Colorado Evaluation & Action Lab
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Early Childhood Mental Health Consultation

A Gap Analysis of Available Mental Health Consultants and Unmet Need in Colorado

REPORT HIGHLIGHTS:

- This report describes the **current support and available capacity** of Colorado's Early Childhood Mental Health Consultation program and estimates **staffing need and associated costs** to maintain or increase program reach**.**
- To maintain the current reach of state-funded consultants beyond June 30, 2024 would require a minimum additional investment of **$2.09 million**.

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Table of Contents

Tables

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Note on Gender-Inclusive Language

The Colorado Lab affirms our commitment to the use of gender-inclusive language. We are committed to honoring the unique gender identity of each study participant. Throughout this report, we follow the guidance of the Associated Press Stylebook and the Chicago Manual of Style and use the gender-neutral, singular “they” when appropriate.

Purpose

Demand for early childhood mental health consultation (ECMHC) services has been previously documented. Both a 2019 cost estimation[1] and Preschool Development Grant Needs Assessment[2] have indicated an inadequate supply, with findings replicated in 2022.[3] As of July 1, 2023, at current funding and staffing levels, the ECMHC Program cannot serve all potential consultees within the state. The Division of Community and Family Support within the Colorado Department of Early Childhood (CDEC) partnered with the Colorado Evaluation and Action Lab to better understand the unmet need and identify a target number of consultants required to provide increased access to services. As required by State Bill 21-137, the following gap analysis describes the current level of service provision and the additional investment needed to reach scale in Colorado, which would ensure access for all interested, licensed child care providers as well as a substantial number of licensed exempt and individual care providers, including those working in broad early childhood settings where children learn and grow such as elementary schools, home visitation, child welfare, public health, and health care.

Colorado's ECMHC Program

The ECMHC Program is a no-cost, confidential program that pairs Masters-level mental health professionals (or related field) with adults caring for children age birth to six years, including the prenatal and postpartum period, to build the adults' capacity to promote the social-emotional development and mental well-being of the child(ren) in their care. The ECMHC Program is comprised of Early Childhood Mental Health (ECMH) consultants who have deep expertise in early childhood, social-emotional development, and mental health. ECMH consultants use a strengths-based approach to provide culturally and linguistically responsive services to adults across settings where young children learn and grow. Consultants leverage the consultative stance to cultivate knowledge, skills, and reflective capacity within the adults with whom they partner, empowering caregivers to promote children's healthy social-emotional development and effectively respond to behaviors they find challenging.[4]

These services are rooted in the broad body of research evidence demonstrating that positive, secure relationships between caregivers, children, and families are essential to healthy child development. Early life experiences lay the foundation for social-emotional and academic development.[5, 6] Positive relationships formed with caregivers build children's resilience and support children's success across the domains of growth and development.[7] By engaging in this relationship-based work, ECMH consultants promote equity and reduce disparities in access to resources and positive outcomes for young children and their families at a critical moment in child development.

Program Background

Colorado's ECMH Specialist Program was established in the Colorado Department of Human Services (CDHS) by the Office of Behavioral Health in 2007 and transitioned to the Office of Early Childhood in 2012, where it was renamed the ECMHC Program.

Section 26.5-3-702 of the Colorado Revised Statutes instructs that "on or before July 1, 2022, the department shall design, implement, and operate the statewide voluntary program of early childhood mental health consultation to expand and enhance current practices across the state." It also expands upon previously eligible vendors and allowable service settings. Colorado formally released its model of ECMHC on July 1, 2022, documented in its program implementation manual which details model components and provides service delivery guidance to consultants. The Colorado ECMHC Program is

currently engaged in implementation, monitoring, and coaching to ensure high fidelity provision of services. It has also partnered with an external evaluator to evaluate the program by 2026.

The ECMHC Program currently resides in the new CDEC which was established in July 2022. During the five-year funding cycle leading up to State Fiscal Year (SFY) 2021, the program supported 34 full-time equivalent (FTE) employees across 15 community mental health centers and three early childhood councils. With the addition of COVID-19 stimulus relief and recovery funds that were allocated to the ECMHC Program beginning July 1, 2020, the program has been able to expand. As of July 1, 2023, the ECMHC Program supports 52 FTE statewide.

