Understanding the Impact of Infant & Early Childhood Mental Health Consultation in New York State

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NEW YORK STATE | Office of Children and Family Services

Infant & Early Childhood Mental Health Consultation
Empowering Caregivers to Support Emotional Wellbeing

Early Care & Learning Council
United to Promote Quality

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Commissioner

Introduction

In 2019, the New York State Infant & Early Childhood Mental Health Consultation (IECMHC) initiative was launched by the Early Care & Learning Council (ECLC) in partnership with the New York State Office of Children and Family Services (OCFS) and local Child Care Resource Centers (CCRCs). The goal of IECMHC is to improve social-emotional and behavioral outcomes for young children who receive child care. It achieves this goal by providing consultation services to child care providers.

Recognizing that child care providers play a critical role in children's early development, IECMHC was designed to support the adults who care for young children by enhancing their confidence, skills, and capacity to foster children's mental health. This report describes the IECMHC model that is implemented in New York State and discusses data from a statewide IECMHC intervention aimed at measuring the impact of IECMHC on outcomes. Data from nearly 300 child care environments across the state suggested four main findings: (1) IECMHC led to significant improvements within the care environment; (2) improvements were largest for programs that had the highest need; (3) improvements occurred regardless of the length of consultation; and (4) improvements persisted over time.

Infant & Early Childhood Mental Health Consultation (IECMHC)

Overview of the IECMHC Model

Infant & Early Childhood Mental Health Consultation (IECMHC) is a prevention-focused, relationship-based intervention used nationwide to strengthen early child care environments.[1] IECMHC differs from many other early childhood support models in both focus and method. While many other approaches to improving child care emphasize curriculum fidelity or providing direct services to children, IECMHC prioritizes relationship-based support for caregivers (e.g., child care providers and families). Through coaching, consultation, and reflective practice, IECMH consultants partner with child care providers and families to create a care environment that promotes children's social-emotional development and addresses challenging behaviors before they escalate. In other words, rather than providing direct services to individual children, IECMHC focuses on improving child care by supporting caregivers, child care providers, and families. Taking a systems-level approach, consultants work alongside child care providers to integrate strategies across caregiving environments. The goal is to foster broad changes in how providers cope with the stressors inherent to early education by increasing caregivers' capacity to support children. Doing so has been shown in previous research to manifest in improved climates and positive childhood outcomes.[2]

IECMHC Supports Positive Outcomes Nationwide

Research consistently demonstrates that IECMHC improves outcomes for children, child care providers, and families. Studies have shown that IECMHC leads to reductions in suspensions and expulsions and reductions in reports of challenging behaviors within child care environments.[3,4] Research has also shown improvements in provider well-being and retention, and strengthened provider-family relationships.[5] Perhaps most compellingly, one recent paper combined data from 16 different studies of the impact of IECMHC to ask whether IECMHC led to positive outcomes across contexts. While the 16 studies differed in many ways (e.g., geography, research focus, duration of consultation), they demonstrated many strengths of IECMHC. For example, IECMHC led to improvements in important child-level outcomes (e.g., related to behavior; social-emotional growth) in every study where they were measured.[6] This body of evidence underscores IECMHC as an effective strategy for strengthening early child care by supporting caregiving adults at their place of work.

IECMHC in New York State

New York State designed its IECMHC model to align with nationally recognized approaches to IECMHC, including the Georgetown Model of IECMHC and the peer reviewed literature described above.[7]

Because IECMHC is most effective when services align with local needs, it is important to understand the unique features of New York's implementation of the IECMHC model. Below is a review of (1) the growth and expansion of IECMHC in New York in recent years, (2) an overview of the IECMHC process as it is implemented in New York, and (3) important features of New York's implementation of IECMHC that have led to high levels of success and sustainability.

The Growth and Expansion of IECMHC in New York

New York State's IECMHC initiative was established in 2019, and, by 2022, nearly 200 providers were served despite the impact of the COVID-19 pandemic.

