising for them, and feel connected to their respective cultural communities. These training support groups, consisting mostly of providers from the same or similar racial, ethnic, and linguistic backgrounds and facilitated by staff who are culturally matched or embody a stance of cultural humility and/or curiosity, provide a safe and compassionate space for providers to receive the empathy and support they truly need and may not be able to get elsewhere. The structure of the peer groups with knowledge dissemination and focused conversations on the timeliest issues for providers, set within a culturally responsive frame, works well to address their most pressing needs.

> *"One of the reasons our program works is not only is it that cohort of women who are caring for children all day long, who don't really talk to other adults. It's having other people that are maybe three or four blocks who are doing the same work you are. You might not have even known that… The Tias are always supporting them and going to give extra help if they need to. The other reason why it works is because we also do some community events that are very important."*
> — CO, MIXED FOCUS GROUP OF PROGRAM LEADERS AND TIAS

In San Francisco, the organizational culture of IFR with its focus on being in-community and cultural relevancy sets the tone for the peer support activities. IFR recognizes the importance of mirroring the community culturally and linguistically and this approach has led to the creation of great trust, respect, and comradery amongst providers and staff. Given IFR's perspective that all program staff are able to provide "peer" support regardless of their role or position has really created a culture of caring, and a circle of support where everyone feels empowered to help everyone, most especially when it comes to providing emotional support. It is not, therefore, just the responsibility of the MHC to provide mental health support. The commitment of leadership past and present to elevating culture and social connections has created an environment where support is offered organically and naturally to all providers, children, and their families.

> *"At one time, actually, we hired child care providers to be like promotores. A new provider call[s] for help, we'll send someone, another provider to do initial visits, and then we will send a regular consultant…whoever does it needs to be…You have to be a comadre. It needs to be a comadre."*
> — SF, MENTAL HEALTH DIRECTOR

In Colorado, peer supports are found in group sessions or trainings with other FFN providers and enhanced by strong interpersonal relationships with ECNPs. Again, PASO trainers or coaches are referred to as "tias"—the Spanish word for "aunt." This familial title has informal and more trusting implications for the relationship or bond being built between FFN providers and their ECNPs. Although tias are professionally trained in early care and education, their ability to connect with providers is a standout attribute. Promotoras with Cultivando elicit similar feelings of connection as community leaders dedicated to "service from the heart." At Valley Settlement, the leadership is working to offer support groups for FFN providers through play dates or at the library to provide more opportunities for fellowship and connection. Across programs, there was a tremendous amount of respect for culturally steeped peer relationships and their enabling effect, which is most often amplified by ECNPs. Similarly, in Arizona, early childhood specialists with the Arizona Kith and Kin Project facilitated training support groups for Spanish- and English-speaking FFN providers and refugee caregivers to harness the power of peer supports and facilitate connections to incite change.

> *"…in PASO, we try to make a family. Actually, that's why we use the name of Tia, not home visitation, visitors, or something. Tia means auntie. We always say to providers, 'She is not coming to supervise you. She's coming to help you. She's going to be your sister, your older sister. She knows a little bit more than you, she has more experience, so she's going to support you.' That confidence/trust works really good."* — CO, MIXED FOCUS GROUP OF MHCS AND ECNPS

In Michigan, the peer relationships that FFN providers have formed through the monthly training support groups, which are facilitated by the QICs and topically driven by the providers, and monthly engagement events, which are fun activities where they can bring the children, such as a trip to the zoo, a park, museum, library, and so on, are strong drivers for change. The café style conversations, modeled after the parent cafés in the state, enable FFN providers to learn about different topics from one another and strengthen those relationships. Programmatically, the vision was that FFN providers might be more receptive to being part of a cohort of their peers and this group setting could incentivize their completion of the Great Start to Quality (GSQ) orientation training and keep them engaged in additional training and educational opportunities. The seven-hour orientation training covering health and safety topics, first aid, and CPR constitutes level 1 and happens prior to providers receiving the child care subsidy of $1.35/hour. Once linked into the cohort, which is very much practice-oriented, the group of FFN providers might then be more encouraged to engage in level 2 for a pay increase.

Level 2 requires ten additional hours of training every year, typically offered though the GSQ resource centers, leading to a $0.50/hour increase to $1.85/hour. This structure created by the state very much relies on the power of the peer relationship and consultant connection to move FFN providers along a continuum from levels 1 to level 2 or 3, whenever possible.

> *"I was thinking about it in the sense that all of us think about doing any type of relationship-based work is just being an observer, and being an information-gatherer, and putting myself into the student perspective. I know that all of these centers and all of these homes and even all the families, they do have very different cultures no matter what they're living, what race they are, who they grew up with. Every family is different…That's why I take so much time with observation in the beginning…I want to learn about the culture and make sure that I'm not making any assumptions…It's adding in a little bit of that reflective piece, because we are all coming from different places and different walks of life. How can we still continue to work together and be effective if we haven't had the same experiences?"* — MI, SEC

The Role of Early Childhood Network Providers

In hearing about the transformative work of ECNPs during the site visits, it became clear that they are uniquely situated to support FFN child care providers. With programming designed to leverage cultural and linguistic similarities, FFN support programs are tailor-made to address the needs of their FFN provider communities. While IECMHC programs may not be able to serve FFN providers due to funding or other stipulations, early childhood network programs were created to serve this singular goal. In the study sites, ECNPs are largely culturally and linguistically matched to the FFN provider communities they served and acted as natural cultural brokers linking providers to culturally relevant services and supports. By calling ECNPs tias, promotoras, and comadres, this suggests more familial relationships. These relationships exist within programming specifically developed to increase knowledge and understanding of early childhood development and child care to improve quality of care. ECNPs make themselves visible in the community reaching out in spaces and places where FFN providers, children, and families tend to congregate. They also go door-to-door and encourage word-of-mouth to spread the word about programmatic services and supports. ECNPs exemplify an in-community approach and are an effective conduit to link FFN providers to a formal system of support. The training and support for mental wellness and social and emotional health provided by ECNPs is a pivotal resource within a continuum of services and supports for FFN providers and families.

In most states, ECNPs or FFN specialists are required to have a bachelor's degree in an early childhood-related field and some have master's degrees. Often, there are education requirements inherent in their organizations that reflect Standards of Practice enforced by program funders. They also receive extensive and ongoing training and professional development to enhance their knowledge and skill set. Due to the formal education requirements for ECNPs, there are often socio-economic and class differences with providers. Despite these incongruences, ECNPs tend to be hired because of their ability to truly relate to FFN providers. Programs are designed to leverage cultural matches and ECNPs use their culture, language, and background to inform their interactions with providers. Although ECNPs in successful programs, such as PASO and the Arizona Kith and Kin Project, often share the same cultural, ethnic, and linguistic heritage of the FFN providers they serve, they are highly educated, trained, and the relationships they form are the result of explicit and intentional leadership to use a cultural frame to guide programs. ECNPs are highly skilled at relating to FFN providers in a way that yields positive results. Not all agencies who serve FFN providers are able to create inviting and responsive spaces so the work of the FFN programs in this study are exceptional models.

Drilling down, ECNP responsibilities can include gathering information and assessing need at multiple levels (e.g., strengths and needs assessments) to providing basic needs items, incentives, materials, and resources (e.g., baby gates, pack 'n' plays, high chairs, and art supplies). ECNPs can also lead or facilitate training support groups to increase the knowledge and skills of FFN providers and encourage peer support amongst providers. They can make visits to the home to deliver materials and/or offer educational opportunities and work closely with FFN providers to set goals and action steps (e.g., as part of quality improvement plans/visits). ECNPs can lead engagement and special events to foster fellowship and community. They can also provide one-on-one support, as needed, in-person or by telephone, to offer information and guidance as challenges arise for FFN providers. These varied services and supports enabled providers to improve their capacity, intentionality, and self-efficacy. Even though ECNPs do not explicitly state such, there is an undercurrent to attend to the mental and emotional well-being of providers to positively influence caregiving practices. Although there are several ways to interface with ECNPs, it is the relationship-based, individualized support they provide from their cultural lens and expertise that enables FFN providers to better attend to the mental health and other needs of children in their care and themselves.

> *"For many FFN providers, our staff are it. They are the person they trust. They are the person they can go to. As a result, a bunch of stuff gets unloaded on them…I feel like if we can figure out how to support our staff, it will, by evolution, spill into the groups because they're gaining a certain skill set, a technique, and expertise by self-process."* — AZ, PROGRAM DIRECTOR

Across the sites, we learned that training support groups enable the ECNPs to build the knowledge and capacity of FFN providers and families, facilitate dialogue and sharing amongst the peer group, and provide individualized support as needed. ECNPs tend to set the tone by stating that they are a readily accessible resource, always available to help, and will keep the trust and confidence of FFN providers. Some ECNPs open up to providers as "peers" to build rapport and make it clear that they have been in their shoes and share how they personally approached similar, difficult situations. ECNPs also recognize that when one provider asks about a certain topic, perhaps other providers are struggling with the same issue. So any advice or resources are shared group-wide so all providers benefit. The ECNPs optimize the training support group structure by creating a relaxed, informal environment where FFN providers can feel heard and not alone in their struggles. Because of the safe, supportive atmosphere cultivated by the ECNPs, providers feel free to candidly share their most immediate concerns to elicit advice and guidance. It is this flexibility and trust that makes these training support groups so impactful.

> *"Although we call it training, we really tap into the support piece as well. Our trainings are not very formal. They're very informal in the sense that when you walk into a training support group, the facilitator of that group isn't up front of the classroom and isn't necessarily dictating what the participants should be doing, what's right and wrong, "This is how you do guidance and discipline. You're doing it wrong." They're not lecturing, necessarily. They really are facilitating the group and they're tapping into each individual wanting to know what's happening in their home. One of the things that I think has made the program so successful is that we really want to hear from them what's happening in the home. What are some of the issues, struggles, experiences that they're having whether it's directly with the child or within the family in general or with the parent of the child. That way, we can really support them as a whole."* — AZ, EARLY CHILDHOOD SPECIALIST

Curricula topics led by ECNPs can include brain development, guidance and discipline, developmentally appropriate activities, social-emotional development, nutrition, language and literacy, ages and stages, parent caregiver best practices, injury prevention, safety training, toxic stress, and so on. Although weekly sessions may be dedicated to a particular topic, ECNPs across the sites seemed very

flexible and willing to adjust and customize the conversation based on what the providers need most. ECNPs also spoke about incorporating self-care into curricula to help combat the stigma of mental health. By taking an approach toward wellness rather than looking at mental health from a deficit perspective, there is increased understanding and buy-in of these topics among FFN providers. ECNPs further shared that they stay after training support groups and make it a point to show that they are not in a hurry so they can be available to speak to any provider who feels so inclined. These informal opportunities to talk and get to know one another better greatly enhanced connections and made ECNPs the go-to resource whenever FFN providers or families were struggling.

> *"You can't provide what you don't have. So you have to take care of yourself and have your resting time."* — CO, ECNP

Early Childhood Networks of Support by Site

Looking at the ECNP role by site, the Colorado Statewide Parent Coalition (CSPC) provides advocacy and training for parents and child care providers to be meaningfully engaged in children's educational success. With equity in mind, CSPC aims to serve all historically under-represented children and their families to ensure access to equitable educational opportunities. With approximately 406,000 children in Colorado under six years of age and one in three or approximately 134,00 children relying on FFN care, the PASO training program provides comprehensive training and coaching to FFN providers in low-income Latino communities to improve the quality of early care and education in these FFN settings, and enable Latino children served to enter kindergarten school ready. PASO prepares FFN providers to apply the CDA, a national credentialing program, and demonstrate their knowledge of the CDA's six competency standards and thirteen functional areas. PASO was able to align their curriculum with CDA credentialing with funding from Mile High United Way. PASO also offers certification in First Aid, CPR, Universal Precautions, and Medication Administration.

The tias, professionals trained in early care and education, act as coaches and mentors, lead/facilitate trainings, and play a home visiting role. PASO is a very intensive 120-hour, thirty-session, nine month long early childhood education program to prepare FFN providers to receive their CDA credentials. A cohort consists of twenty providers and each tia works with ten providers. The PASO training consists of thirty separate four-hour seminar classes. There are also three individualized home visits throughout the fifteen-weeks. The curriculum focuses on child development principles, such as cognition (e.g., Jean Piaget's theory of cognitive development), language and literacy, social and emotional development, physical and motor development, nutrition, learning environment, behavioral issues, discipline, child safety, school readiness, and so on, and continues to evolve. For example, a module on toxic stress was added more recently. The tias are available to respond to questions, make sure points are understood by providers, and discuss how to apply learnings to their home settings, so homes can become hubs of learning for young children.

With regard to the home visits, the tias give providers all the materials they need to create a safe and stimulating environment for the infants and children. This can include baby gates, sleeping mats, small tables and chairs, and so on. Observation is a very important part of the home visits and tias can spend an entire session observing a child's behavior, how they learn, and how providers scaffold their learning. Tias then link what they see during the home visits back to the curriculum reiterating that the topics will help the provider better help the children learn, grow, and thrive. Home visit logs are used by the tias to track what they have done with the providers and what they have seen regarding the children. An evaluation tool is also used to look at both the environment and child interaction. The tool is aligned with their curriculum and the CDA. Events are also held for each cohort to celebrate the

achievements of the providers and bring the providers, children and their families together to socialize and increase their connections. PASO has an 85-90% attendance and graduation rate and to date have graduated approximately 400 FFN providers from the program. Providers have also demonstrated improvement in all CDA areas.

> *"I'm proud of these ladies, the work that they do every day. I know it's not easy. They go in and do those classes and they do their home visits and the build such great relationships. But at the end, when they're graduating, to hear the stories of the women, the ones who say, "This saved my life. This changed my life." To hear that from providers later on, they call the office and they're advocating for children in their community, they're more respected, they're getting paid better...To hear parents say, "My child before was watching TV and now she knows her numbers and she knows her colors." Those stories...This program has to continue to exist because those providers, those children and families, would not receive this if it wasn't for PASO."* — CO, PROGRAM LEADER

United Way of Weld County in Greeley, Colorado, offers the PASO Institute. The organization's mission is to improve lives by mobilizing the caring power of their community. They are dedicated to the health, education, and financial stability of every person in their community. In 2007, HB 1062 identified a statewide need to increase and sustain quality, accessibility, capacity, and affordability of early childhood services for all families. In response, the PASO Institute, as developed by CSPC, was offered as an early learning and development effort at United Way of Weld County to address the achievement gap between Latino and non-Latino children by helping providers create high quality care environments, exposing providers and parents to the need for quality early childhood care and education, to better prepare Latino children for school success. With the majority of children in Weld County in FFN care and the drastic underperformance in school of children of Hispanic origin compared to their white counterparts, PASO is seen as a way to support FFN providers to better support children with the most need. Providers complete 120 hours of early childhood care and education training mostly during weekend classes and there are three visits from tias to reinforce learning. In 2017, the United Way of Weld County's PASO graduated twenty-two FFN providers who care for 139 children from fifty families.

Also, during the site visit, Mile High United Way, as the birthplace of the international movement and leader within United Way Worldwide, and a leader in FFN advocacy, hosted a mix of ECNPs, representing programs and institutions such as Denver Public Schools, Early Childhood Councils from different counties in Colorado, and local family resource centers. All participants shared their knowledge and understanding of FFN providers, the needs of children and families in their communities, and the extent to which their services reached this specific population of child care providers. Mile High United Way seeks to build the capacity of communities through professional development, service provision, and partnerships with other community organizations and programs. Services and supports to FFN providers through these local partnerships include trainings, classes, home visits, linkages to community resources, and mini-grants to help them move along the continuum toward licensure, whenever possible, and improve quality of care. At the ECNP level, the goal of the FFN learning community is to support those who are directly supporting FFN providers by sharing resources and promoting the impactful work that is happening. To engage in dialogue and planning around FFN care, there are two workgroups, a strategic partnership group and a policy group, comprised of ECNPs and other stakeholders.

North Range Behavioral Health in Weld County offers early childhood programs that provide a strong start for a child and nurture emotional and mental well-being. Family Connects is the prevention and intervention program that has five teams focusing on the early years. Their mission is to increase

the capacity of families, caregivers, and professionals to support the developmental, behavioral, early learning, literacy, and overall wellness needs of young children prenatal through eight years of age. Expert staff work on strengthening relationships between adult caregivers and children using preventative practices, evidence-based interventions, and school-readiness curricula that include the whole family. Alongside IECMHC, Family Connects implements four other primary evidence-based programs, in their wraparound services with participants, including FFN providers. The evidence-based programs are Home Instruction for Parents of Preschool Youngsters (HIPPY), Incredible Years®, Parents as Teachers (PAT)® home visiting model, and the SafeCare® parent-training and case management.

Further, in Colorado, Cultivando practices a "promotora model" that emphasizes the need for community leaders of color to be engaged in initiatives to increase health equity in their communities. Cultivando works to train and support emerging leaders from the Latino community in an effort to impact sustainable change. In 2016 and 2017, Cultivando developed a leadership curriculum to train and support Spanish-speaking emerging community leaders in cultivating their internal leadership, emotional health and self-care, collaboration, and understanding local systems to make positive change for their community. Promotoras are skilled and respected community members working within their community to provide services, supports, and resources and advocate for individual and community change. These highly skilled leaders offer servicio de corazón or "service from the heart." Cultivando also partners with Visión y Compromiso, one of the most respected promotora training and advocacy organizations nationally, to offer their trainings and to support a collaborative promotora model in Colorado. Cultivando also offers technical assistance to partner organizations to better understand and effectively implement the promotora model by strengthening their focus on organizational equity, inclusivity, and community engagement.