Colorado's ECMHC Theory of Change

ECMHC's mental health lens allows consultants to uniquely contribute to the development, mental health, and well-being of teachers, early childhood program leaders, family members, and others providing care to young children. ECMHC operates at no cost to consultees. While services are responsive to clients' needs, ECMHC emphasizes upstream prevention of mental health and social-emotional concerns by partnering with adults to build the skills needed to support children. By equipping adults with increased capacity to support young children, the program explicitly aims to reduce exclusionary discipline in early childhood settings. State-funded ECMHC sites and their consultants operate in all 64 counties across Colorado.

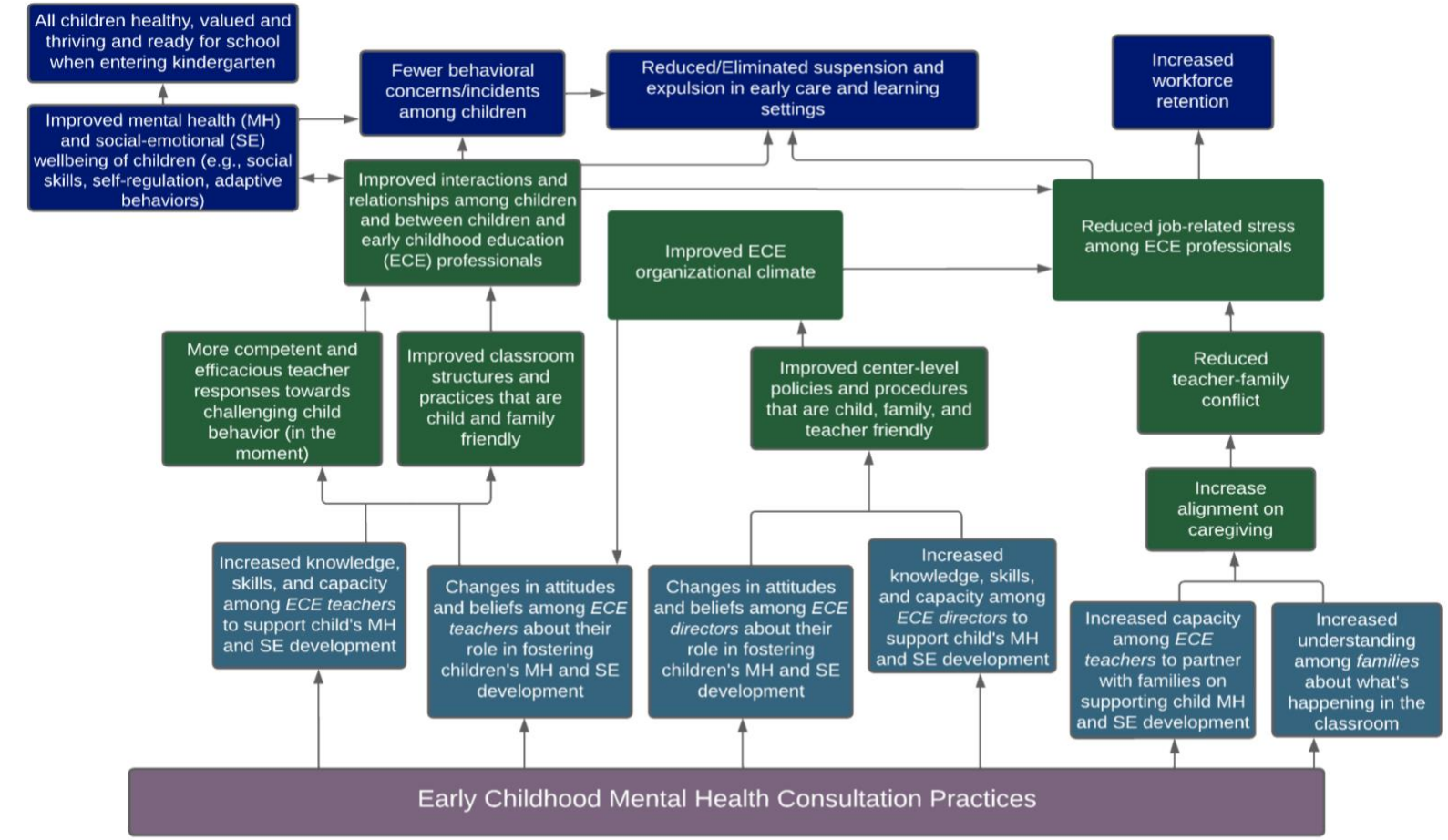
The anticipated benefits of ECMHC are described in the Theory of Change (Figure 1).[8] An early care and education setting is used to illustrate Colorado's theory of change. Consultative practices, changes in attitudes and beliefs, and gains in adult capacity are expected to be similar across settings where children learn and grow, in service of the shared north star outcomes of child well-being, workforce retention, and increased family stability. The Colorado model of ECMHC serves children birth to six, including the prenatal period.[9]