Since then, a cumulative total of 927 child care rooms have been served across 56 (90.3%) of 62 counties in the state (Fig. 1). While the NYS IECMHC initiative began by serving caregivers of infants and toddlers (e.g., ages birth to 3), the project expanded in 2025 to serve preschool-aged environments (e.g., child care environments serving children aged 4 and 5).

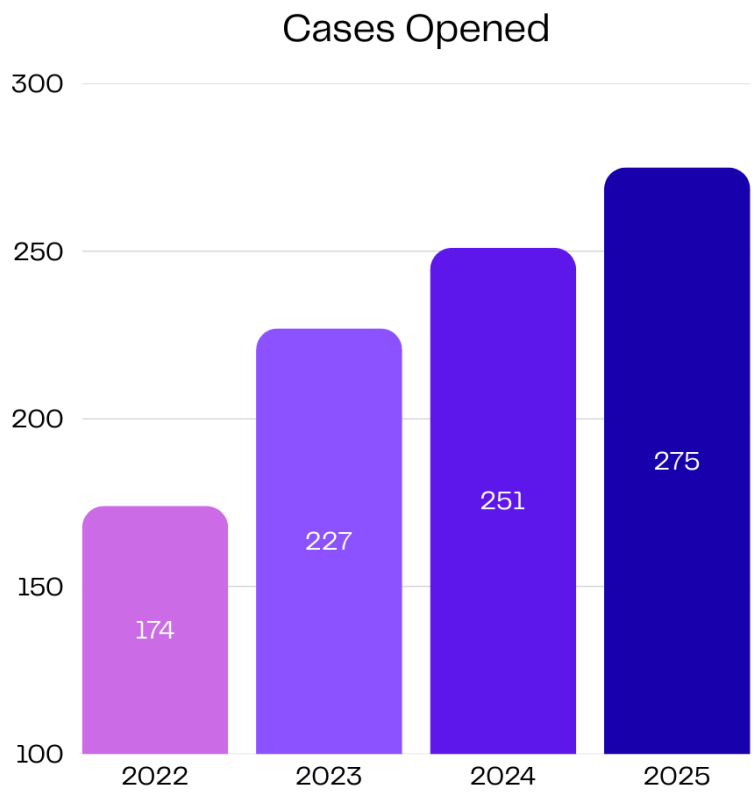


Figure 1. Number of new IECMHC cases opened per year.
Each case represents a unique child care room that initiated the consultation process.

Overview of the IECMH Consultation Process in New York State

New York State IECMHC operates through the Early Care & Learning Council and local Child Care Resource Centers (CCRCs). IECMH consultants are directly embedded in the communities they serve via the CCRCs, allowing for care that is tailored to the needs of their unique population. Any licensed or registered care provider is eligible to receive consultations. Child care providers who are interested in beginning the IECMHC process can contact their local CCRC. This will allow a consultant to reach out to them to collaboratively determine the level of need and whether to engage in the consultative process.

The consultative process differs based on the nature of the program and the needs of the caregiver, but there are always five phases: initiation, plan development, plan implementation, post-assessment, and termination/transition (Fig. 2).