Through regular, ongoing trainings in Adams County and the Denver region with Spanish-speaking FFN providers and parents, resources are being directed toward children who do not have access to structured, licensed child care/preschool. All of Cultivando's trainings are offered in Spanish and were developed by and for the Latino community honoring the inherent strengths in the community to incite positive change. First off, Cultivando developed a 3-hour training focused on healthy eating at home called Healthy Kids at Home. Although originally created for Head Start with a focus on healthy eating, active living (HEAL), with the vast majority of children being cared for outside of licensed care in Adams County, the curriculum was revamped to focus on FFN settings. Promotoras support FFN providers and parents to build knowledge and skills around healthy eating, physical activity, early literacy, bilingualism, and kindergarten readiness to nurture health and educational equity. The need for information and resources, however, stretched beyond the three-hour curriculum. Therefore, promotoras also conduct home visits with FFN providers at the convenience of the providers. These one-on-one interventions focus on HEAL, advocacy, and addressing any pressing provider needs and usually last between two to three hours each time. Promotoras share tools to help providers apply learnings from the curriculum to encourage more developmentally appropriate activities, positive interactions, healthy behaviors, and early learning. They also encourage providers to engage in greater self-care. Last year, promotoras visited the homes of approximately sixty FFN providers and spent upwards of twelve hours per provider.

To provide even more intensive training opportunities, in April 2016, Cultivando trained twenty local leaders including Cultivando staff to offer the Abriendo Puertas/Opening Doors training. It is the nation's first evidence-based comprehensive training program by and for Latino parents with children ages 0-5 years. This ten-week curriculum, developed in California by Latino parents and early

childhood experts for Latino parents and child care providers, is focused on parents being involved in their children's education and supports and reinforces cultural and linguistic pride and strength. Abriendo Puertas uses a two-generation approach to build parent leadership skills and knowledge to increase family health and educational outcomes. The curriculum is focused on key aspects of early childhood development, such as cognitive, language, physical, and social-emotional development, as well as early literacy, numeracy, bilingualism, health, attendance, civic engagement, parent leadership, goal settings, and planning for family success. The curriculum offers another launching point for more individualized support to providers and families, such as how to detect social and emotional issues early on, navigate the educational system, and link to community resources. Overall, these culturally steeped educational opportunities, which build upon each other, offer a stepwise approach for promotoras to build the capacity of FFN providers and families to foster health, mental health, and educational equity for the Latino community.

Lastly, Valley Settlement in Carbondale, Colorado, started out as a project under the Manaus Fund to understand the experiences of immigrant families in Roaring Fork Valley. With no organization in the community that was systematically reaching out to welcome and engage immigrant families with young children, Valley Settlement became a standalone 501c3 nonprofit organization continuing to engage immigrant families in their local schools and community. The early childhood specialists are working with approximately ten FFN providers providing training based on the PAT curriculum. ECNPs conduct home visits twice a month with each FFN provider and each visit lasts about one-and-a-half to two hours. For the first home visit, the initial part of the visit is informational, asking questions and learning from the providers. The second part is more active with modeling practices or behaviors for the provider. For the second "home" visit, ECNPs try to get the providers out of the home on a field trip such as a trip to the library, if the month's theme is focused on literacy and learning. Once a month, providers also receive materials. For example, providers receive a library of ten to twelve books to keep and use during the literacy and learning theme, and a set of 1000 blocks when the focus is on fine motor skills. A future goal is that the FFN providers will form a peer support group.

> *"A lot of our families come here, and they come with no family. They come with no friends. They come with no contacts, so it's difficult to try and feel a sense of belonging in your community when you don't know anyone. We want to try and help that. Hopefully, in September, our mission is to start a group session. To have a group session per month where you get most of your information and your materials. To have two follow-up home visits just to make sure that changes are being made."* — CO, PROGRAM LEADER

> *"We have lots of kinesthetic learners...We used to think, I'll give them this flyer, They'll read it. They'll learn more. Almost making things easier for us, but it doesn't happen. A million things are going through these FFNs. They barely have time for themselves...We have really narrowed down our teaching to a lot of modeling, a lot more doing, a lot more demonstrating, coaching, and not so much read, what do you think? Not our model."* — CO, PROGRAM LEADER

In Arizona, the early childhood specialists with the Arizona Kith and Kin Project provide training and support to FFN providers in a culturally sensitive manner. Specialists tend to be bicultural and not only bilingual in their work with Latino and refugee communities. The Kith and Kin curriculum is fourteen weeks long and the early childhood specialists and providers meet once a week for two hours. The majority of the trainings happen in the middle of the day or morning, which tend to be better times for providers caring for infants, toddlers, and preschool aged children. The training support groups are held at various community partner locations that are embedded in the FFN provider communities. On-site child care and transportation are offered as well since lack of those amenities can be tremendous barriers to participation. The Arizona Kith and Kin Project training series is for Spanish- and English-speaking and refugee caregivers with most training support groups offered in Spanish. Topics covered

include brain development, guidance and discipline, nutrition, language and literacy, ages and stages, parent-caregiver best practices, and so on. In facilitating these training support groups, the specialists are tapping into each provider's experience caring for children in their home and customizing the information to relate to their struggles and needs. Groups are generally capped at twenty providers but there is spillover at times. In a year, approximately 1,500-1,600 providers are served by fourteen or so specialists. The Arizona Kith and Kin Project tends to have a fall session and then a spring session with a break inbetween and during the summer.

> *"We know there's a curriculum that we have to deliver. That there's certain topics that we have to deliver at a certain time. However, when we come into the group, let's say we're covering nutrition that day and the participant starts to open up and talks to us about how they punish their child, and when they punish the child, they don't give them a snack or they punish them if they don't finish their food. Then we tap into that, we really hear what the group is talking about...we know that's our cue to come back and deliver guidance and discipline. We let the group almost guide the topics...We let it happen naturally based on the conversation of the group."* — AZ, EARLY CHILDHOOD SPECIALIST

In Michigan, the QICs, who play an ECNP role, attend the seven hour GSQ orientation training to act as a supportive resource for FFN providers engaging in the subsidy process. Although they do not conduct the training, they use this opportunity to connect with and encourage providers to stay engaged in the process and use these interactions to bolster their quality improvement work. Next, the QICs conduct a strengths and needs assessment with FFN providers after which they are eligible to participate in trainings that are hosted by the cohort, or they can attend trainings offered by the resource center at no cost to further advance in the subsidy process. QICs also help support the environment or care setting by delivering incentives, resources, and materials to FFN providers. More specifically, the QICs can assess health and safety needs and work to support safe sleep practices. They have been able to provide materials such as baby gates, fire extinguishers, carbon monoxide detectors, pack 'n' plays, cribs, and so on. They visit homes to deliver these incentives and ensure that providers are able to use the incentives. These are not home visits in the traditional sense, though, because the visit is not for educational purposes. It is to deliver an incentive and ensure that the provider is able to properly use the incentive.

During quality improvement visits to the home, the strengths and needs assessment helps more clearly identify FFN child care provider needs. The QICs partner with the FFN providers to articulate and then write their goals and steps toward completion of those goals. Goals could range from enhancing the learning environment in their home to serving healthier food to getting their General Equivalency Diploma (GED), CDA, or even learning sign language. As long as the goal helps improve the quality of care, it will most likely be approved and funded. QICs also plan and lead fun engagement events for providers, children, and families to unwind, engage in fellowship and play, and enjoy local sights. These opportunities allow for greater self-care. QICs can also refer FFN providers to other consultants, as needed. Though their responsibilities are varied, the focus is on providing the most targeted and timely supports possible so the providers and children in their care can thrive.

> *"The educational piece is very, very important. There's some amazing people working in that, like the QICs, who often are doing some mental health pieces without them knowing that they're doing the mental health pieces."* — MI, STATE LEADER

In San Francisco, family resource specialists from Casa Corazón, the FRC at IFR, facilitate parenting classes, parent leadership and education workshops, parent support groups such as Las Comadres art therapy class, Hijas de la Luna, or Daughters of the Moon dance therapy class, and Cirdulo de Padres, a support group for fathers, parent-child activities such as a parent-child interactive activities, children's

group, family night, kiddie play group hour, and additional family support services such as individual consultation, information and referrals, case management and family advocacy, and mental health services to families as well as FCC and FFN child care providers. The groups, classes, and workshops are an important mechanism for forming relationships, building knowledge and skills, and encouraging self-care. The family resource specialists, in their ECNP role, do a lot of observation and role modeling and tend to use one-on-one conversations to delve more deeply into any issues families and providers may be experiencing. Although they have a mental health frame in all interactions with families and providers, they do not make it apparent or convey interactions as such.

Early Childhood Network Provider Peer Support

The support ECNPs provide to one another informally often parallels the peer support FFN providers have with one another in training support groups (e.g., Cultivando, PASO, Arizona Kith and Kin Project, IFR). Given the stress ECNPs take on and internalize in supporting FFN providers, they need opportunities to vent, share, and reset. From the organization side, supports to ECNPs can include an open door policy, reflective supervision, monthly team meetings, trainings, and staff retreats, so they are able to reflect, debrief, and elicit feedback. Growing the internal capacity of organizations to support their own ECNPs instead of relying on outside sources of support is ideal. When organizations consciously provide the time, space, and flexibility for self-care, ECNPs report a sense of renewal. Better supports to staff will then trickle down to better support for providers. Importantly, ECNPs tend to be a very close and cohesive affinity group. The support they naturally provide to one another is restorative. Not only can they understand administrative pieces such as a heavy caseload and provide information and recommendations to their fellow specialists, but they can also understand what it is like to be greatly affected by turmoil and struggles that providers are sharing and what it feels like to be depleted and unable to give more of one's self. This knowledge and understanding comes with doing the work. This suggests that more opportunities for ECNP-to-ECNP peer support should be encouraged to reduce burnout and encourage self-care. This dynamic should also be taken into consideration when contemplating indirect models of mental health consultation in FFN care settings.

The Role of Mental Health Consultants

The role MHCs play in improving quality of care in early childhood settings is evident in the work they perform. MHCs tend to provide group consultation, case consultation, or support to administrators and work in all settings where young children learn and grow, such as home visiting, child care, and preschool. Within FFN child care settings, for direct IECMHC, MHCs work with providers and families to build their capacity to support children's social and emotional development so they can promote its healthy growth. Activities include facilitating support groups, providing individualized consultation, and/or facilitating child/family and group consultation to help mediate any problems that are hindering a child's development. With indirect IECMHC, MHCs work with ECNPs to support them and their work with FFN providers. This support can take the form of weekly check-in calls, coleading training support groups, and/or facilitating opportunities to engage in reflective supervision.

> *"Consultation is really the gracious exchange of expertise...Let's learn together."* — AZ, PROGRAM LEADER

Although we visited sites with the greatest potential for an intersection between FFN child care and IECMHC, there was little to no access to IECMHC for most FFN providers. However, we did learn about the role of MHCs through interactions with FCC providers and ECNPs. MHCs seemed adept at employing specific strategies, such as purposeful use of the consultative stance, use of reflective practice, understanding of the processes of change, and the ability to create an empathic environment, to

encourage increased well-being for FCC providers and ECNPs, and positively affect child and family outcomes. In addition, in-depth conversations with participants lead us to a promising approach wherein MHCs provide support to both ECNPs and FFN providers through co-facilitating training support groups, for instance, allowing consultants and specialists to simultaneously support FFN providers and for MHCs to provide more grounded support to ECNPs to alleviate any secondary trauma they may experience from taking on the burdens of FFN providers. It is critical to continue exploring innovative IECMHC models to serve the FFN community.

The "Consultative Stance"

Johnston and Brinamen (2006) describe the consultative stance as a consultant's "way of being." This way of being is essential to developing strong consultation relationships and can be characterized by the following 10 elements:

1. Mutuality of endeavor,
2. Avoiding the position of expert,
3. Wondering instead of knowing,
4. Understanding another's subjective experience,
5. Considering all levels of influence,
6. Hearing and representing all voices—especially the child,
7. The centrality of relationships,
8. Parallel process as an organizing principle,
9. Patience, and
10. Holding hope.

With regard to the qualifications of MHCs, it is important to note that the MHCs represented in this study's sites are typically master's-trained, licensed or license-eligible individuals with background and experience in mental health. For example, in Michigan, for the RTT-ELC grant, MHCs are master's-prepared, infant-mental-health-endorsed, clinically trained and experienced with a minimum of three to five years of providing home-based clinical family work under the supervision of a licensed, endorsed clinical director/manager, and receive ongoing reflective supervision. MHCs possess a core knowledge of infant and early childhood mental health, child development, early childhood settings, evidence-based practices, early childhood service systems, and community resources. The approach utilized by MHCs is grounded in a consultative stance (Johnston & Brinamen, 2006) that is relationship-based at its core and focused on mutual understanding and capacity building. Importantly, they work in partnership with "consultees" to promote healthy social and emotional development in children, and recognize and respond to any potential concerns, given their experience working with young children ages birth to five and their families. Some MHCs, known as infant mental health specialists, have specialized training working with very young children, birth to three, and their families. MHCs are adept at engaging, co-creating meaning, modeling, and coaching others to nurture the growth of young children, so they are able to successfully reach social and emotional milestones, and are able to identify mental health problems early on.

> *"There are natural support systems all over our communities. They exist in every community. How do you take natural support systems and then complement with the skills that we have that are in the area of well-being in mental health consultation and integrate all the understanding we have on emotional support development of children?"* — SF, PROGRAM DIRECTOR

Because IECMHC is used more for center-based child care and primarily sanctioned for licensed providers, it was largely inaccessible to most FFN child care providers across the study sites. Given that FFN providers are mostly isolated and stay at home all day with the infants and children in their care, they lack consistent opportunities to learn and stretch, connect with other adults, and feel validated and supported. IECMHC has the potential to enhance caregiver well-being and children's social and emotional health in FFN settings, if available. We learned that MHCs who were able to successfully deliver consultative supports to licensed FCC providers focused on growing the relationship organically and gradually over time, building trust and comradery, showing compassion and empathy, meeting the providers where they are to provide them with what they need when they need it, and cultivating the evolving relationship. The most effective consultants seem to take a listen-and-learn approach and individualize support as much as possible for each provider based on need and circumstance. MHCs

also make the most of informal opportunities—outside of formal program offerings—to connect and offer additional support. It is critical to determine whether these practices, which have been successful with licensed FCC providers, also apply to FFN providers.

> *"The other barrier is really, from the mental health consultation side, is making sure that our workforce understands the nature of what this is. So much of the work right now is still focused on centers. I know we're doing more and more with home visiting, but really thinking about the implications for training our consultation workforce to really understand, "Why would we go into communities and work with those providers? How do we do that? How do we build relationships?...It's both worlds getting to know each other."* — AZ, STATE LEADER

MHCs can work to improve quality of care in home-based settings by imparting developmental guidance (e.g., developmental milestones, developmentally appropriate activities, when referrals are needed), relational guidance (e.g., parent-child and adult-adult interactions, strengthening attachments), and family supports (e.g., how to navigate complex family dynamics and effectively communicate with parents) to child care providers to build their knowledge, skills, and capacity. They can also work with them to validate their caregiver role, encourage them to engage in self-care, take advantage of peer supports and other supportive services, and connect them to community resources to enhance their self-efficacy. Readiness on the side of the provider to actively engage in the process can have a critical impact on the consultation experience and whether these goals are realized. The relationships MHCs have with their providers guide the interventions with consultants attuning to the needs of providers and responding immediately to any basic needs and stressors. IECMHC is most effective when it is flexible and adaptable with the MHCs listening deeply and intently to what is most needed by the home-based providers to prosper.

> *"Really help them with their own sense of efficacy as well, so probably information to help them feel more successful and help them gain understanding of their work and how their work is meaningful... A lot of times, the work is figuring out what the need is so that we can figure out how we can meet that in a different way."* — AZ, MHC

As previously noted, complex family dynamics are often a source of stress for providers. First off, home-based providers may elicit help from MHCs because of concerns with their own family members or children. Stressors could range from not being able to communicate well to substance abuse issues to monetary problems. Therefore, one portal for entering into supportive relationships with consultants could be focused on how to navigate complex family issues within the providers' own families. Secondly, providers may need help navigating stressful situations related to the children in their care. In these instances, MHCs can play a mediator, messenger, and/or motivator role with parents and families to try new strategies or seek assistance. Since MHCs are oftentimes seen as specialized professionals by families, and their opinions carry weight with parents who may be resistant to hearing concerns about their children, their presence can bring about a renewed perspective with parents. Providers can ask MHCs to speak jointly or directly to parents in the hopes that any concerns or recommendations would be better received. For home-based providers, having the advice and support of the MHCs oftentimes facilitates more positive interactions with parents by giving them more tools and confidence to share their concerns and get children the assessments and services they may need to thrive. Collaboration between the consultant, provider, and parent is a dynamic worth cultivating and MHCs can act as an important connector.

Given the stress and intensity that can come with providing IECMHC, multiple support mechanisms for MHCs are available across the four sites. In Arizona, consultants have access to course work in higher education, in-service training, supervision, peer networking sessions, and technical assistance[17]. New employee orientation through Smart Support is comprehensive and includes a year of on-the-job learning and training. Following their first year of employment, MHCs are encouraged and supported to attend the Harris Infant and Early Childhood Mental Health Training Institute at Southwest Human Development to deepen their understanding of infant mental health and the application of infant mental health principles to their consultation work. Additionally, special guest speakers are brought in for in-service trainings for Smart Support consultants. Weekly reflective supervision is provided to all MHCs. Supervisors have the dual role of providing reflective and administrative supervision. Monthly group supervision and monthly small group book clubs also take place with groups of six to eight consultants to one supervisor. Finally, monthly technical assistance is provided to a group of MHCs dedicated to learning more about equity and cultural inclusion for their own practices, and to enhance the practice of Smart Support overall.