As illustrated, consultants elicit change and long-term outcomes through three primary pathways.

- **Teacher Intervention** (leftmost light blue boxes): Consultants change attitudes and beliefs about teachers' role in fostering children's mental health and social-emotional development and increase the capacity of early care and education (ECE) teachers. Teachers improve their own practice (become more competent and efficacious) and improve classroom structures (green boxes).
- **Director Intervention** (middle light blue boxes): Consultants change attitudes and beliefs and increase the capacity of ECE center directors, who improve center-level policies and procedures, therefore contributing to an improved organizational climate (green boxes).
- **Partnership Support** (rightmost light blue boxes): Consultants increase the capacity of ECE teachers to partner with families—and increase understanding among families of classroom practices—thereby supporting alignment on caregiving and reducing teacher-family conflict (green boxes).

These changes work together to improve interactions and relationships among children and between children and ECE professionals and reduce provider stress and burnout (green boxes). In the long term, this supports improved mental health and social-emotional well-being of children, fewer behavioral concerns/incidents among children, reduced suspensions and expulsion in the early care setting, and increased workforce retention (dark blue boxes).

Figure 1. Early Childhood Mental Health Consultation Theory of Change



Note: An early care and education setting is used above to illustrate Colorado's theory of change. Consultative practices, changes in attitudes and beliefs, and gains in adult capacity are expected to be similar across settings where children learn and grow, in service of the shared north star outcomes of child well-being. Children are defined as birth through six, including the prenatal period.

COLORADO
Department of Early Childhood

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Colorado ECMHC Program Current Support and Available Capacity

Currently, implementation of the Colorado model of ECMHC includes both state-funded and non-state-funded consultants. Current reach described in this report is based on all consultants entering case data into the state data system at any point in SFY23. This "full consultant workforce" included approximately 81 FTE in SFY23.[10] It should be noted that this reach is not exclusively funded through state-administered funds but also includes the efforts of consultants funded by philanthropic contributions.

Colorado's state ECMHC Program funding is layered, including contributions from State General Funds, Child Care Development Funds (CCDF), and COVID-19 stimulus relief and recovery funds. In 2020, states struggled to meet the mental health needs of children and families impacted by the COVID-19 pandemic. In Colorado, Governor Polis issued an Executive Order appropriating $1.4 million of the CCDF available through the Coronavirus Aid, Relief, and Economic Security (CARES) Act for use by the CDHS ECMHC Program from July 1, 2020, to June 30, 2021. These newly appropriated federal relief funds supported a workforce increase of 15 FTE, bringing the total *available* FTE from 34 FTE to 49 FTE. Most recently, the ECMHC Program was awarded another $7.78 million in COVID Response and Relief Stimulus Act (CRRSA) and American Rescue Plan Act (ARPA) Discretionary funding to be used from July 1, 2021, to June 30, 2024. To date, these funds have been used to maintain the additional ECMH consultant positions initially filled through CARES funding,[11] and further expand the program by eight consultants, bringing the total state-funded consultant FTE to 52. The addition of these eight FTE has supported the program in piloting innovative service delivery methods, such as Statewide Brief Consultation.[12]

In SFY23, the state-funded ECMHC Program budget (State General Funds, CCDF Funds, CRRSA/ARPA Stimulus Funds) totaled $5.78 million, $3 million (52%) of which will expire June 30, 2024. The majority of the program budget, $4.84 million (84%), is invested directly into contracted consultant FTE (i.e., ~52 FTE boots on the ground). Of the contracted FTE, $2.09 million (43%) will expire June 30, 2024, which supports roughly 22.25 of the current 52 FTE.