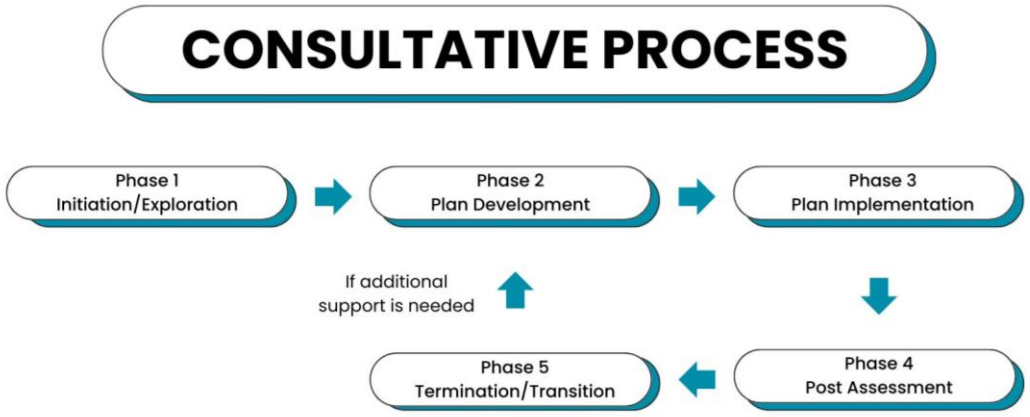


Figure 2. The IECMHC model.

During the initiation and exploration phase of IECMHC, consultants collaboratively determine the level of need and administer pre-assessments. Consultation can be room-based or program-based, and so the initiation and exploration phase will involve understanding the needs of the room and/or program. Next, during the plan development phase, IECMH consultants partner with child care providers to create a plan of action. The plan of action contains specific goals that are strength based and mutually agreed upon.

The majority of the consultative work takes place during the plan implementation phase. During this phase, consultants work with the child care provider to find approaches to meeting the agreed-upon goals. This can involve a wide variety of interventions and a great deal of trial and error. There is no direct service provided to specific children in a care setting. Consultants do not engage in therapy, and do not diagnose children or adults. Instead, because IECMHC is a relationship-based practice, time and attention are devoted to increasing the provider's reflective capacity, managing stress levels, and identifying creative solutions to achieve the agreed-upon goals.

Post-assessment is the next stage of consultation and determines what course of action happens next. If new goals are identified, a consultant may stay, transitioning to another cycle of consultation. New York's IECMHC model allows for two cycles of consultation per provider per year, if needed. If goals are met, the consultation process ends. In order to assess the sustainability of the consultative goals and outcomes, a second post-assessment is recommended.[8] This post-assessment occurs after the case has been closed for three months. While the primary goal of the post-assessment is to understand whether the program's goals have been met, assessment data also provides a unique opportunity for studying the efficacy of IECMHC and its impacts on the populations served. This is discussed in greater detail below.

Important Features of IECMHC Implementation in New York

Robust Data Collection and Storage

In January of 2022, IECMH consultants began using MITCH, the Early Care & Learning Council's (ECLC's) centralized database, to track their work. Specifically, MITCH tracks consultation sessions, assessment scores, and the demographics of the child care providers and children served. Establishing MITCH allows for the systematic testing and tracking of the effects of consultation on outcomes -- these results are reported below. It also allows the state to better understand who is being served by IECMHC.

Having a statewide system for tracking IECMHC data has allowed the state to understand the impact of IECMHC on the child care landscape. Since consultants began to track their work using MITCH, 37,817 children were enrolled in settings receiving consultation, with 8,472 of these children in rooms directly served by consultants. Service settings where IECMH consultations occurred represented the full range of licensed and registered modalities across the state, including infant, toddler and pre-school/pre-K environments, continuity-of-care programs, and family child care homes. The providers and children served reflected the diverse racial and ethnic backgrounds of communities across New York State. Among providers who reported their race, 344 (42.4%) identified as white, 131 (16.1%) as Black, 276 (34.0%) as Hispanic/Latino, 46 (5.7%) as Asian, and 15 (1.8%) as multi-racial.

Systematic Support for Consultants

In order to ensure that the implementation of IECMHC is consistent and high quality, New York State has made a commitment to supporting mental health consultants via effective reflective supervision consultation (RSC; Figure 3). RSC goes beyond administrative or clinical supervision: "Reflective supervision offers empathy, supports reflective practices, and encourages self-awareness to help consultants explore their reactions to the work, manage stress, and understand the parallel process of relationship-based work."[9] RSC is specific to the IECMHC model, and is a key element of project sustainability, because it leads to lower rates of turnover, provides support to mental health consultants, and results in greater consistency for providers.