In Colorado, consultants receive in-service training, supervision, peer networking sessions, and technical assistance[18]. For example, they are trained in DC:0-5™ Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood, a groundbreaking manual published by ZERO TO THREE, with a training for advanced infant and early childhood mental health professionals. Efforts have also been made for common training on tools such as the Climate of Healthy Interactions for Learning and Development (CHILD) (Gilliam & Reyes, 2017), the Devereux Early Childhood Assessment-Clinical (DECA-C) for use with children showing significant behavioral concerns, and the competency checklist developed by the Center of Excellence for IECMHC[19]. There is a contract stipulation that MHCs receive reflective supervision from a supervisor who has expertise and experience in early childhood mental health[20].

In Michigan, consultants receive in-service training, peer networking sessions, and technical assistance[21]. In particular, MHCs receive an orientation to the model, implicit bias and cultural equity training, trainings on developmentally appropriate practices, trauma informed practice, data/evaluation collection and entry, and the Center on the Social and Emotional Foundations in Early Learning (CSEFEL) Infant and Toddler Train-the-Trainer series. There are monthly peer meetings to reflect, case consultation as well as sharing of resources. There are biweekly check-ins via phone with the state early childhood social-emotional health coordinator and availability to reach out as needed, as well as monthly supervisor calls with the state coordinator. In California, MHCs, including those at our site in San Francisco, can receive an Infant-Family and Early Childhood Mental Health (IFECMH) endorsement through the California Center for IFECMH, administered and housed by the WestEd Center for Prevention and Early Intervention[22]. This endorsement offers linkages for preservice training and professional recognition through endorsement as a mental health specialist or transdisciplinary mental health provider with 0-5 expertise, which may be applied in early care and education settings through IECMHC.

[17,18,19,20,21,22] These data were obtained from our National Scan on the Intersection of IECMHC and FFN Care Settings

Infant and Early Childhood Mental Health Consultation by Site

Three of the four study sites offered IECMHC to home-based providers, primarily licensed, FCC providers. These sites are described in this subsection. One site used an indirect IECMHC model with MHCs working with the early childhood specialists; this will be described in the following section.

Looking more closely by site, historically, Michigan has had a robust mental health consultation program with the Child Care Expulsion Prevention (CCEP) from 1999 until 2010. The CCEP programs, operated through community mental health organizations, provided a model of IECMHC for parents and child care providers caring for children ages 0-5 who were experiencing behavioral or emotional challenges putting them at risk for expulsion from child care. The aims of CCEP were to reduce expulsions, improve the quality of child care, and increase the number of parents and providers who successfully nurture the social-emotional development of infants, toddlers, and preschoolers. Sixteen CCEP projects served thirty-one Michigan counties with funding from the Michigan Department of Human Services (DHS). CCEP came to an end in 2010 when DHS had a change in their budget. This loss of funding affected forty-four MHCs. However, the CCEP model continues to provide the foundational framework for Michigan's work through Project LAUNCH and RTT-ELC especially in enhancing the equity work. The RTT-ELC funding was seen as an opportunity to revitalize the CCEP work, based on infant mental health principles, and refine it to integrate into the current GSQ system.

Although Michigan's IECMHC through the RTT-ELC grant is focused on home-based providers, they can also provide services to center-based providers. As such, IECMHC is available to licensed child care providers in child care centers, Head Start and Early Head Start, and licensed FCC homes for infants, toddlers, and preschoolers ages 0-5 in specific counties including Kalamazoo, Muskegon, Saginaw, Genesee, St. Clair, Detroit Wayne, Oakland, Macomb, and central Upper Peninsula[23]. A provider must be participating in the GSQ Star Rating system to be eligible. There are currently nine MHCs providing services and supports. The state IECMHC coordinates with a multitude of system partners, agencies, and programs, including Early Intervention/Part C-IDEA, Child Care Resource and Referral, Preschool Special Education/Part B, Section 619-IDEA, State Head Start/ Early Head Start Collaboration Office, Child Welfare, Primary Care, Home Visitation, Public Health, Education, and Social Services[24].

In Michigan, there is an interesting differentiation of roles amongst the RTT-ELC specialized consultants. The SECs provide mental health consultation to help providers build quality supportive relationships, attend to social-emotional development, reduce challenging behaviors, and attend to their own mental health needs. The SECs provide services and supports to licensed and registered home providers, such as family and group homes, while the QICs and FECs, work with unlicensed FFN providers and families to improve quality and engagement with the system. QICs can refer FFN providers to SECs for additional supports though, so more targeted assistance for social-emotional issues is available to FFN providers, as needed and requested. The IECMHC work through RTT-ELC will continue beyond the end in funding with new and varied funding sources that will continue to grow and expand the program.

In California, the contextual factors that influenced the development of IECMHC efforts were preschool expulsion data, CCDBG requirements, historical expertise with the DayCare Consultants Program, and the University of California, San Francisco[25]. IECMHC is available to child care centers,

[23,24,25] These data were obtained from our National Scan on the Intersection of IECMHC and FFN Care Settings

Head Start and Early Head Start, licensed FCC homes, and FFN providers for infants, toddlers, and preschoolers ages 0-5 in specific jurisdictions. Availability and eligibility are determined by local funding efforts, initiatives, and/or staff capacity. The state IECMHC does coordinate with the education system[26]. In San Francisco, after an informal "charla" (support group) from the community organically formed with the organization's guidance in the late 1980s, IFR began to offer IECMHC to impact the natural support systems in their communities.

As pioneers launching the use of IECMHC in the 1990s decades before others across the country, IFR partnered with natural child care support systems, like home-based providers, as well as teachers in center-based settings, to build the capacity of and strengthen the well-being of these child care providers and positively impact the social-emotional development of children. Currently, the Early Intervention and School-Based Program at IFR provides IECMHC services to FCC providers of children ages 0-14 years. Experienced MHCs provide mental health consultation services to early learning sites and school-based mental health consultation services to San Francisco Unified School District elementary and middle schools, and services for Latino FCC providers, including individualized consultation and the charla, which is open to FFN providers. At IFR, FRC staff at Casa Corazón can also identify FFN providers in need of individualized consultation and provide a warm hand off to link these providers to MHCs. This approach to linking FFN providers to IECMHC is an innovative workaround that could be used in other communities.

> *"Before, she used to come twice a month, but now she told me, "Since you have a lot of experience, you can call me whenever you need...Every single time that I feel I need help, I just text her...She calls me right back."* — SF, FCC PROVIDER

Interestingly, during mental health consultation visits to home-based programs, MHCs in San Francisco spoke about coming in contact with other family members or friends such as husbands, partners, and aunties. Therefore, MHCs may end up working with both the FCC provider as well as the assistant or other family members or even the whole family. *"I had an opportunity where I was working with the provider and she wanted to meet for consultation with all the family. The mama, the papa, the grandma came, and the two other siblings, and the child"* (SF, MHC). In these situations, MHCs are flexible to the needs of the provider and family and fully engage to understand what is happening in the home to best meet the needs of the provider, child, and family. In addition to home visits, MHCs are readily available to providers via phone or text. FCC providers spoke about how comfortable they were reaching out to their MHCs whenever the need arose and how responsive and helpful they always were. Within these trusting relationships, providers received highly individualized supports to alleviate any impending stresses and handle difficult situations.

Unlike other support groups, in San Francisco, there has been a tension around whether the charla should include classes. The group of providers who have remained connected to IFR for over twenty years have clearly articulated that they do not want classes as part of the structure. They see the charla as a way to connect especially given the trauma and stresses these providers and families experience and the need for a safe place to vent, share, and gain strength and ideas from one another. Usually the MHC will open by asking the group what they would like to talk about this time and the providers will chime in with what they are currently experiencing or struggling with for the group to embrace. Self-care seems to be the primary reason why these providers come together. As such, an annual retreat is open to all child care providers, including FFN providers, as a way to build knowledge and capacity for those who are interested, while the monthly charla remains a sacred space for peer support facilitated by a MHC.

[26] These data were obtained from our National Scan on the Intersection of IECMHC and FFN Care Settings

> *"We all try to share our difficulties. How to help each other, and I think this is a space that we (e)specially need, not only for the children, but for ourselves."* — SF, CHILD CARE PROVIDER

> *"Eight years ago my husband passed away and one of the consultants was with me through it.... I'm grateful to God and to the program.... I have to go and vent. I come tired and I leave really light."* — SF, CHILD CARE PROVIDER

Additionally, in San Francisco, the MHCs with the Fu Yau Project provide center-based consultation and also work with FCC providers in the Asian-Pacific Islander community. Services include on-site program and child observation, clinical consultation with child care staff and families, on-site intervention with individuals and groups of children, parenting classes and support groups, and in-service training for the child care staff relating to child development and mental health-related issues. On a monthly basis, MHCs work with FCC providers at Wu Yee Children's Services, a child care and resource organization, to engage in consultation with providers, child observations, meet with families when needed, and train providers and families. Additionally, a support group for FCC providers facilitated by MHCs meets monthly in the evening. The group size can range from eight to ten providers with some larger groups of twenty to twenty-five throughout the year during holidays. The support group reaches out to providers who do not get monthly home visits. It provides an opportunity for the providers, including FFN providers, to reflect, feel supported, and connect with other providers in their community.

> *"What I hear from them is a lot of their experiences are around being taught something, classes, and so this is a little different, like a space for them to be able to reflect on what's coming, what's happening, what's challenging...to hear the experience of others...to ask questions."* — SF, MHC

Moreover, in San Francisco, there is an initiative called the Family Child Care Quality Care Network with more than 200 FCC providers. The network is designed to improve the quality of services that providers offer to children who are in subsidized child care slots. Each of the providers is assigned a IECMHC program where they can access services. The providers are not required to have mental health consultation. It is their choice. For instance, an FCC provider can call a provider agency, such as the Fu Yau Project, and ask for a MHC to come out and work with them around a particular issue, to supplement support they may be receiving in a support group or in lieu of a group. At the time of the site visit, there were approximately fourteen MHCs at the Fu Yau Project working to meet the varying needs of providers and families in San Francisco's Asian-Pacific Islander community. Although IECMHC is not directly available to FFN providers in San Francisco, the tremendous work done with FCC providers could be a rallying point to expand the availability of individualized consultation to FFN providers.

> *"There will be a specialist in your house...It's a wonderful resource. It helps the families and it helps the children, and us as well...Because this job is beautiful but we also need to have our own space."* — SF, CHILD CARE PROVIDER

In 1997, in Colorado, the legislature funded two pilot programs in Denver and Boulder looking at IECMHC as an approach to reduce out-of-home placements for children in the child welfare system. In 2002, there was an innovation through a federal grant from the Office of the Assistant Secretary for Planning and Evaluation to partner with the health system bringing primary care screenings, including developmental, oral health, hearing, and vision, into the child care program and extending services to licensed FCC providers. Then in 2006, with evaluation data from the two pilots, the legislature allocated state general funds to provide one full-time equivalent (FTE) in each of the seventeen mental health centers. So, for over a decade, IECMHC has been an approach available statewide for infants,

toddlers, preschoolers, and school-age children, and for all child care providers including, in some limited instances, to FFN providers. In 2016, contextual factors influenced the expansion of IECMHC efforts and included federal policy papers and recommendations on preschool expulsions, civil rights data on expulsions, and the CCDBG reauthorization. Spending authority was granted for the CCDBG funds to double the program leading to thirty-four FTEs in state-funded positions.

In Colorado, mental health specialists work in child care centers, Head Start and Early Head Start, licensed FCC homes, and in FFN home settings[27]. There is consultation at the child, classroom, and program levels that varies across programs and locations. Years back, an informal survey was conducted with MHCs before the expansion in Colorado. Thirteen of the seventeen MHCs responded and 80% of respondents indicated that they were not currently providing IECMHC to FFN child care providers. The three MHCs who were providing consultation in these informal settings were engaged in providing training or linking to training opportunities. The consultants also shared that they spend approximately 10% of their time working with FFN providers. Connections usually occurred directly via a program, a local community organization, or through a local council. Two MHCs also responded that they used a formal model of consultation when providing services to FFN providers.

> *"Every single program has a different community approach."* — CO, STATE LEADER

It is important to understand that Colorado has a long history of local control; meaning that while there are state programs that are paid for with state funds, local leaders retain a great deal of authority about how to reach goals and implement programs. Most mental health consultation programs grew on their own based on local conditions and concerns. As one example, North Range Behavioral Health in Weld County offers early childhood prevention programs that provide a strong start for a child and nurture emotional and mental well-being. Expert staff in the Family Connects program work with parents and other caregivers to evaluate young children who are exhibiting behavioral challenges, and provide support in many ways, one of which is through early childhood social-emotional development consultation. The IECMHC team provides direct consultation, training, and indirect support by phone. After finishing their pilot, an expanded partnership with the Department of Human Services led to the funding of another position focused on IECMHC consultation in home-based settings, both exempt and licensed. This will provide great learning opportunities about how to measure readiness and change in provider interactions. The Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO™), a tool with twenty-nine observable developmentally supportive parenting behaviors in four domains (affection, responsiveness, encouragement, and teaching) has been chosen as a way to measure relationship changes with home-based providers and children.

With each local community/organization making decisions about implementation, consistency and continuity have been challenging. This has led to multiple service delivery models used across programs. At the state level, much progress has been made to develop and ensure consistency in hiring, training, and supporting MHCs. A central hub is being created for MHCs to use to obtain training, gather resources, network, and continue to develop skills. Instead of having IECMHC as an approach that is implemented differently across programs/communities, there is interest in exploring ways to institute one service model to be used in all sites across the state. Currently, there are approximately sixty-five MHCs providing services and supports statewide to all child care providers. Working with a MHC can earn provider's quality rating points in the Colorado Shines, QRIS system.

[27] These data were obtained from our National Scan on the Intersection of IECMHC and FFN Care Settings

Indirect Infant and Early Childhood Mental Health Consultation

In addition to providing supports at the child care provider level, there are opportunities for MHCs to provide support at the ECNP level through indirect mental health consultation. In FFN settings, indirect consultation occurs when MHCs work with ECNPs to support them and their work with FFN providers. This support can take the form of weekly check-in calls, coleading training support groups, and/or facilitating opportunities to engage in reflective supervision. For this supportive relationship to be successful, we learned it is most helpful when the partnership between MHCs and ECNPs is the focal point and each works to understand the other's perspective and goals. Like other relationships, the building of trust is essential to cultivate a strong relationship between MHCs and ECNPs, and maintaining consistency and continuity is also necessary for the relationship to grow and flourish. It is vital that MHCs learn more about the culture and reality of FFN care to provide the best support and for ECNPs to understand how consultation can help improve their work with providers to fully engage in the partnership. We found that an openness and willingness to engage are necessary for the collaboration to take shape and have an impact.

It is also critical that MHCs understand the approach of ECNPs with regard to how they structure their support groups, how they work to empower the voices of FFN providers, and how they prefer to communicate, and for ECNPs to understand the MHCs frame and approach to shift any power dynamics that may be at play. It is also important to acknowledge that ECNPs have received extensive education and specialized training in early childhood and hold a tremendous amount of knowledge and insight about child care, child development, as well as the FFN provider community. In addition to this education and training, ECNPs could benefit from the integration of a mental health lens into their work, an important role played by MHCs. Further, given the secondary trauma ECNPs may be carrying from their intense and exhaustive work with FFN providers, MHCs can hold a safe space for ECNPs to process and reflect on what is happening with their providers and in their training support groups to help mitigate stress and burnout. Indirect IECMHC can also benefit ECNPs by exploring resources and referrals that ECNPs might be able to pass onto FFN providers.

Despite these many potential benefits, given the heavy workload on both sides, we learned it is often difficult for MHCs and ECNPs to find times to connect and/or consistently connect in meaningful ways. Prioritizing the time and connection is paramount. Moreover, participants reported that ECNPs informally provide support to one another and act as their own peer group; therefore, adding in mental health consultation can sometimes be cumbersome. ECNPs as a cohesive affinity group naturally support one another and their personal connections should be encouraged. Also, as previously mentioned, organizational supports for ECNPs can include an open-door policy, reflective supervision, monthly team meetings, trainings, and staff retreats giving ECNPs other opportunities to reflect, debrief, and elicit feedback within their home institutions. Until organizations can grow their internal capacity to fully support their own ECNPs, MHCs can play a pivotal support role to enhance mental well-being. We also learned about the importance of acknowledging cultural and linguistic mismatches between MHCs and ECNPs and how this may affect interactions. To optimize the MHC-ECNP dynamic, it is important to be culturally humble and culturally curious and employ a racial equity lens to inform and strengthen the connection.

> *"We're not consulting in a vacuum. Again, it's knowing, "Who is the population? Who are you trying to help? What experiences have they had?"...Consultants, we need to appreciate that. We need to appreciate the complexity of specialists soliciting that story, what that means, and establishing themselves as a trusted ally and distinct from other people in the community that may be people to actually fear."* — AZ, IECMHC PROGRAM DIRECTOR

In Arizona, the contextual factors that influenced the development of IECMHC efforts were preschool expulsion data and school readiness factors. Funding began in 2009 through a new state agency, First Things First, which was created through a voter-approved tobacco tax dollar set-aside for children's programs and services. IECMHC was identified as a promising strategy at that time. IECMHC is available in specific regions (twelve of Arizona's First Things First regions) to child care centers, Head Start and Early Head Start, and licensed FCC homes for infants, toddlers, and preschoolers[28]. With program funding directed toward MHCs working with licensed providers, mental health consultation was provided to program-based, early childhood specialists who worked with FFN providers. The administrative home and major mental health consultation services provider is known as "Smart Support" and is operated by the nonprofit organization, Southwest Human Development. Smart Support teamed with one of the most prominent FFN provider programs in the state, the Arizona Kith and Kin Project, which has 167 locations and is operated by the Association for Supportive Child Care. Their early childhood specialists, who are representative of the population which they serve, lead training support groups for the FFN providers.

Smart Support paired each of their MHCs with an FFN specialist to support their work with FFN providers. However, this indirect IECMHC model for the Inclusion Project did not work out entirely as planned. Due to cultural differences, the FFN specialists felt the MHCs did not fully understand their needs. Additionally, the FFN specialists were already supporting one another in a peer-to-peer capacity and preferred instead that the MHCs consult around the FFN providers themselves and their challenges. In thinking together with the FFN providers, the consultative model was restructured and is now being implemented. The plan is for MHCs to attend FFN training support groups and to act as co-facilitators with the specialists. This will allow for more face-to-face interaction with FFN providers and in vivo support for them and for the FFN specialists. It is important to note that due to the vastness of the Arizona Kith and Kin Project and the limited number of MHCs, MHCs will likely rotate among FFN specialists but will stay with one specialist and one training support group for an entire fourteen week session. We anticipate that the feedback regarding this changed model will be much more positive—as a small exploratory evaluation is planned as well. This redesign, based on the experiences of the FFN partner agency and the FFN specialists, does underscore how important it is to consider innovative ways in which MHCs can simultaneously support ECNPs and FFN providers.

> *"I think the best thing is also the relationship that you build with your consultee, or also being in the environment that they're in, so you're able to witness or observe what's happening. That, to me, is key."* — AZ, MHC

> *"The mental health consultant's role became that [of a] co-facilitator [for the Inclusion Project]. They were part of the group every week. They became a familiar face, part of the trainer group of people, so that they could listen to the conversations that were happening and give input, based on their mental health perspective."* — AZ, FFN PROGRAM DIRECTOR

With the recent change to First Things First's Standards of Practice following our site visit to Arizona, IECMHC is now directly available to FFN providers. One region, Pinal County, received funds for a MHC to provide quarterly trainings to FFN providers and support to specialists with more funding expected in the future, especially with growing interest. With this broadening of settings to include FFN care, it will be important to discuss potential issues and evaluate the expansion. For example, with forty-five MHCs currently to support providers, continued strategic planning needs to be done to ensure that demand can be met, more consultants can be recruited, if needed, and that MHCs are trained and supported to most effectively engage with FFN providers. This remarkable policy

[28] These data were obtained from our National Scan on the Intersection of IECMHC and FFN Care Settings

and funding change underscores the importance of dialogue, identifying barriers, and implementing tangible changes to better support FFN providers who have been left largely unsupported by early childhood systems.

The Need for Support at All Levels—Parallel Processes of Support

A core understanding in infant mental health is that all relationships are important. The concept of the parallel process of support is focused on building effective relationships at all levels. More specifically, staff who are reflective help parents expand reflective capacity and supervisors who are reflective help staff expand reflective capacity (Heffron, 2013). In FFN child care settings, there are parallel processes of mental health-related supports, or the need for analogous support structures, at the ECNP, FFN provider, and child levels. Just as FFN providers need support to better attend to the needs of children in their care, ECNPs need support to alleviate stress and burnout from their intense work with FFN providers. Each layer is modeling for the next layer how to do the "work" through such practices as increased self-care and reflection. Supports at each of these levels trickles down to ultimately improve child and family outcomes.

Using an ecological framework to better understand parallel processes of support, stressors experienced at one subsystem (e.g., families, children) may impact stress experienced at another subsystem (e.g., FFN providers, ECNPs, MHCs). Therefore, FFN providers and ECNPs may be experiencing secondary trauma from working with providers, children, and families experiencing toxic stress and/or trauma. The parallel processes of this traumatic stress contagion may affect the quality of supports FFN providers can offer to the children and families in their care and thus adversely impact children's social and emotional development. Therefore, providing services and supports across groups is needed to improve mental well-being and quality of care.

More explicitly, the types of peer-to-peer supports we found at multiple levels include:

- **FFN provider—FFN provider** in which providers who tend to share similar cultural and linguistic backgrounds can talk openly about struggles and feel confident that they will receive empathy and suggestions from other providers who may have experienced the same issue. Amongst this peer group, knowledge is freely shared and MHCs and ECNPs, who facilitate these peer support groups, are also focused on building knowledge and capacity and encouraging peer connections. Not only can providers learn from one another but connecting to other providers helps negate feelings of loneliness and isolation and enables them to take pride in their work.
- **FFN provider—family** with most providers already supporting their family members, friends, or neighbors, in a variety of ways, from speaking candidly about issues a child may be experiencing and how to get help to inviting parents to take advantage of program services and supports to encouraging parents to take better care of themselves in times of turmoil and stress.
- **FFN provider—ECNP** with ECNPs largely culturally and linguistically matched to the FFN provider communities they serve. In some of our sites, we found that ECNPs are often part of the community and not distinguished or different from providers. Programs are designed to leverage cultural matches and ECNPs use their culture, language, and background to inform their interactions with providers. Though ECNPs can act as cultural brokers, the comradery enables ECNPs to more naturally connect with providers to offer services and supports. Additionally, with the specialized training and experience ECNPs possess, they are able to build the capacity of providers and be a source of consummate support in times of stress or when providers need to talk through personal or child care related difficulties.

- **ECNP—ECNP** mirrors the peer support FFN providers have with one another in that they are a cohesive group with a great willingness and ability to support each other. In the process of providing support to FFN providers, ECNPs internalize and take on a lot of stress. Just as they attend to the mental well-being of providers so they are better able to care for the children in their homes, ECNPs need opportunities to decompress, regroup, and reset as well. These supports can be organizational such as an open-door policy, supervision, and monthly team meetings; however, ECNPs are a natural affinity group and the support they provide to one another is tremendously impactful.

Relationship-based supports, such as those provided by peers, ECNPs, and MHCs, enable FFN and FCC providers to see their value, strengthen intentionality, engage in greater self-care, and bolster their knowledge and skills so they are better able to attend to the social and emotional development of children in their care. Peer supports create a sense of community for these individuals reminding them they are not alone in their struggles; thereby decreasing isolation and increasing connection. In addition, the parallel processes of secondary trauma and stress on support systems informs the role of MHCs. MHCs work to strengthen relationships, communication, and the quality of interactions between providers, children, and families by providing mental health supports, strategies, and resources in an effort to buffer the negative effects of stress on FCC providers and the children in their care and improve child and family outcomes.

In addition to relationship-based supports, self-care is another strategy that may combat the transmission of stress across these FFN subsystems. ECNPs highlighted the fact that in order to provide optimal child care, providers must first attend to their own mental health needs, which highlights the importance of self-care for providers and its relationship to child and family outcomes. Therefore, a broad array of programmatic services and supports, with an emphasis on bolstering peer supports and self-care practice for FFN providers and families, needs to be offered to improve mental well-being and the quality of care. Programs have added self-care modules to curricula with some interesting and fun hands-on activities such as "50 Ways To Take A Break," coloring to relieve stress, and making sugar scrubs for use at home. They have also encouraged providers to find time for restorative activities such as exercising, journaling, crafting, gardening, mediating, and so on.

> *"Really keeping that conversation consistent, like "We're going to talk about how you're feeling and what you're doing to take care of yourself."* — MI, SEC

> *"If they feel someone is creating space and they're feeling valued, then they're going to do that with their little one. It's always about the parallel process and how do we make them recognize that they're important and that we're here to support them so that they can turn back and do that to the kids that are in their care."* — SF, MHC

At the ECNP level, some staff seem to struggle supporting FFN providers while protecting their own mental health. Though ECNPs are there to support FFN providers through training, education, or connecting them with resources, the services they offer are oftentimes outside the scope of their work and much more personal. ECNPs from multiple programs expressed difficulty separating themselves from their clients because of the strong relationships and genuine care and concern they have for the well-being of the FFN providers, children and their families. Often the ECNPs are a cultural and linguistic match for the communities they serve, as previously mentioned, so they too may also be experiencing similar challenges as their FFN providers. ECNPs also expressed challenges with juggling multiple priorities and balancing their personal and professional lives, especially when they are so ingrained in their communities. ECNPs are in the best position to offer frontline support to FFN providers when they have the emotional reserve to effectively process stress. Indirect consultation has the potential to be beneficial in this capacity.

For example, in Colorado, staff at Valley Settlement—although they want to deliver a curriculum—struggle to do so because they are responding to the more immediate needs of their FFN providers (e.g., economic instability), which may trump other goals. Additionally, PASO tias expressed addressing the trauma of their FFN providers first, before they can bring them to *"the next phase of wanting to grow and learn."* These ECNPs are laying the groundwork for change by attending to the hierarchy of needs and working to ensure that providers are emotionally open to change. Supporting the mental health of staff working with FFN providers is also important because it affects how staff are able to serve the providers. The parallel process of support leads to a trickledown effect of greater support to providers, children, and families. The airplane phrase, *"Put your own mask on before you help others,"* reflects a metaphor of parallel process that promotes self-care of staff, so that they can be more present and supportive to their FFN providers.

> *"I've always remembered that you've got to take care of yourself first, before you take care of other people. It's almost like the stewardess on the airplane or attendant that says, "Put your mask on before you help others." The trauma paradigm really does fit because I think a lot of our families and the providers have historical trauma or have heightened levels of experiences. Especially now."*
> — CO, MIXED FOCUS GROUP OF PROGRAM LEADERS AND TIAS

A Continuum of Services Addressing Mental Health in Family, Friend, and Neighbor Child Care

We hypothesized that as we explored various professional development opportunities and quality initiatives for FFN child care providers across the four sites, we might discover a continuum of services and supports for children's social and emotional learning that might include examples of IECMHC as well as more general supports that are congruent with what is important for supporting young children's mental and behavioral health outcomes (e.g., training on attachment relationships, supporting the well-being of the FFN providers themselves, and community resources and referrals). Although this study focused on the intersection between IECMHC and FFN child care settings, the services and supports offered by the four sites include a wider array of activities and strategies beyond formal mental health consultation, which tended to be available only to FCC providers.

Our analysis highlights the significance of access to training and selected social-emotional resources provided by ECNPs to bolster the knowledge and skills of FFN providers, attend to their emotional well-being, and improve practice and behaviors, especially when access to IECMHC is limited. The programs confirmed that ECNPs are an essential source of support, along with peers of similar cultural and linguistic backgrounds and lived experience. Given the limited availability of IECMHC, early childhood networks of support and culturally mediated peer support models are needed and important to attend to caregiver well-being and children's social and emotional health in FFN settings.

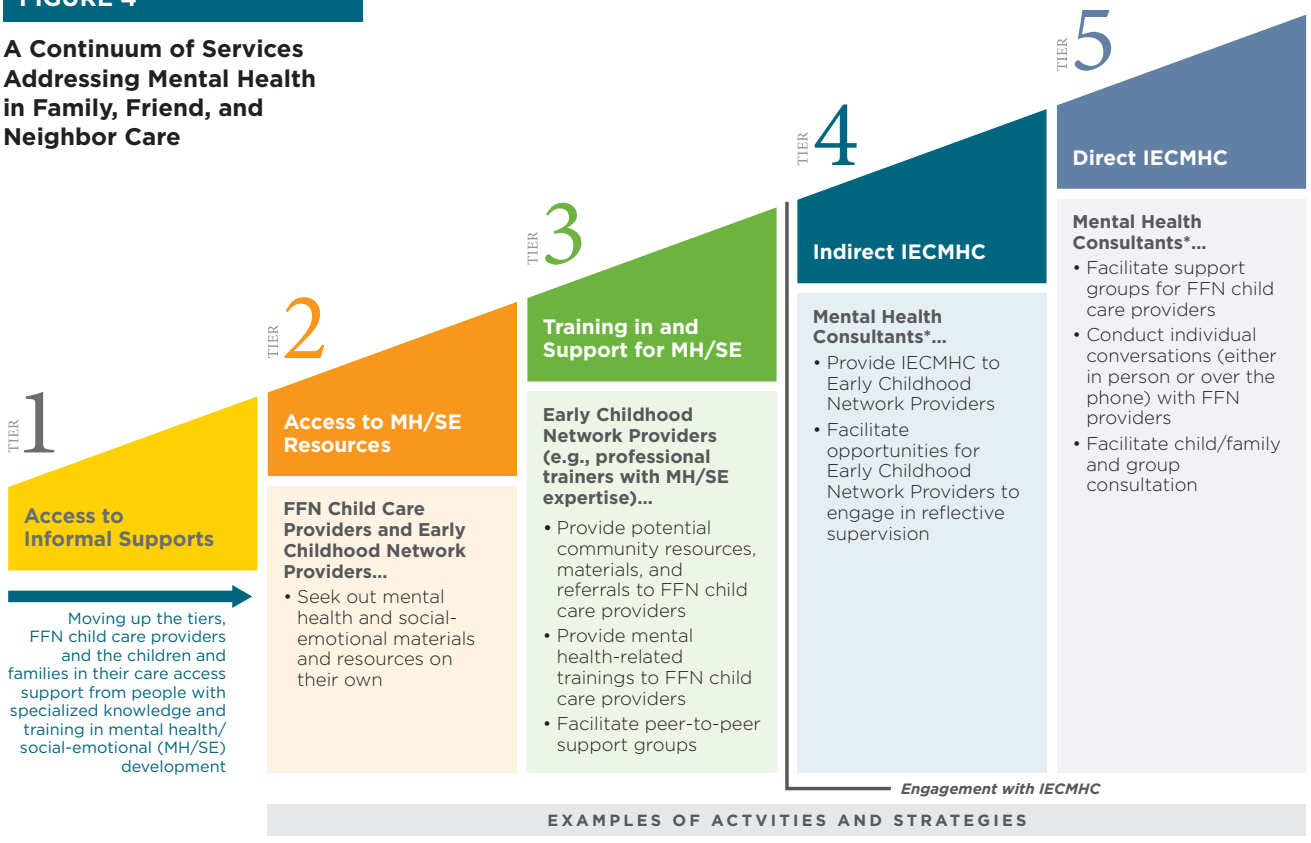
Figure 4: A Continuum of Services Addressing Mental Health in FFN Care lays out a tiered structure for thinking about the mental health-related service array for FFN child care providers. Moving up the tiers, FFN providers and the children and families in their care access support from individuals with specialized knowledge and training in mental health and social-emotional development. Tiers 1-3 are focused on building knowledge and awareness while tiers 4-5 have a greater focus on skills-building given the engagement with IECMHC.

More specifically:

- **Tier 1** is the most general with access to informal supports, such as talking to family, friends, or other confidants from providers' personal social networks about issues and stressors.
- In **Tier 2**, FFN providers and ECNPs seek out mental health and social-emotional materials and resources on their own.
- In **Tier 3**, ECNPs provide potential community resources, materials, and referrals to FFN providers. They also provide mental health-related trainings to FFN providers and facilitate peer-to-peer support groups.
- **Tier 4** is indirect IECMHC where MHCs provide IECMHC to ECNPs, who are working directly with FFN providers. MHCs also facilitate opportunities for ECNPs to engage in reflective supervision and receive support.
- **Tier 5** is direct IECMHC where MHCs facilitate support groups for FFN providers, conduct individual conversations with FFN providers either in person or over the telephone, and facilitate child/family and group consultation, as needed.

FIGURE 4

A Continuum of Services Addressing Mental Health in Family, Friend, and Neighbor Care



*An infant and early childhood mental health consultant is a licensed or certified mental health professional who is working towards or has the skills and knowledge outlined in the IECMHC competencies (http://www.samhsa.gove/iecmhc).

Programs visited across the four sites fell into tiers 3-5. The following are short program descriptions and our assessment of where each program falls along the continuum of services addressing mental health in FFN child care:

Tier 3: Training in and Support for Mental Health and Social-Emotional Development

- In Arizona, the mission of the **Arizona Kith and Kin Project**, housed within the **Association for Supportive Child Care**, is to improve the quality of care for "kith and kin" FFN child care providers through training support groups. The early childhood training and support is focused on increasing knowledge of the elements of quality of care and understanding of ways to challenge and stimulate young children.
  - Early childhood specialists provide training and support to the FFN providers through a fourteen-week long training-support group that meets once a week for a minimum of two hours.
- The **Colorado Statewide Parent Coalition (CSPC)** developed the **Providers Advancing School Outcomes (PASO)** training program with professional development to Latino FFN providers to promote school readiness for children birth to five years old. The PASO program follows a community-based model aimed at closing the achievement gap between Latino and non-Latino children before they enter kindergarten.
  - Trained early childhood education coaches, known as tias, engage FFN providers in an intensive, early childhood education program, aligning their curriculum with Child Development Associate credentialing.
- In Colorado, **Cultivando** is a leadership, advocacy, and capacity-building organization that works in collaboration with community leaders and partners. The organization practices a promotora model that emphasizes the need for community leaders of color to be engaged in initiatives to increase health equity in their communities.
  - Promotoras are building the educational capacity of Spanish speaking FFN providers in Adams County and Denver to reach the majority of low-income children who do not have access to licensed preschool with high quality educational opportunities.
- In Colorado, **Mile High United Way** seeks to build the capacity of communities through professional development, service provision, and partnerships with other community organizations and programs. The networks of support provided by ECNPs from programs and institutions such as Denver Public Schools, Early Childhood Councils from different counties in Colorado, and local family resource centers, are using a community-driven model with reflective supervision and peer supports.
  - These ECNPs provide varying levels of service to FFN providers.
- In Colorado, **North Range Behavioral Health** in Weld County offers early childhood prevention programs that provide a strong start for children and nurture emotional and mental well-being. Alongside IECMHC, Family Connects implements four other primary evidence-based programs in their wraparound services with participants: HIPPY, Incredible Years®, PAT® home visiting, and the SafeCare® parent-training and case management.
  - Expert staff work with families, FFN providers, other caregivers, and professionals to offer these evidence-based programs.
- In Colorado, **United Way of Weld County** in Greeley, Colorado, brings together the community to solve health and human problems and improve the lives of people in the community. Within the Early Education program, they offer the PASO Institute, as developed by CSPC, to address the

achievement gap between Latino and non-Latino children by helping providers create high quality care environments and exposing providers and parents to the need for quality early childhood care and education.

  – For the PASO Institute, tias are working with FFN providers and families.