Figure 3. The role of RSC in supporting consultants.

Understanding the Impact of IECMHC in New York State

In order to understand the effect of IECMHC on child care in New York State, it was important to assess whether IECMHC was associated with better child care outcomes. Doing so would allow for identification of areas of need, places to grow, and successes across the state. Below is a description of the impact of IECMHC on child care in NY. Data were collected from 297 child care providers from January 1, 2022 to July 1, 2025. All child care providers who completed at least one cycle of consultation during this time period were included in analyses.

Measurement

The pre-assessment and post-assessment used the Climate of Healthy Interactions for Learning and Development (CHILD) tool, developed by Dr. Chin Reyes and Dr. Walter Gilliam at Yale University. The CHILD and its predecessors have been used to assess the efficacy of infant and early childhood mental health consultation initiatives in other states.[10,11]

The CHILD assesses nine core elements of early care environments: transitions; directions and rules; social and emotional learning; adult awareness; adult affect; adult cooperation; adult-child interactions; individualized and developmentally appropriate practices; and child behaviors. Scores range from -2 to 2, with higher scores indicating stronger alignment with best practices. In general, positive scores are thought to indicate a responsive, strength-based child care environment, while negative scores indicate a higher needs environment. Because the CHILD focuses on observable practices and climate rather than data about individual children (e.g., individual diagnoses, individual levels of achievement), it is well suited for assessing systems-level change and the impact of consultation across programs and regions.

Design

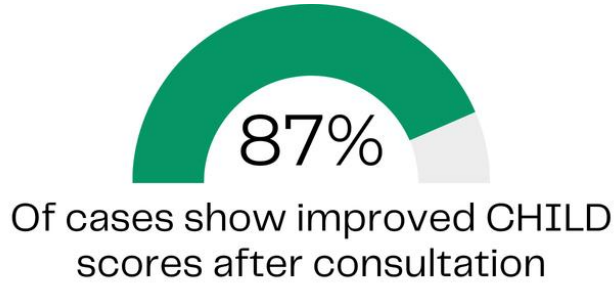
To assess impact, child care environments were assessed before and after participation in the implementation phase of consultation (Figure 2). These scores measured changes in program-level outcomes over the course of consultation.

As is typical for IECMHC, the length of consultation differed based on program needs, consultant assessment, and logistical constraints within early care settings. This flexible approach allowed consultants to tailor the intensity and duration of support while maintaining fidelity to the core IECMHC model. Across the project, the shortest consultation period was four weeks and the longest was 41 weeks, with an average consultation length of 14 weeks. Based on implementation experience and observed outcomes, the recommended consultation length is approximately 13 to 16 weeks.[12] This recommended length granted consultants the time needed to develop relationships and institute achievable goals, while keeping consultation short enough to ensure as many providers as possible were served.

Key Findings and Outcomes

Across analyses, IECMHC led to consistent and measurable improvements in the child care environment.

Finding 1: Widespread and Significant Program Improvements



Programs demonstrated significant increases in CHILD scores from pre-assessment to post-assessment, with an average increase of 0.40 points (out of 4). Improvements were observed in 87% of completed consultation cycles.[i] The data indicates meaningful strengthening of caregiving practices following consultation.

Finding 2: Greater Improvements Where Need Was Highest

Some early education interventions can have a "barrier to entry" or a minimum level of performance that is required for the intervention to make a difference. We saw no evidence for this in New York's IECMHC. Instead, programs that had the most to gain at the outset showed the greatest growth. This means that IECMH consultation had the biggest benefit in programs where the need was highest.

Specifically, programs with the lowest CHILD scores at pre-assessment experienced the greatest growth by post-assessment.[ii] This means that consultation was most effective for child care rooms that initially scored the lowest. For example, consider the 38 programs that had negative pre-assessment scores, indicating a higher needs environment. These 38 programs showed an average gain of 0.72 (median = .66) on the CHILD, typically moving them into the positive range post-consultation.[iii] In practical terms, the size of improvement for these programs was large.