- In Colorado, **Valley Settlement** started out as a project under the Manaus Fund to understand the experiences of immigrant families in Roaring Fork Valley. With no organization in the community that was systematically reaching out to welcome and engage immigrant families with young children, Valley Settlement became a standalone 501c3 nonprofit organization continuing to engage immigrant families in their local schools and community.
  – Their early childhood specialists use the PAT® FFN curriculum to engage with FFN providers and also conduct two home visits a month with each FFN provider.
- Michigan's **Race to the Top-Early Learning Challenge (RTT-ELC)** funding was seen as an opportunity to revitalize the Child Care Expulsion Prevention (CCEP) work and ensure that greater numbers of children with high needs are able to access high quality early learning and development programs and that these programs are embedded within an integrated state system of programs and supports for young children. For RTT-ELC, the populations prioritized are providers within the QRIS and family/group home providers.
  – Specifically, for FFN providers, Quality Improvement Consultants, who act as ECNPs, are focused on increasing the number of home-based providers participating in the program and work with the FFN providers in the cohort.
- In San Francisco, **Casa Corazón** offers family programs within **Instituto Familiar de la Raza (IFR)** to ensure that families receive a continuum of services and supports to enhance resilience. The Family Resource Center staff provide case management, parent education, and early intervention services.
  – Family resource specialists facilitate parenting classes, parent leadership and education workshops, parent support groups, parent-child activities, and additional family support services such as individual consultation, information and referrals, case management and family advocacy, and mental health services to families as well as FCC and FFN child care providers.

Tier 4: Indirect IECMHC

- Arizona's **Smart Support Program**, housed within the large Phoenix-based nonprofit, **Southwest Human Development**, provides IECMHC to child care providers with two goals in mind. The first is to improve the overall quality of early care and education settings so that they are better able to support the social and emotional development of all children in their care. The second goal is to increase the capacity of early care providers to address the mental health needs and challenging behaviors that place individual children at risk for negative outcomes in the early years of life and beyond.
  – Smart Support MHCs provided support to the Arizona Kith and Kin Project early childhood specialists who support FFN providers.

Tier 5: Direct IECMHC

- In Colorado, **North Range Behavioral Health** in Weld County offers early childhood prevention programs that provide a strong start for children and nurture emotional and mental well-being. Expert staff in the Family Connects program use early childhood social-emotional development consultation to increase the capacity of families, caregivers, and professionals to support the

developmental, behavioral, wellness, learning, and literacy needs of young children to enhance school readiness and build healthy relationships.
  - MHCs work with FFN providers, other caregivers, and families.

- In Michigan, the **CCEP** operated though community mental health organizations providing a model of IECMHC for parents and child care providers caring for children ages 0-5 who were experiencing behavioral or emotional challenges putting them at risk for expulsion from child care. Although the funding ended in 2010, CCEP provided the foundational framework for Project LAUNCH and RTT-ELC. In the IECMHC model, the consultant was a master's-prepared, infant-mental-health-endorsed mental health clinician through the local community mental health agency and would connect directly to providers and families requesting services.
  - MHCs supported providers in center-based and family and group home settings and relative providers and daycare aides.
- In San Francisco, the **Early Intervention and School-Based Program at IFR** provides mental health consultation services to child care providers of children ages 0-14 years. Focused on promotion, early intervention, and building community resiliency, the Early Intervention team offers services that address the unique developmental, behavioral, and social-emotional needs of children and their families by enhancing supportive relationships, embracing the families' world view, and fostering positive learning environments.
  - MHCs provide mental health consultation infant/preschool services, school-based mental health consultation to elementary and middle schools in the Mission and Outer Mission Districts, and San Francisco Unified School District schools, and services for Latino FCC providers including a support group that is open to FFN providers.
  - FFN providers can also gain access to IECMHC through the Family Resource Center at IFR with Family Resource specialists providing a warm hand off of FFN providers to MHCs.
- In San Francisco, the **Fu Yau Project** provides prevention and early intervention health services to the family resource centers and child care community that cares for children ages 0-5 years. Services include on-site program and child observation, clinical consultation with child care staff and families, on-site intervention with individuals and groups of children, parenting classes and support groups, and in-service training for the child care staff relating to child development and mental health related issues.
  - MHCs also facilitate a support group for FCC providers twice a month. The support group reaches out to providers who do not get monthly home visits. It provides an opportunity for the providers to still get mental health support and have greater connections with other providers in the community.

Once the findings were compiled, the IECMHC programs and early childhood networks of support across the four sites confirmed the usefulness of this continuum and agreed with where their programs fell within the tiered model. We believe this graphic accurately captures the types of services and supports available to FFN child care providers. Although visually depicted as discrete tiers, we understand that activities and strategies may overlap between tiers. This horizontal continuum of services can also be thought of as increasing in intensity of support from left to right. As communities, states, and jurisdictions continue to build out a continuum of services to address mental health in FFN care, attention should be paid to each tier and how services and supports can build upon one another to provide coordinated and comprehensive networks of support to attend to the mental health and other needs of FFN providers, children and their families.

Impacts at the Provider, Child, and Family Levels

In learning from sites about desired impacts and achieved outcomes, we hypothesized that engagement with a continuum of services and supports can lead to significant changes in knowledge, attitudes and perceptions, and skills and behaviors, which may affect caregiver well-being and quality of care in FFN settings. As a theory of change, increased provider knowledge, skills, and abilities could ultimately affect the healthy social and emotional development of children and other outcomes, such as early literacy and school readiness. **Figure 5** visually depicts theoretical multi-level outcomes as a result of program offerings along the continuum. Changes could happen to a greater or lesser extent depending on FFN providers' level of interaction and engagement with various training and support opportunities, including IECMHC, along the tiered continuum of services.

Although we were able to parse out reported impacts at the FFN provider, child, and family levels, primarily as a result of participating in programming offered by early childhood networks of support, a key finding is the interconnectivity of these impacts. Reported impacts on the FFN provider level are primarily due to participating in culturally mediated peer support groups, attending classes, workshops, and trainings, and connecting one-on-one with ECNPs and other program staff. Although many early childhood programs may have licensing as a goal for FFN providers, palpable change can still occur in FFN care settings even if licensing is not achieved (Shivers et al., 2016a). Impacts were also noted for FCC providers as a result of IECMHC providing insight into what might be possible for FFN providers, if consultation were more accessible. **Table 2** highlights changes reported by participants across the four sites due to programmatic efforts focused on supporting home-based providers.

FIGURE 5

Theoretical Multi-Level Outcomes

TABLE 2: Theory of Change for Child and Family Level Outcomes

Variable		Components
Increased Knowledge for FFN Providers		• Understanding the importance of attachments and positive child-provider-adult interactions • Understanding the importance of smaller group sizes or lower provider-to-child ratios • Understanding the importance of play and parallel process • Learning how to engage in conversation with parents • Learning how to manage emotions and decrease stress on self and children • Learning strategies to promote children's social-emotional development and manage challenging behaviors • Learning about brain and child development
Changes in FFN Attitudes/Perceptions		• Acknowledging mental health stigma and its effects • Favoring lifelong learning • Having greater self-affirmation • Seeing value in role as a caregiver • Seeing value in providing child care • Understanding that you make a difference in children's lives • Affirming what you know • Rethinking what you thought you knew • Realizing you cannot give what you do not have
Improved Skills/Behaviors for FFN Providers		• Learning positive discipline strategies • Learning emotion coaching skills for children in their care • Gaining crisis management skills • Being more cognizant
Improved Caregiving Well-being	Improved Mental Health for FFN Providers	• Experiencing improved mental health hygiene • Connecting to resources to support mental health
	Increased Self-efficacy for FFN Providers	• Believing in ability to complete tasks, fulfill goals, and accomplish change • Realizing the important role they play in children's development
Improved Process Aspects of Quality of Care	Strengthened Relationships	• Strengthening relationship quality with parents and families • Having opportunities to connect with and learn from others (e.g., peers, program staff) • Learning how to build supportive relationships • Facilitating positive caregiver-child interactions • Feeling supported trickling down to better relationships with children and their families • Strengthening family connections
Positive Child and Family Outcomes	Improved Child Outcomes	• Improved emotion regulation and self-regulation skills for children and caregivers • Improved child behaviors • Improved mental and physical health • Healthier diets and exercise routines • Greater kindergarten readiness • Greater school readiness
	Improved Family Outcomes	• Increased use of referral resources • Stimulating and developmentally appropriate home environment that facilitates learning • Increased positive child rearing practices • Increased positive parental behavior to serve as models for children • Improved stress management • Improved caregiver-child interaction • Improved mental and physical health • Healthier diets and exercise routines

> *"Licensing, I don't think that's what our ultimate goal is. I think our ultimate goal is to be able to walk into an FFN's home and just know automatically that that is a safe, caring, loving environment where any kid can be taken care of. That we have given all of our knowledge and education to them so that then they are able to just continue to grow, share with other parents, and just a better quality. I think that's the biggest thing. We need to increase the quality of care all these kids are receiving from FFNs."* — CO, PROGRAM LEADER

> *"...turn on the TV and the child can remain sitting there for eight hours, if it's that or more, and you just feed them and sometimes when they'd remember later, "Wash your hands." Right? So then they'd just feed them and the child would go again to the TV. Now, through (PASO) we have learned that...well, honestly TV isn't good for them. Because a provider is supposedly not just a nanny who is looking after a child but also someone who is focused on teaching those children, to be on their way to preparing them for pre-kinder, right? Their first school levels. So what should we do? Well, teach them their ABC's, the letters so that they learn them well...numbers, colors, explain to them what's outside, about the environment. I mean, like take them to a garden, explain to them, "Look this is what this flower is," the birds, the animals, explain it well to them. And the children start to learn. They're like they told us—children's minds are like sponges. They absorb everything and it registers in them."* — CO, FFN PROVIDER

Interestingly, a participant spoke about FFN providers as conduits of information for their families. If FFN providers, a large segment of child care providers who have traditionally been unsupported and disconnected from systems of support, are then strongly connected to community resources as well as programmatic services and supports that boost their knowledge, skills, and self-efficacy, then those resources can bolster their personal growth and development as child care experts. Providers can then impart knowledge and learnings to the child to strengthen their social and emotional health and also support the parents and families who may be struggling or dealing with a multitude of stressors. By strengthening families, providers are, in turn, strengthening their communities. The ripple effects could be very tangible and especially impactful. With the majority of young children in FFN care settings, child and family outcomes cannot be affected if providers are not given the services and supports they need to thrive. By supporting FFN providers, early childhood networks of support are working to positively affect outcomes for caregivers, children and their families.

> *"The role that I see an FFN caregiver providing for families in communities is that they become a conduit of information for families. If they're strongly connected to community resources, to their own personal growth, their own professional development, for that group of people, the transmission of that information to the child directly, you're going to see positive outcomes from that child, and you can have this triangle where you can support the parents. When you strengthen families, you're going to have stronger communities."* — AZ, STATE ADMINISTRATOR

Lessons Learned

Embedding lessons learned within Bronfenbrenner's Ecological Systems Theory of Human Development (see Figure 2), it is important to remember that children in FFN child care settings are exposed to a complex array of influences at the micro- and meso-levels that can affect their social and emotional health (Aquino et al., 2018). At the microsystem, to better ground and inform the work of programs seeking to support FFN child care providers, it was important to contextualize the FFN landscape and the families in care. To recap, there are high levels of trauma-exposure in this population that come from experiences such as poverty, immigration, racism, and discrimination. There is also a need and desire for resources and supports to help FFN providers take better care of themselves and their families. Families are dealing with many life stressors and tend to work nontraditional jobs requiring a flexible and affordable child care arrangement. They also seek FFN care because it feels safer to leave children with caregivers who share similar cultural and linguistic backgrounds.

At the mesosystem, it is critical to understand how community programs recruit and engage FFN providers. Engaging FFN providers in services and supports proves difficult when providers do not self-identify as child care providers, are a hidden population, and are reluctant to seek out services for culturally informed reasons. A combination of formal and informal strategies that are individualized, relationship-based, and considerate of the particular needs and culture of FFN providers proved beneficial to early childhood programs reaching and engaging these communities. Also, to combat stigma-related barriers, successful programs approached mental health services with cultural responsivity and cultural humility. By placing the emphasis on wellness instead of taking a deficit-oriented approach, mental health and self-care are normalized.

Thinking about interactions between the micro- and meso-levels, relationships and culturally mediated peer support models become essential. Programs that successfully engaged FFN child care providers created space for them to gather. An opportunity to build relationships with staff and other providers mirrors the peer support that FFN providers give their families, as relatives, friends, or neighbors. Relationship-based approaches also act as a vehicle for change as FFN providers feel a sense of empowerment and support in their role as invaluable caregivers. This empowerment leads to their sustained engagement in programs and may ultimately lead to higher quality environments for young children to grow, learn, and thrive.

With this framework in mind, the following section describes lessons learned from the cross-site analysis with regard to barriers to effective engagement of FFN providers in the aforementioned continuum of services to address mental health needs in FFN care as well as components of successful models working with FFN providers. These takeaways highlight important considerations as programs work to enhance outreach to and engagement with FFN providers and work to build and/or improve program offerings for FFN providers. Although there may be different intervening factors or special considerations in each community, state, or jurisdiction, these learnings provide valuable insights on potential challenges inherent in serving and supporting FFN providers and programmatic facilitators of success to meet the mental health and other needs of providers. FFN providers, as the most underserved group of child care providers, are in need of accessible services and supports that speak to their distinctive needs as FFN caregivers. We hope these lessons learned will contribute to the growing discourse on how to effectively construct support and educational opportunities for FFN providers to improve the quality of care. Lastly, we echo the need for future research on effective outreach and programmatic efforts and studies that link programs to improvements in quality of care.

Barriers to Effective Engagement of Family, Friend, and Neighbor Child Care Providers in a Continuum of Services

From the program perspective, effective recruitment and engagement of FFN child care providers in the continuum of services to address mental health in FFN settings can be complicated by personal, systemic, infrastructure, and logistical barriers. These barriers make it difficult to identify, recruit, and engage providers in services and supports that might be needed and welcomed, if they were known and trusted. These barriers may also complicate the delivery of services and supports to child care providers who already receive little to no support. Programs that are able to acknowledge these barriers and develop innovative strategies to overcome them are in the best position to support FFN providers.

To recap, barriers to effective engagement of FFN child care providers in services and supports include:

- Being in the shadows and tending not to self-identify as FFN providers,
  - Although an array of services and supports may be available through early childhood networks of support or IECMHC programs, since FFN providers do not self-identify as "FFN providers" and are mostly in the shadows, identification and recruitment can be extremely challenging.
  - Simply putting up fliers or marketing to "FFN providers" will not resonate with caregivers who do not self-identify as such.
  - The use of trusted cultural brokers who are out in community settings where young children, providers, and families naturally gather and congregate (e.g., schools, community centers) is essential to engaging with providers who are unconnected to formal systems.
  - Once programs have a toehold in a community, then word-of-mouth from providers who have engaged and found benefit in services and supports can grow program interest and participation exponentially.
  - Increasing visibility in the community by attending community events can be an effective way to make programs more visible and expand reach.
- Fear, mistrust of systems, and lack of buy-in,
  - FFN providers and families may think of FFN provider serving programs as part of social services or another agency that may monitor or report them, if they partake of services or supports.
  - Therefore, programs have to grapple with how to explain their intent and differentiate themselves from negative associations with other entities to gain the buy-in and trust of providers.
  - By teaming with trusted community organizations or utilizing cultural brokers, programs can earn the respect and trust of providers and families.
  - By attending to the relationship and offering culturally and linguistically relevant services, supports, and materials, programs can help dispel any lingering distrust and offer programming that fits the needs of FFN provider communities.
- Push to move FFN providers along the formal path towards licensure,
  - FFN providers may be hesitant, ineligible, or unable to get licensed for a myriad of reasons due to legal status and other constraints such as the hefty requirements or time commitment that are part of the licensing process.
  - Even if providers are unable to get licensed, many are extremely eager for more training, support, and professional development opportunities, which still connects them to the formal child care system.
  - State preferences to move more FFN providers along the professional development continuum can be a sticky point for programs that want to offer an array of services and supports including but not limited to moving providers towards licensure.
  - Provider intentionality can still be affected through programmatic services and supports regardless of whether licensing has to be the ultimate goal.
  - There needs to be greater recognition that providers should have access to a wide array of services and supports to improve their capacity and child care practices regardless of intent to pursue the formal path to licensure.
- Lack of or inadequate funding and resources,
  - Funding is a challenge as funding for some programs is lacking, unstable, or in competition with other programs. Limited funding trickles down to limited services and supports for FFN providers, children, and families.

  - Funding stipulations or contracting language can prohibit the provision of IECMHC to FFN providers limiting their access to an effective support mechanism.
  - Minimally low state-instituted payment systems for unlicensed, subsidized providers in an attempt to shrink the population can make it even more challenging for providers who may already be struggling financially.
  - Given that the majority of children across the country are cared for within FFN settings, providers and families should receive as much compensation and support as possible, if we want to improve outcomes for all young children.

- Workforce development shortages and insufficient bilingual and bicultural staff, and
  - Programs may struggle with recruiting and hiring qualified staff who are bilingual and bicultural. This seemed to be especially true with regard to MHCs who tend not to mirror FFN providers, families, or ECNPs that they may be supporting.
  - There is a need to reassess qualifications perhaps giving more credence to lived experience and knowledge than degrees and credentials. Education does not necessarily equate to being better able to connect with FFN providers and families.
  - With fewer staff, workloads may be overloaded. Given how stressful supporting FFN providers and families can be, this can take a toll on staff requiring parallel processes of support.

- Lack of understanding about IECMHC.
  - Although mental health consultation has been shown to be beneficial in many early childhood settings, much of the early childhood workforce does not understand what it is and how it can help.
  - It is still believed that IECMHC is a center-based intervention so there is misunderstanding about how it could be applied to home-based settings and specifically with FFN providers.
  - Workforce development is needed for MHCs to better understand FFN child care settings and for ECNPs and other program staff to understand the benefits of consultation and the ways it can be delivered.

Components of Successful Models Working with Family, Friend, and Neighbor Child Care Providers

Analysis of programmatic approaches across the four sites revealed several components that enabled early childhood programs to overcome barriers and work effectively with FFN child care providers. As states and communities grapple with how to reach out to and integrate FFN providers into their formal systems and IECMHC programs figure out how best to extend support to FFN providers, these components could act as guideposts for programmatic development to meet the mental health and other needs of FFN providers. How these components are implemented depends on the particulars of the site, such as racial and ethnic make-up, community partners, workforce, capacity, resources, and so on to make the strategies as specific to the locale as possible. These elements, however, can be viewed as a launching point for strategic planning in IECMHC programs on how best to engage with and meet the mental health and other needs of FFN providers. Many of these components are consistent with earlier comprehensive studies about IECMHC (Duran et al., 2009).

In this study, we found that successful programs across the four sites working with FFN child care providers tend to:

- Use a cultural and community-informed frame to guide their approach,
  - When programs optimize the protective factors of culture and community in their services and supports, the program offerings are more rich, tailored, and impactful.
  - Cultural considerations with regard to staffing are critical. Bilingual and bicultural staff seem better able to create rapport and trust with FFN providers. ECNPs model the importance of cultural matching or cultural mirroring whenever possible and the effect it can have on provider engagement.
  - With insufficient bilingual and bicultural staff, it is important for staff from different backgrounds to be culturally humble, respectful, and curious to establish a connection with providers.
  - Facilitating an atmosphere that views mental health consultation as a "gracious exchange of expertise" and that both parties involved are experts in their own right, sets up greater opportunities for mutual learning and shared understanding. This entails not only teaching FFN providers about IECMHC, but also teaching MHCs about FFN child care—shared learning is critical. This also extends to MHCs and ECNPs reciprocally sharing their expertise and perspectives.
- Use cultural brokers to help build relationships,
  - Since recruitment of FFN providers is one of the most challenging aspects of serving this population, community-based organizations with cultural brokers or trusted individuals in the community who are involved in or deliver services to the community may help most effectively in reaching out to and engaging with hesitant providers in need of support.
  - ECNPs are uniquely situated to act as cultural brokers and support staff for FFN providers.
- Outreach with intention to FFN providers in innovative ways,
  - Cultural brokers act as natural entrees to link providers to programs.
  - By framing services as educational and support opportunities, programs turn the focus away from "professionalizing" to building capacity and enhancing well-being.
  - Greater acceptance of FFN providers who choose not to or cannot become licensed will allow for more inclusive recruitment of FFN providers and a more supportive environment overall for a range of provider goals.
  - There is a tremendous need for a continuum of services and supports including, but not limited to, moving providers along the professional development continuum.
- Acknowledge Maslow's hierarchy of needs, historical practices in communities, trauma in communities, and other influencing factors,
  - By acknowledging the impact of these contextual factors on FFN providers, children and their families, programs can work to mitigate some of the negative impacts and offer knowledge, tools, and strategies to build capacity, self-efficacy, and intentionality.
- Build strong relationships, especially peer relationships,
  - As the foundation for change, it is critical to build relationships at all levels (e.g., ECNP to FFN provider, FFN provider to FFN provider, ECNP to MHC, MHC to FCC/FFN provider, FFN provider to family, ECNP to family, MHC to family).
  - Peer relationships are an invaluable source of support for FFN providers and can strengthen their resiliency and resolve, be a source of inspiration, and an impetus for change.

  - Culturally mediated peer support models foster the protective factors of culture, community, and social connections and can enhance caregiver well-being, especially when IECMHC is unavailable to FFN providers.

- Build on effective current approaches to working with FFN providers, especially training support groups,
  - Many of the social emotional consultation trainings are based on the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) model.
  - Trainings also include sharing resources and experiences and learning about child development (e.g., brain development, ages and stages, continuous and discontinuous developmental milestones, language and literacy).
  - Offering consistent training support groups for FFN providers allows relationships to form and strengthen.
  - Although programs may adopt training approaches and develop curricula, by remaining open to adjustments and perhaps adopting a "grow, develop, evolve" philosophy, they are better able to meet the needs of FFN providers in a timely manner.
  - Training support groups, facilitated by ECNPs and/or MHCs, offer opportunities to build the knowledge and capacity of FFN providers, facilitate dialogue and sharing amongst the provider peer group, and provide individualized support as needed.

- Engage with FFN providers to determine their unique needs,
  - The most successful training support groups are flexible and adaptable to the urgent and ever-changing needs of FFN providers.
  - When ECNPs play a facilitative role offering opportunities for FFN providers to share their pressing issues, ask probing questions, and receive peer support from their fellow providers, the training support groups are much more effective.
  - By supplementing training content with real life experiences, the training support groups become much more relevant and germane for FFN providers.
  - Understand that FFN providers are oftentimes navigating complex family dynamics as family, friends, or neighbors of the children in their care, and need strategies to effectively deal with family-related stress and/or difficult interactions with parents around child development concerns, challenging behaviors, financial issues, and so on.

- Offer individualized consultation, as needed, and
  - Having MHCs present in training support groups as co-facilitators and "familiar faces" to build relationships and rapport may be a promising approach worth implementing and evaluating. Ideally, as a consistent presence, MHCs would learn how to better "match the right entry point" and provide more appropriate and effective support to providers and the children in their care as well as ECNPs working on the frontlines with providers to support quality improvement.
  - Making sure MHCs are available to ECNPs and/or providers, as needed, through ongoing face-to-face opportunities or by telephone, is imperative.
  - MHCs should keep in mind their use of technical skills. If they are overusing reflections and other clinical approaches with providers, they may be viewed as disconnected by ECNPs and/or home-based providers.
  - In addition, maintaining a relaxed organic conversation with a non-inquisitive approach will increase rapport and trust in the relationship leading to a more successful and informed consultation experience.

- Provide administrative and monetary support.
  - In order to increase attendance, programs that offer instrumental incentives, such as transportation or gas cards, child care, and food, and are cognizant of scheduling, enable FFN providers to attend and actively participate in programming.
  - Programs that offer material incentives, such as carbon monoxide detectors, fire extinguishers, baby gates, cribs, pack 'n' plays, high chairs, car seats, art supplies, and so on are helping to improve the structural quality of FFN care settings.
  - By hosting sponsored activities for providers and families to unwind and have fun together, such as trips to parks, museums, or libraries, programs are offering more opportunities for self-care and stress release.

SECTION 9

DISCUSSION

Currently, Infant and Early Childhood Mental Health Consultation (IECMHC) is expanding into new types of settings that serve infants, young children, and their families, such as domestic violence shelters, home visitation programs, primary care offices, and other child-serving organizations. Although these settings have long been staffed by social workers, nurses, doctors, and care coordinators, newly defined collaborations with infant and early childhood mental health consultants (MHCs) are offering an approach that emphasizes the capacity of the caregiver to understand and respond to the unfolding needs of the young child. Expansion of IECMHC into family, friend, and neighbor (FFN) child care represents one of the newest trends in the exploration of IECMHC models in diverse settings (Ash, Mackrain, & Johnston, 2013). As IECMHC moves into new settings where professionals support families and children, core components of IECMHC that are utilized in more traditional settings, such as use of the Consultative Stance (Johnston & Brinamen, 2006), provide a framework for how to integrate the consultation into these new systems. Implementation of these core components and elements sets the stage for services that are relationship-based, individualized, and more likely to engage partners and families (Ash, Mackrain, & Johnston, 2013).

Despite the large percentage of children in FFN child care settings, there is no definitive research on how social and emotional development is being addressed in FFN child care settings or the extent to which IECMHC is being used in FFN child care settings to build the capacity of FFN child care providers. The research to date on IECMHC has been conducted almost exclusively in formal, licensed child care settings. IECMHC has the potential of offering increased effective assistance to a larger number of young children, their families, and the caregivers who care for them. As we scanned the literature, we discovered FFN child care providers currently receive very little support that is directed toward the mental well-being of the children in their care. Therefore, we wanted to determine the extent to which IECMHC was available in FFN child care settings, and if/when available, whether IECMHC could be a viable and helpful approach in these home-based settings. We also wanted to describe the components of effective IECMHC programs for and on behalf of FFN providers.

Although this study focused on the intersection between IECMHC and FFN child care settings, the services and supports offered by the four sites represented in this study include a wider array of activities and strategies beyond formal mental health consultation, which tended to be available only to licensed family child care (FCC) providers. Our analysis highlighted the significance of access to training and selected social-emotional resources provided by community-based early childhood networks of support to bolster the knowledge and skills of FFN providers, attend to their emotional well-being, and improve practice and behaviors, especially when access to IECMHC is limited. The programs confirmed that community-based early childhood network providers (ECNPs) or FFN specialists are an essential source of support along with peers of similar cultural and linguistic backgrounds and lived experience. Given

the limited availability of IECMHC, early childhood networks of support and culturally mediated peer support models are needed and important to attend to caregiver well-being and children's social and emotional health in FFN settings. Nevertheless, the extensive findings in our cross-site analysis warrant a discussion of implications at the program, policy, and systems levels. Recommendations are framed as a call to action to increase services and supports for FFN child care providers and encourage greater exploration of IECMHC in FFN child care settings.

Multi-Level Implications

In exploring the extent to which mental health consultation, as a capacity-building and problem-solving intervention implemented in early childhood settings, is available in FFN home-based settings, we encountered minimal intersection. Despite the solid evidence for IECMHC in formal child care settings, in the four study sites, it is largely unavailable or inaccessible to the FFN provider communities. The strategy remains mostly within the grasp of licensed child care providers. IECMHC is still seen as more of a center-based intervention and early childhood MHCs are typically only sanctioned in grants, contracts, and Standards of Practice to work with licensed providers. This leaves FFN providers unable to access more individualized consultation and reliant on community-based ECNPs to play a supportive role to improve their capacity. We cannot advance IECMHC as a potential strategy to improve caregiver well-being and children's social and emotional outcomes in all early childhood settings if it is systemically absent from an array of supportive services for FFN providers. Changing this reality requires a shift in understanding about the potential for IECMHC to support FFN providers and/or community-based ECNPs, altering stipulations and policies to allow for greater intersection between IECMHC and FFN care, and engaging in program evaluation to determine the impact of IECMHC models in FFN settings.

Lessons learned from the training and education opportunities offered by community-based ECNPs represented in this study and others can contribute to the growing literature on how best to support FFN child care providers. In addition, our exploration of how IECMHC has supported licensed FCC providers can inform future efforts to explore the potential of IECMHC to benefit unlicensed, FFN providers. Findings from this study are consistent with other research on IECMHC, which demonstrates that to be most successful, MHCs must seek to learn as much as possible about the culture of the setting and the factors that influence practice. Ash and colleagues (2009) provide a list of other considerations. They include understanding the history of the service and the setting, bureaucratic and programmatic pressures, and program philosophy. Additional layers of influences to consider are interpersonal. How are staff interacting and speaking with one another? How do the hierarchies of authority and responsibility operate? What are the informal ways of getting things accomplished? Implementing this stance of culturally-informed curiosity can assist IECMHC programs and staff in establishing what to do and how to be in each setting.

Findings from the cross-site analysis of early childhood networks of support and IECMHC programs has led to the formulation of implications at the program, policy, and systems levels. These implications represent areas ripe for improvement to advance the work of programs dedicated to serving FFN provider communities and areas in need of further research to grow understanding about how best to impact quality of care in FFN settings.

Implications for Infant and Early Childhood Mental Health Consultation Program Design and Implementation

Based on the study results, the major implications for IECMHC programs with regard to FFN child care are:

1. Invest more time and energy in exploring and understanding the nature of FFN child care, including who uses it, who provides it, and who supports it.
2. Be prepared to support the mental health and other needs of FFN child care providers as well as the ECNPs who serve them.
3. Enhance the ability of the current mental health consultation workforce to authentically integrate a socio-cultural and equity lens into their work with FFN child care providers, families, and ECNPs.
4. Increase IECMHC workforce diversity, so that there are more cultural, ethnic, and linguistic matches among MHCs and the communities they serve.
5. Develop authentic partnerships with the organizations that house ECNPs to collectively meet the needs of FFN child care providers and create comprehensive early childhood networks of support for FFN caregivers.
6. Conduct research and evaluation to explore what works in terms of IECMHC models to best support FFN child care settings. For example:
   a. Which IECMHC models (e.g., direct vs. indirect) are most effective with which types of early childhood networks of support?
   b. Do the Theories of Change differ when MHCs work with FFN child care providers?
   c. Do the core constructs and core components commonly found in IECMHC programs still stand (Duran et al., 2009)?

Implications for Family, Friend, and Neighbor Support Program Design and Implementation

The study findings informed the following implications for FFN support programs within early childhood networks of support to enhance the mental well-being of FFN child care providers and the children and families with whom they work:

1. Focus on the importance of referring FFN child care providers to mental health resources for themselves and the children and families in their care.
2. Enhance ECNPs' understanding of trauma, attachment, early intervention, and other mental health-related topics.
3. Design FFN training support programs to intentionally explore ways they can attend to and be more attuned to the well-being of FFN child care providers in a culturally responsive way.
4. Cultivate relationships with other local mental-health focused programs in addition to IECMHC programs and move to strategically leverage these services and supports.
5. Increase the organizational capacity of community-based early childhood networks of support who serve FFN child care providers to integrate more opportunities for reflective supervision for their ECNPs who might experience secondary trauma as the result of working with FFN providers who often experience acute trauma as well as the impact of intergenerational, historical trauma.
   a. This might include additional training and/or education for supervisors and leadership at these agencies that will enable them to integrate an infant mental health lens and trauma-informed care into their respective programs.

Implications at the Policy and Systems Levels

Implications at the policy and systems levels related to FFN child care and a continuum of services to support the mental health of FFN child care providers include:

1. Embrace the reality of FFN child care and allocate resources to enhancing quality of care.
2. Acknowledge the importance of FFN child care and the influence of caregiver well-being on the social and emotional development of children in FFN care settings.
3. Identify, examine, and reduce structural barriers that can adversely impact FFN child care providers offering care and/or connecting to formal systems of support.
4. Expand availability of IECMHC for FFN child care providers by changing stipulations that limit use of IECMHC to licensed child care providers.
5. Fund increased research into innovative strategies with the potential to better serve the FFN provider community, including IECMHC.

> *"In general, the early childhood field has remained relatively silent about FFN child care in policy and research discourses surrounding child well-being and quality initiatives." — Shivers et al., 2016*

A Call to Action

FFN child care continues to be marginalized and operates outside of our early childhood systems. It is often referred to as "underground" or "invisible" child care (Shivers, 2012; Wilder & Bruner, 2013). Without inclusive systems that benefit all children and work to remedy inherent biases in our society, we cannot expect to close the achievement gap for our most vulnerable children. Further, the fragmented, patchwork services and supports for FFN providers are insufficient to have an indelible and widespread impact. It is imperative that we develop and support programs that are tailored around the unique characteristics and needs of FFN providers, children and their families. With the vast majority of young children in FFN child care settings, if we want to affect quality of care and reduce and eliminate inequities, then FFN providers, as a crucial but neglected segment of the child care workforce, need access to relationship-based, culturally and linguistically appropriate services and supports to attend to their mental well-being and the social and emotional health of children in their care.

Enhanced partnerships between IECMHC programs and early childhood networks of support to offer an array of services and supports to meet the mental health and other needs of FFN providers seems to be a promising way of maximizing capacity and resources to better serve a larger number of FFN providers. To encourage these partnerships, funding should be dedicated to implementing and evaluating innovative program designs that promote culturally steeped initiatives and greater collaboration between MHCs and ECNPs to collectively meet the needs of FFN providers as well as engage in parallel processes of support. Funding is also needed for workforce development, training, and technical assistance to support the distinct yet synergetic roles of MHCs and ECNPs in supporting FFN providers, children and their families. Leveraging federal, state, local, and private funding is a promising approach to support this synergy.

By integrating equity and mental health lenses with FFN child care, we can ensure that all young children, most especially children of color, children in poverty, children who have experienced trauma, children from immigrant families, and other vulnerable groups, are receiving the best opportunities to learn, thrive, and succeed. To accomplish this feat, we need to attend to caregiver well-being for all child care providers to help ensure healthy social and emotional development, early learning, and school

readiness for all children, and positive family dynamics and meaningful child and family outcomes for all families. This includes thinking through ways to reach FFN child care providers who remain in the shadows unconnected to formal systems. As we learned from the study sites, use of trusted cultural brokers as the first point of contact for FFN child care providers who may be hesitant to connect is a winning outreach and recruitment strategy.

FFN child care tends to fall through the cracks of the silos that represent early care and education and family support with neither taking the lead to provide a continuum of services and supports for FFN providers. FFN child care, as the point of intersection between these silos, presents an opportunity to expand our systems thinking in both directions to jointly figure out how to best support the greatest number of FFN providers and families. A broader array of program offerings may better attend to the multi-faceted needs of FFN providers as family members dedicated to supporting the healthy development of children in their care, and child care providers committed to providing high quality care to ensure success in life. IECMHC, an effective strategy utilized by both systems, could help bridge the gap between these systems and connect these silos. Without significant commitment to and funding of an enhanced portfolio of training and support opportunities, informed by best practices across systems, which includes use of IECMHC in early childhood settings, we cannot expect to enhance outcomes for the millions of children in FFN care settings.