Although the greatest growth was seen in child care environments with lower pre-assessments, the 259 providers that scored above 0 on the pre-assessment also showed meaningful growth,[iv] and the size of the effect of consultation was massive for an educational intervention. This shows that child care environments of all types can benefit from engaging in consultation.

To summarize, IECMHC led to benefits for the vast majority of participating child care programs. Given the project's goal of serving providers equitably and making a difference in historically underserved communities, these data present an encouraging picture of the possible effects of consultation on outcomes.

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[i] $t(296) = 17.22$, $p<.0001$, $d = .99$ [CI: .85, 1.14];

[ii] We predicted the shift in scores from pre- to post-assessment from pre-assessment scores. We found a significant negative predictive relationship ($B = -.36$, $SE = .04$, $p<.0001$, $r^2 = .24$), such that the lower the initial score at pre-assessment, the greater the amount of growth after consultation.

[iii] $t(37) = 8.97$, $p<.0001$, $d = 1.45$ [CI: .99, 1.91].

[iv] $t(258) = 15.68$, $p<.0001$, $d = .975$ [CI: .83, 1.12].

Finding 3: Benefits Across Different Lengths of Consultation

Child care programs benefited from IECMHC regardless of consultation length. Although consultation duration differed across programs, positive changes were observed across the board. There were no differences whatsoever in average improvement on the CHILD depending on consultation duration.[v] This means that consultation can be effective even at smaller doses.

Importantly, this finding does not mean that the duration of consultation has no impact on outcomes in general. Instead, it likely means that programs received the amount of consultation that they needed. The duration of consultation is not random: the consultative process has built-in mechanisms for identifying whether program needs have been met and for adjusting the length of consultation in response (Figure 2). Because the duration of consultation is responsive to a program's changing needs, these data suggest that the process used for identifying the length of consultations was effective in NY.

Finding 4: Sustained Improvements Over Time

Among the small subset of programs with multiple post-assessments (n = 19), gains were maintained over time, with no significant decline observed at follow-up (average 99 days later).[vi]

Why the effect of IECMHC is big enough to matter:
One measure of the practical impact of an intervention is called "effect size": an effect size of .2 indicates a small but meaningful effect, an effect size of .5 indicates a medium effect, and an effect size of .8 indicates a large effect. Some have even argued that in educational contexts, meaningful effect sizes are much smaller with an effect size of .2 being considered "large" (Kraft, 2020). The providers who struggled the most at pre-assessment showed an effect size of 1.45, which is an astonishingly large effect. Similarly, the providers who initially scored the highest on the CHILD showed growth with an effect size of .975.

Conclusions

Overall, data suggest that New York State's Infant & Early Childhood Mental Health Consultation is an effective and equitable strategy for strengthening adult capacity and supporting positive child outcomes across diverse early care settings. By centering relationships, reflective practice, and prevention, and by pairing flexible implementation with rigorous evaluation, New York State's IECMHC initiative demonstrates a replicable and scalable model for improving early childhood care quality.

In addition to demonstrating the strengths of IECMHC, this study demonstrated the importance of tracking and analyzing data for promoting improvements in early child care. By collecting thorough data describing the IECMHC intervention, it was possible to demonstrate a measurable effect on the early care environments of the providers who engaged in consultation. This data has proven essential in discussing the future of the project with stakeholders, constituents, and funders. Furthermore, the uniformity of the MITCH data system encourages collaboration between agencies across New York State. Finally, ongoing efforts to track and study the efficacy of IECMHC make it possible for the state to spot gaps in service and ensure that the project is serving populations across New York equitably.

[v] B = .000, SE = .001, p = .66, r^2 = .000
[vi] $t(18)$ = 1.11, p = .28, d = .25 [-.20, .71]

Endnotes

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