Cross-system collaboration on behalf of FFN providers and the young children and families in these care arrangements needs to be a priority for all child-serving systems to ensure an equitable and successful start for all young children. The social and emotional health of young children in FFN settings cannot be positively affected without attending to the multi-faceted needs of their caregivers. As such, investment in IECMHC for FFN child care could be an effective way to address the social and emotional health of some of our most vulnerable children. The early childhood building blocks of strategic planning, policies and procedures, interagency partnerships, maximized and flexible funding, prepared workforce, and outcome evaluation can provide a roadmap for what needs to be taken into consideration to build up FFN focused services and supports for FFN providers, including the potential for IECMHC to benefit FFN providers and the community agencies that serve them.

Greater collaboration is needed to systemically integrate services and supports for FFN providers into early childhood systems and develop coordinated and comprehensive networks of support in all states to affect the capacity, self-efficacy, and well-being of providers. To embolden the national dialogue on how to create a greater intersection between IECMHC and FFN child care, the Center of Excellence for IECMHC[29] and FFN organizations such as the Alliance for Family, Friend and Neighbor Child Care[30] or the National Women's Law Center[31] could cohost a series of conversations around FFN child care to influence thinking in both spheres. By connecting existing groups that are already convening to discuss the need for increased training and support for FFN providers and the need for innovative strategies, such as IECMHC, to improve children's social and emotional development and the quality of care in FFN settings, we can leverage expertise from both fields to better serve FFN providers, children and their families.

[29] https://www.samhsa.gov/iecmhc
[30] http://www.familyfriendandneighbor.org
[31] https://nwlc.org

REFERENCES

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review, 31*(6), 934-48. Doi:10.1016/j.cpr.2011.05.003.

Adams, G., Zaslow, M., & Tout, K. (2007). *Early care and education for children in low-income families: Patterns of use, quality, and potential policy implications.* Urban Institute. Retrieved from http://www.urban.org/url.cfm?ID=411482.

Ainsworth, M. D. S., Belhar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Erlbaum.

Anderson, S., Ramsburg, D., & Scott, J. (2005). *Illinois study of license-exempt care.* Urbana-Champaign, IL: University of Illinois at Urbana-Champaign.

Annie E. Casey Foundation. (2006). *KIDS COUNT data book.* Baltimore, MD: Annie E. Casey Foundation.

Aquino, A. K., Lavin, K., Le, L., Shivers, E. M., Perry, D. F., & Horen, N. M. (2018). *Applying an ecological and sociocultural lens to Family Friend and Neighbor (FFN) Care to inform quality improvement efforts in states and communities.* Poster presented at The National Research Conferences on Early Childhood (NRCEC) 2018 conference, Arlington, VA.

Ash, J., Mackrain, M., & Johnston, K. (2013). Early Childhood Mental Health Consultation: Applying central tenets across diverse practice settings. *Zero to Three, 33*(5), 28-33.

Bailey, R. K., Milapkumar, P., Barker, N. C., Ali, S., & Jabeen, S. (2011). Major depressive disorder in the African American population. *Journal of the National Medical Association, 103*, 548-557.

Boushey, H., & Wright, J. (2004). *Working moms and child care* (Data Brief No. 3). Washington, DC: Center for Economics and Policy Research. Retrieved from https://www.researchconnections.org/childcare/resources/3636.

Bowlby, J. (1969/1982). *Attachment and loss, Vol. I, Attachment* (2nd ed.). New York: Basic Books.

Brandon, R. N. (2005). *Enhancing family, friend and neighbor caregiving quality: The research case for public engagement.* Seattle, WA: University of Washington, Human Services Policy Center.

Brandon, R., Maher, E., Joesch, J., & Doyle, S. (2002). *Understanding family, friend and neighbor care in Washington state: Developing appropriate training and support* (Full Report). Retrieved from https://www.childcare.org/ckfinder/userfiles/files/HSPC_FFN_report_2002.pdf.

Brennan, E. M., Bradley, J. R., Allen, M. D., & Perry, D. F. (2008). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. *Early Education and Development, 6*, 82-102.

Bretherton, I. (1985). Attachment theory: Retrospect and prospect. *Monographs of the Society for Research in Child Development, 50*(1/2), 3-35. doi:10.2307/3333824

Bromer, J. (2006). *Beyond child care: The informal family support and community roles of African-American child care providers.* Unpublished doctoral dissertation, University of Chicago-Chicago.

Bromer, J., Paulsell, D., Porter, T., Weber, R., Henly, J., & Ramsburg, D. (2011). Family-sensitive caregiving: A key component of quality in early care and education. In M. Zaslow, K. Tout, T. Halle, & I. Martinez-Beck (Eds.), *Next steps in the measurement of quality in early childhood settings*. Baltimore, MD: Brookes Publishing.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

Brown-Lyons, M., Robertson, A., & Layzer, J. (2001). *Kith and kin-informal child care: Highlights from recent research*. New York: National Center for Children in Poverty.

Bussing, R., & Gary, F. A. (2012). Eliminating mental health disparities by 2020: Everyone's actions matter. *Journal of the American Academy of Child and Adolescent Psychiatry, 51*(7), 663.

Capizzano, J., Tout, K., & Adams, D. (2000). *Child care patterns of school-age children with employed mothers* (Occasional Paper Number 41). Washington, DC: The Urban Institute.

Center of Excellence for IECMHC. (2016). *Center of Excellence equity statement*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/IECMHC/center-excellence-equity-framing-statement.pdf.

Center on the Developing Child at Harvard University. (2013). *InBrief: Early childhood mental health*. Retrieved from https://developingchild.harvard.edu/resources/inbrief-early-childhood-mental-health.

Chase, R. (2008). *State policies for supporting family, friend and neighbor care: BUILD initiative policy brief*. St. Paul, MN: Wilder Research. Retrieved from http://www.familyfriendandneighbor.org/pdf/BUILD_FFN_and_Systems.pdf.

Chase, R., Arnold, J., Schauben, L., & Shardlow, B. (2006). *Family, friend and neighbor caregivers: Results of the 2004 Minnesota Statewide Household Child Care Survey*. St. Paul, MN: Wilder Research.

Chase, R., Arnold, J., Schauben, L. & Shardlow, B. (2005). *Child care use in Minnesota: 2004 Statewide Household Child Care Survey*. St. Paul, MN: Wilder Research.

Chase, R., & Bruner, C. (2012). *Family, friend and neighbor care: Achieving healthy child development by strengthening families*. (Policy brief for the BUILD Initiative). Retrieved from https://www.wilder.org/wilder-research/research-library/family-friend-and-neighbor-care-achieving-healthy-child.

Chaudry, A., Pedroza, J. M., Sandstrom, H., Danziger, A., Grosz, M., Scott, M., & Ting, S. (2011). *Child care choices of low-income working families*. Washington, DC: The Urban Institute.

Coffman, J. (2007). *A framework for evaluating systems initiatives*. Retrieved from http://www.buildinitiative.org/content/evaluationQsystemsQchange. Retrieved from http://www.buildinitiative.org/WhatsNew/ViewArticle/tabid/96/smid/412/ArticleID/621/Default.aspx

Cohen, E., & Kaufmann, R. K. (2000). *Early childhood mental health consultation* (DHHS Pub. No. CMHS-SVP0151). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Crosnoe, R. (2007). Early child care and the school readiness of children from Mexican immigrant families. *International Migration Review, 41*(1), 152-181. Retrieved from http://dx.doi.org/10.1111/j.1747-7379.2007.00060.x

DiClemente, C. C., & Velasquez, M. M. (2002). Motivational interviewing and the stages of change. In W. R. and S. Rollnick (Eds.), *Motivational interviewing: Preparing people for change* (pp. 201-216). New York: Guilford Press.

Drake, P. J., Unti, L., Greenspoon, N., & Fawcett, L. K. (2004). *First 5 California informal child caregiver support project: Focus group and interview results*. Sacramento, CA: First 5 California Children and Families Commission.

Duran, F., Hepburn K., Irvine, M., Kaufmann, R., Anthony, B., Horen, N., & Perry D. (2009). *What works?: A study of effective early childhood mental health consultation programs*. Washington, DC: Georgetown University Center for Child and Human Development.

Emarita, B. (2006). *Family, friend, and neighbor care best practices: A report to Ready 4 K*. St. Paul, MN: Ready 4 K.

Fuller, B., Holloway, S. D., & Liang, X. (1996). Family selection of child care centers: The influence of household support, ethnicity, and parental practices. *Child Development, 67*, 3320-3337.

Fuller, B., Kagan, S. L., Loeb, S., & Chang, Y. (2004). Child care quality: Centers and home settings that serve poor families. *Early Childhood Research Quarterly, 19*, 505–527.

Gallimore, R., & Goldenberg, C. (1993). Activity settings of early literacy: Home and school factors in children's emergent literacy. In E. Forman, N. Minick, & C. A. Stone (Eds.), *Contexts for learning: Sociocultural dynamics in children's development* (pp. 315-335). Oxford: Oxford University Press.

Garcia Coll, C., Lamberty, G., Jenkins, R., McAdoo, H. P., Crnic, K., Wasik, B. H., & Garcia, H. V. (1996). An integrative model for the study of developmental competencies in minority children. *Child Development, 67*, 1891-1914.

Gilkerson, L., & Shahmoon Shanok, R. (2000). Relationships for growth: Cultivating reflective practice in infant, toddler, and preschool programs. In J. D. Osofsky & H. E. Fitzgerald (Eds.), *WAIMH handbook of infant mental health: Vol. 2. Early intervention, evaluation, and assessment* (pp. 3-32). New York: John Wiley.

Gilliam, W. S. (2005). *Prekindergarteners left behind: Expulsion rates in state prekindergarten systems*. New Haven, CT: Yale University Child Study Center.

Gilliam, W. S., & Reyes, C. R. (2017). *Climate of Healthy Interactions for Learning and Development (CHILD)* (Draft Manual). New Haven, CT: Yale Child Study Center.

Guzman, L. (1999). *The use of grandparents as child care providers* (NSFH Working Paper No. 84). Madison, WI: University of Wisconsin Center for Demography and Ecology. Retrieved from https://www.researchconnections.org/childcare/resources/424.

Hamilton, J. L., Shanley, J., Dailey, D., & McInerney, M. (2003). *Providing technical assistance to local school districts: Lessons learned*. Washington, DC: American Institutes of Research.

Heffron, M. C. (2013). *Parallel processes-relationships matter: A key concept in infant and early childhood mental health approaches*. Oakland, CA: Children's Hospital & Research Center Oakland. Retrieved from https://www.fresnostate.edu/chhs/ccci/documents/09.26.13.powerpoint.pdf.

Henly, J. R., & Bromer, J. (2009). The work-family support roles of child care providers across settings. *Early Childhood Research Quarterly, 24*, 271-288.

Hepburn, K. S., Perry, D. F., Shivers, E. M., & Gilliam, W. S. (2013). Early childhood mental health consultation as an evidence-based practice: Where does it stand. *Zero to Three, 33*(5), 10-19.

Herbst, C. M. (2008). Who are the eligible non-recipients of child care subsidies? *Children and Youth Services Review, 30*(9), 1037-1054.

Hoffmann, E., & Conway Perrin, T. (2009). *Extending home visiting to kinship caregivers and family, friend, and neighbor caregivers*. Washington, DC: Center for Law and Social Policy.

Howes, C. (2000). Social-emotional classroom climate in child care, child-teacher relationships, and children's second grade peer relations. *Social Development, 9*, 191-204.

Howes, C., James, J., & Ritchie, S. (2003). Pathways to effective teaching. *Early Childhood Research Quarterly, 18*, 104-120.

Howes, C., & Shivers, E. M. (2006). New child-caregiver attachment relationships: Entering child care when the caregiver is and is not an ethnic match. *Social Development, 15*, 574-590.

Jaccard, J., Dodge, T., & Dittus, P. (2002). Parent-adolescent communication about sex and birth control: A conceptual framework. *New Directions for Child & Adolescent Development, 97*, 9-41.

Jaccard J., Litardo, H. A., & Wan C. K. (1999). Subjective culture and social behavior. In J. Adamopoulos & Y. Kashima (Eds.), *Social psychology and cultural context* (pp. 95-106). Thousand Oaks, CA: Sage Publications.

Johnson, J. (2005). *Who's minding the kids? Child care arrangements: Winter 2002*. Washington, DC: U.S. Census Bureau. Retrieved from https://www2.census.gov/library/publications/2005/demo/p70-101.pdf.

Johnson, D. J., Jaeger, E., Randolph, S. M., Cauce, A. M., Ward, J., & The NICHD Early Child Care Research Network. (2003). Studying the effects of early child care experiences on the development of children of color in the U.S.: Towards a more inclusive research agenda. *Child Development, 74*, 1127-1244.

Johnston, K., & Brinamen, C. (2006). *Mental health consultation in child care: Transforming relationships among directors, staff, and families*. Washington, DC: ZERO to THREE Press.

Kisker, E., Hofferth, S. L., Phillips, D., & Farquhar, E. (1991). *A profile of child care settings: Early education and care in 1990*. Washington, DC: U.S. Government Printing Office.

Kontos, S., Howes, C., Shinn, M., & Galinsky, E. (1995). *Quality in family child care and relative care (Early Childhood Education Series)*. New York, NY: Teachers College Press.

Kreader, J. L., & Lawrence, S. (2006). *Toward a national strategy to improve family, friend, and neighbor child care*. Report of a symposium hosted by the National Center for Children in Poverty, Baltimore, MD.

Kruse, T. P. (2012). Making the match: Culturally relevant coaching and training for early childhood caregivers. *Early Childhood Research & Practice, 14*(2). Retrieved from http://ecrp.uiuc.edu/v14n2/kruse.html.

Lamb, M. E. (1998). Nonparental child care: Context, quality, correlates, and consequences. In W. Damon, I. E. Sigel, & K. A. Renninger (Eds.), *Handbook of child psychology (Vol. 4) Child psychology in practice* (5th Ed., pp. 73-133). New York: Wiley.

Lavin, K., Aquino, A. K., Le, L., Shivers, E. M., Perry, D. F., & Horen, N. M., (2018). *Supporting the mental health of family, friend, & neighbor care providers and the children in their care*. Poster presented at The National Research Conferences on Early Childhood (NRCEC) 2018 conference, Arlington, VA.

Layzer, J. I., & Goodson, B. D. (2006). *National study of child care for low-income families—Care in the home: A description of family child care and the experience of families and children that use it. Wave 1 Report*. Cambridge, MA: Abt Associates.

Lazarus, R. S. (1966). *Psychological stress and the coping process*. New York: McGraw-Hill.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer Publishing Company.

Lerner, R. M. (1986). *Concepts and theories of human development (2nd ed.)*. New York: Random House.

Lerner, R. M. (1991). Changing organism-context relations as the basic process of development: A developmental contextual perspective. *Developmental Psychology, 27*, 27-32.

Liang, X., Fuller, B., & Singer, J. (2000). Ethnic differences in child care selection: The influence of family structure, parental practices, and home language. *Early Childhood Research Quarterly, 15*, 357-384. http://dx.doi.org/10.1016/S0885-2006(00)00071-5

Li-Grining, C. P., & Coley, R. L. (2006). Child Care Experiences in Low-Income Communities: Developmental Quality and Maternal Views. *Early Childhood Research Quarterly, 21*(2), 125-141.

MacQueen, K. M., McLellan, E., Kay, K., & Milstein, B. (1998). Codebook development for team-based qualitative analysis. *Cultural Anthropology Methods 10*(2), 31-36.

Maher, E. J. (2007). *Measuring quality in family, friend, and neighbor care: Conceptual and practical issues*. New York, NY: Columbia University Mailman School of Public Health National Center for Children in Poverty, Child Care and Early Education Research Connections.

Maher, E. J., & Joesch, J. M. (2005). *The prevalence and characteristics of child care provided by family, friends, and neighbors*. Paper presented at the Society for Research in Child Development Biennial Meeting, Atlanta, GA.

Mashburn, A. J., Pianta, R. C., Hamre, B. K., Downer, J. T., Barbarin, O. A., Bryant, D., Burchinal, M., Early, D. M., & Howes, C. (2008). Measures of classroom quality in prekindergarten and children's development of academic, language, and social skills. *Child Development, 79*, 732-749.

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review, 50*(4), 370-96.

McCloyd, V. C. (1990). The impact of economic hardship on black families and children: Psychological distress, parenting, and socioemotional development. *Child Development, 61*, 311-346.

Morgan, G., Elliott, K., Beaudette, C., & Azer, S. (2001). *Non-licensed forms of child care in homes: Issues and recommendations for state support*. Boston: Wheelock College, Institute for Leadership and Career Initiatives. Retrieved from https://www.researchconnections.org/childcare/resources/3452

Mulligan, G. M., Brimhall, D., & West, J. (2005). *Child care and early education arrangements of infants, toddlers, and preschoolers: 2001*. (NCES 2006-039). U.S. Department of Education, National Center for Education Statistics. Washington, DC: U.S. Government Printing Office. Retrieved from https://nces.ed.gov/pubs2006/2006039.pdf.

National Alliance on Mental Illness (NAMI). (2017). *The doctor is out: Continuing disparities in access to mental and physical health care*. Arlington, VA: NAMI.

National Institute of Child Health and Human Development (NICHD) Early Child Care Research Network. (1999). Child outcomes when child care center classes meet recommended standards for quality. *American Journal of Public Health, 89*, 1072-1077.

National Institute of Child Health and Human Development (NICHD) Early Child Care Research Network. (2005). Early child care and children's development in the primary grades: Follow-up results from the NICHD Study of Early Child Care. *American Educational Research Journal, 42*(3), 537-570.

National Research Council and Institute of Medicine. (2000). *From neurons to neighborhoods: The science of early child development*. Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, eds. Board on Children, Youth, and Families. Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

National Survey of Early Care and Education Project Team. (2015). *Fact sheet: Who is providing home-based early care and education?* (OPRE Report No. 2015-43). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Available at https://www.acf.hhs.gov/opre/resource/fact-sheet-who-is-providing-home-based-early-care-and-education.

O'Donnell, N. S., Cochran, M., Lekies, K., Diehl, D., Morrissey, T. W., Ashley, N., & Steinke, P. (2006). *Sparking Connections Phase II: A multi-site evaluation of community-based strategies to support family, friend and neighbor caregivers of children: Part I: Lessons learned and recommendations*. New York: Families and Work Institute.

Paulsell, D., Mekos, D., Del Grosso, P., Rowand, C., & Banghart, P. (2006). *Strategies for supporting quality in kith and kin child care: Findings from the Early Head Start Enhanced Home Visiting Pilot Program evaluation final report*. Princeton, NJ: Mathematica Policy Research, Inc.

Perry, D. F., Allen, M. D., Brennan, E., & Bradley, J. (2010). The evidence base for mental health consultation in early childhood settings: A research synthesis addressing children's behavioral outcomes. *Early Education and Development, 21*, 795-824.

Perry, D. F., Dunne, M.C., McFadden, L., & Campbell, D. (2008). Reducing the risk for preschool expulsion: Mental health consultation for young children with challenging behavior. *Journal of Child and Family Studies, 17*, 44-54.

Pianta, R. C., Hamre, B. K., & Allen, J. P. (2012). Teacher-student relationships and engagement: Conceptualizing, measuring, and improving the capacity of classroom interactions. In S. L. Christenson et al. (Eds.), *Handbook of research on student engagement* (pp. 365-386). New York: Springer-Verlag.

Pianta, R. C., Steinberg, M., & Rollins, K. (1995). The first two years of school: Teacher-child relationships and deflections in children's classroom adjustment. *Development and Psychopathology, 7*, 295-312. http://dx.doi.org/10.1017/S0954579400006519

Polakow, V. (2007). *Who cares for our children: The child care crisis in the other America*. New York, NY: Teachers College Press.

Porter, T. (1998). *Neighborhood child care: Family, friends and neighbors talk about caring for other people's children*. New York: Bank Street College of Education.

Porter, T., Nichols. T., Del Grosso, P., Begnoche, C., Hass, R., Vuong, L., & Paulsell, D. (2010a). *A compilation of initiatives to support home-based child care*. Washington, DC: Mathematica Policy Research.

Porter, T., Paulsell, D., Nichols, T. Begnoche, C., & Del Grosso, P. (2010b). *Supporting quality in home-based child care: A compendium of 23 initiatives*. Washington, DC: Mathematica Policy Research.

Porter. T., Rice, R., & Mabon, S. (2003). *Doting on kids: Understanding quality in kith and kin child care*. New York, NY: Bank Street College of Education, Institute for a Child Care Continuum, Division of Continuing Education. Retrieved from https://www.researchconnections.org/childcare/resources/3650.

Porter, T., & Vuong, L. (2008). *Tutu and me: Assessing the effects of a Family Interaction Program on parents and grandparents*. New York: NY: Bank Street College of Education, Institute for a Child Care Continuum, Division of Continuing Education. https://www.researchconnections.org/childcare/resources/14825.

Powell, D. (2008). *Who's Watching the Babies? Improving the Quality of Family, Friend and Neighbor Care*. Washington, DC: Zero to Three.

Prochaska, J., & DiClemente, C. (1983). Stages and processes of self-change in smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 5*, 390-395.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to the addictive behaviors. *American Psychologist, 47*(9), 1102-1114. PMID: 1329589.

RAINE Group. (2014). *Early childhood mental health consultation protects and maximizes our national investment in early care and education*. Retrieved at http://indigoculturalcenter.org/wp-content/uploads/2015/11/RAINE-ecmhc_infographics_finalF_Proof5.pdf

Reschke, K. L., & Walker, S. K. (2006). Mother's child caregiving and employment commitments and choices in the context of rural poverty. *Affilia: Journal of Women and Social Work, 21*(3), 306-319.

Rogoff, B. (2003). *The cultural nature of human development*. New York: Oxford University Press.

Shanok, R. S., Gilkerson, L., Eggbeer, L., & Fenichel, E. (1995). Reflective supervision: A relationship for learning. In *A guidebook and videotape*. Washington, DC: Zero to Three: National Center for Infants, Toddlers and Families.

Shivers, E. M. (2003). *Where the children are: Predicting provider-child relationships in informal (kith and kin) child care settings*. Doctoral dissertation. Retrieved from ProQuest. (Order No. 3117704).

Shivers, E. M. (2006). A closer look at kith and kin care: Exploring variability of quality within family, friend and neighbor care. *Journal of Applied Developmental Psychology, 27*, 411-426.

Shivers, E. M. (2008a). Exploring emotional availability along the child care continuum. *Journal of Early Childhood and Infant Psychology, 4*, 27-38.

Shivers, E. M. (2008b). *Exploring the training needs of family friend and neighbor child care providers*. Technical Report: Prepared for Zero to Three with support from the Annie E. Casey Foundation and the Federal Child Care Bureau.

Shivers, E. M. (2012). *The invisible child care provider: Arizona Kith and Kin Project evaluation report*. Prepared for the Association for Supportive Child Care, with support from First Things First. Report available at http://www.familyfriendandneighbor.org/pdf/AZ_Kith_and_Kin_Evaluation_2012.pdf.

Shivers, E. M., & Farago, F. (2016). Where the children are: Exploring quality, community and support for family, friend and neighbor child care. In K. Sanders & A. Wishard Guerra (Eds.), *The culture of child care: Attachment, peers, and quality in diverse communities*. Oxford University Press: New York, NY.

Shivers, E. M., Farago, F., & Goubeaux, P. (2016). *Arizona Kith and Kin Project Evaluation Brief #1: Improving quality in family, friend and neighbor child care settings*. Prepared for the Association for Supportive Child Care, with support from First Things First and Valley of the Sun United Way.

Shivers, E. M., Howes, C., Wishard, A., & Ritchie, S. (2004). Teacher-articulated perceptions and practices with families: Examining effective teaching in diverse high quality child care settings. *Early Education & Development, 15*, 167-186.

Shivers, E. M., Sanders, K. E., & Westbrook, T., (2010). Measuring culturally responsive care. In M. Zaslow & K. Tout (Eds.), *Measuring quality in early childhood settings*. Baltimore, MD: Brookes Publishing.

Shivers, E., & Wills, S. (2001). *License-Exempt Assistance Project Final Report–2001*. Los Angeles, CA: Crystal Stairs, Inc.

Shivers, E. M., Yang, C., & Farago, F. (2016a). *Arizona Kith and Kin Project Evaluation Brief #2: Latina family, friend and neighbor provider characteristics and the features of child care they provide*. Prepared for the Association for Supportive Child Care, with support from First Things First and Valley of the Sun United Way.

Shivers, E. M., Yang, C., & Farago, F. (2016b). *The Arizona Kith and Kin Project Evaluation Brief #4: Increasing cultural and social capital by linking family, friend, and neighbor providers to resources in the early childhood system*. Indigo Cultural Center, for the Association for Supportive Child Care, with support from First Things First and Valley of the Sun United Way.

Smolensky, E., & Gootman, E. (2003). *Working families and growing kids: Caring for children and adolescents*. Washington, DC: National Academy Press.

Snyder, K., & Adelman, S. (2004). *The use of relative care while parents work. Findings from the 1999 National Survey of America's Families*. Washington, DC: The Urban Institute. Retrieved from https://www.researchconnections.org/childcare/resources/5334.

Snyder, K., Dore, T., & Adelman, S. (2005). *Use of relative care by working parents*. (Snapshots of America's Families III No. 23). Washington, DC: The Urban Institute. Retrieved from https://www.researchconnections.org/childcare/resources/5978.

Sonenstein, F. L., Gates, G. J., Schmidt, S., & Bolshun, N. (2002). *Primary child care arrangements of employed parents. Findings from the 1999 National Survey of America's Families* (Occasional Paper No. 59). Washington, DC: The Urban Institute. Retrieved from https://www.researchconnections.org/childcare/resources/587.

Suarez-Orozco, C., Yoshikawa, H., & Tseng, V. (2015). *Intersecting Inequalities: Research to Reduce Inequality for Immigrant-Origin Children and Youth*. A William T. Grant Foundation Inequality Paper.

Susman-Stillman, A. (2003). *Family, friend and neighbor care: Promoting quality care and children's healthy development*. Sacramento, CA: First 5, California Children and Families Commission.

Susman-Stillman, A., & Banghart, P. (2008). *Demographics of family, friend and neighbor child care in the United States*. New York: Child Care and Early Education Research Connections, National Center for Children in Poverty.

Susman-Stillman, A., & Banghart, P. (2011). *Quality in family, friend and neighbor child care settings*. New York: Child Care and Early Education Research Connections, National Center for Children in Poverty.

Thomas, J., Boller, K., Jacobs Johnson, C., Young, M., & Hu, M. (2015). *Setting the stage: The importance of informal child care in California* (Issue Brief). Princeton, NJ: Mathematica Policy Research.

Todd, C., Robinson, V., & McGraw, L. (2005). *Contextual influences on informal caregivers: Implications for training*. Paper presented at the biennial meeting of the Society for Research in Child Development, Atlanta, GA.

Tonyan, H. A., Paulsell, D., & Shivers E. M. (2017). Introduction: Understanding and incorporating home-based child care into early education and development systems. *Early Education & Development, 28*, 633-639.

Tout, K., & Zaslow, M. (2006). *Observations of family, friends and neighbors in Minnesota: A report of the Minnesota child care research partnership*. St. Paul, MN: Minnesota Department of Human Services.

U.S. Department of Health and Human Services and U.S. Department of Education (2014). *Policy statement on expulsion and suspension policies in early childhood settings*. Retrieved from https://www2.ed.gov/policy/gen/guid/school-discipline/policy-statement-ece-expulsions-suspensions.pdf.

Vesely, C., Ewaida, M., & Kearney, K. B. (2012). Capitalizing on early childhood education: Low-income immigrant mothers' use of ECE to build human, social, and navigational capital. *Early Education & Development, 24*, 744-765.

Vesely, C., & Ginsberg, M. (2011). *Exploration of the status of services in immigrant families in early childhood education programs*. Washington, DC: National Association for the Education of Young Children.

Ward, H., Morris, L., Atkins, J., Herrick, A., Morris, P., & Oldham, E. (2006). *Child care and children with special needs: Challenges for low-income families*. Catherine E. Cutler Institute for Child and Family Policy, Muskie School of Public Service, University of Southern Maine. Supported by a three year grant (Federal Grant # 90YE0036) from the Child Care Bureau, Office of Family Assistance, Administration for Children and Families, U.S. Department of Health and Human Services.

Weber, R. B. (2013). *A review of the literature: Improving quality of family, friend, and neighbor care*. Oregon State University Family Policy Program, Oregon Child Care Research Partnership.

Weiss, R. S. (1994). *Learning from strangers: The art and method of qualitative interview studies*. New York: The Free Press.

Wishard, A. G., Shivers, E. M., Howes, C., & Ritchie, S. (2003). Child care program and teacher practices: Associations with quality and children's experiences. *Early Childhood Research Quarterly, 18*, 65-103.

Yoshikawa, H. (2011). *Immigrants raising citizens: Undocumented parents and their young children*. New York, NY: Russell Sage.

Zheng, Y., Bender, S. L., & Tableman, B. (2012). Implementing a statewide early childhood mental health consultation approach to preventing childcare expulsion. *Infant Mental Health Journal, 33*, 3.

APPENDIX A

OVERVIEW OF THE CODING STRUCTURE

Constructs	Perspective (Who)	How Used
FFN Landscape	Multiple Levels/Layers	Context National State Policy Community Prevalence Individual FFN Providers
FFN Provider Needs	FFN Provider (Self) ECNPs	Training Peer Support Materials Referrals Readiness Factor
Program Description	Early Childhood Network Programs IECMHC Programs	Services offered Funding/Sustainability Staff Infrastructure Mission and Goals Collaboration
Relationships	Multiple Levels/Layers	Cultural Considerations Family Dynamics Role of MHCs Strategies to Build Relationships Outcomes of Relationships Pathways to Outcomes
Mental Health	FFN Providers Families ECNPs	Perspective Knowledge Self-Reflection
Challenges (to Engagement)	FFN Providers ECNPs IECMHC Programs	Capacity Language Barriers Limitation/Eligibility Payment Informal/Formal Child Care
Facilitators (of Engagement)	FFN Providers Early Childhood Network Programs IECMHC Programs	Collaboration with Other Organizations Access to Resources Match Pathway to Outcomes

Constructs	Perspective (Who)	How Used
Outcomes (of Participation in Program(s))	FFN Providers State Community	Might have Direct/Indirect Impact on Families Sustained Collaboration Data Collected Desired – Achieved Outcomes Theory of Change Short-term – Intermediate – Longer-term Proximal – Distal
Recommendations	Early Childhood Network Programs IECMHC Programs State	Provider Outreach Program Implementation Policy Implementation

APPENDIX B

KEY TERMS AND ACRONYMS

Here is a list of important terminology and acronyms used throughout the report.

Challenging behavior: This term is inclusive of both internalizing (e.g., withdrawn) and externalizing (e.g., physical aggression) behaviors that suggest a need for social and emotional support/intervention.

Early childhood network providers (ECNPs): In FFN care settings, ECNPs are responsible for providing education and training to FFN child care providers and families. Their background qualifications generally include a Bachelor's degree in child development, early child education, or a related field. ECNPs also receive ongoing training and professional development to enhance their knowledge and skill set. ECNPs play the role of cultural broker, trainer, coach, facilitator, mentor, and confidant. For this study, the larger umbrella term of ECNP includes FFN specialists, tias, promotoras, family resource specialists, and specialized consultants, such as quality improvement consultants, family engagement consultants, and physical health consultants that interface with FFN providers or support programmatic offerings focused on FFN care.

Early childhood networks of support: Community-based organizations who are focused on supporting FFN child care providers, children and their families to improve the quality of care in FFN child care settings. Programs offered within early childhood networks of support are generally led by early childhood network providers and can include training, home visits, and engagement opportunities.

Family child care (FCC): With regard to home-based settings, family child care or family day care are terms commonly used for registered, licensed or regulated home-based child care (Tonyan, Paulsell & Shivers, 2017).

Family, friend and neighbor (FFN) child care: This is one of the oldest and most common forms of child care. Also referred to as kith and kin care, relative care, informal care, home-based care, and license-exempt care. This type of child care is any regular, non-parental, non-custodial child care arrangement other than a licensed center, program or family child care home (Brandon et al., 2002). Relatives and non-relatives who are not licensed or regulated by a government agency for the provision of child care, including family members, friend, and neighbors. Care may be provided in the caregiver's home or in the child's home (Powell, 2008). FFN child care is often exempt from licensing or regulations and these home-based settings tend to be less formal than required by typical regulations governing FCC; therefore, this type of child care can also be called license-exempt or informal care (Tonyan, Paulsell & Shivers, 2017).

Infant and early childhood mental health consultation (IECMHC): In early childhood settings, mental health consultation is a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more caregivers, typically an early care and education provider and/or family member. IECMHC aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age 6 and their families (adapted from Cohen & Kaufmann, 2000).

Intentionality: How a child care provider views their role in children's lives, their motivations for providing care, how they organize their day, and so on are important factors in determining a high quality child setting and could be a factor in whether or not they pursue additional training and support—including technical assistance for licensing/regulations (Kontos, Howes, Shinn, & Galinsky, 1995).

Mental health consultants (MHCs): Professionals with mental health expertise who also have knowledge and experience related to working with young children (birth to five) and their families. MHCs promote healthy growth in young children's social and emotional development by guiding and supporting the caregivers and parent's in the child's life to recognize, understand, and support social and emotional development (Center for Early Childhood Mental Health Consultation[32]).

Parallel process: A core understanding in infant mental health is that all relationships are important. The concept of the parallel process of support is focused on building effective relationships at all levels. More specifically, staff who are reflective help parents expand reflective capacity and supervisors who are reflective help staff expand reflective capacity (Heffron, 2013). As FFN child care providers need support, staff at the frontlines working directly with providers also need support. These differing levels of support parallel one another. For articles and resources related to parallel process, visit the Michigan Association for Infant Mental Health Endorsement[33].

Professional development: This includes all types of facilitated learning opportunities, which can include courses, workshops, and trainings, to support professional advancement. In early childhood, professional development can consist of a continuum of learning and support activities designed to prepare individuals for work with and on behalf of young children and their families, as well as ongoing experiences to enhance this work. These opportunities lead to improvements in the knowledge, skills, practices, and dispositions of early childhood professionals (NAEYC[34]).

Protective factors: Conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities that, when present, increase the health and well-being of children and families (Child Welfare Information Gateway[35]).

Reflective supervision: A respectful and reciprocal relationship for learning that becomes a model for relating to a family and to their child (Shanok, et al., 1995). Reflective supervision is based on shared power, builds on shared understanding of philosophy and practice, diminishes scale, supports ethical practice, supports initiative and effective engaged practice, develops the art of remembering, creates and hones self-knowledge, supports inter-cultural competence, amplifies calm and responsivity, and encourages experimentation and critical thinking (Gilkerson & Shahmoon Shanok, 2000).

Self-efficacy: Belief in one's ability to complete tasks and reach goals.

Social and emotional health: The ability to form strong relationships, solve problems, and express and manage emotions, is critical for early learning, school readiness, and lifelong success (Center of Excellence for IECMHC, 2018[36]).

Quality Rating Improvement System (QRIS): A systemic approach to assess, improve, and communicate the level of quality in early and school-age care and education programs (National Center on Early Childhood Quality Assurance[37]).

[32] https://www.ecmhc.org/index.html
[33] https://mi-aimh.org/endorsement/endorsement-exam/reflection/parallel-process
[34] https://www.naeyc.org/resources/pd
[35] https://www.childwelfare.gov/topics/preventing/promoting/protectfactors
[36] https://www.samhsa.gov/iecmhc
[37] https://qrisguide.acf.hhs.gov