Assumptions to Support Unmet Need Calculations

To estimate unmet need for staffing, we considered statewide licensed provider count, case type, FTE, current size, and reach of the existing ECMH consultant workforce and best practices in case management (e.g., dosage, maximum caseload).

The estimates are likely underestimates of total need.[13] Additionally, the need described in this analysis assumes that any additional investment would come solely from state funds, rather than attempting to anticipate scaling from other funding sources. We err on the side of underestimation knowing that not all providers may engage in voluntary services (e.g., current need, programming requirements/commitment, personal values and beliefs); diverse social-emotional early childhood programming is available (e.g., Incredible Years); and additional, non-state-funded consultation services may be leveraged through direct pay and/or philanthropic support (e.g., federal and state grants).

This analysis uses data collected in SFY23 (all data from July 1, 2022 through June 13, 2023) and entered by ECMH consultants in the state data system (Salesforce). This includes all cases served by state-funded ECMH consultants and many of those served by consultants who are *not* state-funded. State-funded

ECMH consultants are required to enter data into this system at least one time per week (i.e., every five business days). Descriptions of data points informing calculations are shown in Table 1.

Table 1. Data Points Informing Calculations

Key Points for Calculations	Definitions, Assumptions, and Decisions Informing Calculations
(1) Case types	Cases and associated service plans occur at three levels: **Program, Classroom, and Child**. Each level of service has unique dosage requirements, including case duration and hours spent per month.[14] In SFY23, consultants served 1,874 cases **(435 Program**, **442 Classroom,** and **997 Child).**
(2) Consultant caseload	Caseload recommendations are based on dosage requirements, best practice for monthly hours spent on direct service, and share of time spent on different case types. Consultants are recommended to spend approximately **10%** of their time on Program cases, **60%** on Classroom cases, and **30%** on Child cases. Consultants who are employed at 1.0 FTE should not exceed 16 open client cases at any given time and **34 client cases** for the year (July 1 - June 30).[15] These recommendations set a *ceiling* for a consultant's caseload at peak efficiency and regional allocation, meaning that many consultants will work on fewer cases in a year. New hires carry lower caseloads in their first year to accommodate onboarding.
(3) Full-time Equivalent (FTE)	While 81% of consultants work full time, 10% of ECMHC FTE program-wide comes from consultants employed at .75 FTE, 9% from consultants employed at .50 FTE, and less than 1% from consultants employed at .25 FTE. Therefore, the number of individuals providing consultation is higher than the FTE they represent. **In SFY23, 92 individual consultants represented 80.75 FTE.** This total includes both state-funded and non-state-funded consultants contributing to the SY23 case counts within the state data system.
(4) Licensed and unlicensed care[16]	ECMHC occurs in settings where children learn and grow, including both licensed and unlicensed care[14] settings. In SFY23, 86% of Program cases, 95% of Classroom cases, and 83% of Child cases occurred in licensed settings. For our estimates, we **assume an 80%/20% licensed/unlicensed care split for Program and Child** cases and **assume 100% of Classroom** cases occur in licensed care.
(5) Cases per program served	On average, a licensed early childhood program with at least one service plan in SFY23 was associated with **0.74 Program** cases, **0.75 Classroom** cases, and **1.5 Child** cases.

To project staffing needs, we estimated the FTE, consultant workforce, and total cost required to:

- Maintain the current level of state-funded FTE.
- Increase the program's reach by 10% (reaching approximately 20% of providers).
- Reach 35% of licensed providers.
- Reach 65% of licensed providers.
- Reach 100% of licensed providers.

We calculated these under the assumptions that:

- Consultants work within caseload recommendations (Key Point 2).
- In program-level cases, consultants spend 80% of their time in *licensed* care settings and 20% of their time in *unlicensed* care settings (Key Point 4).
- In classroom-level cases, consultants spend 100% of their time in *licensed* care settings (Key Point 4).
- In child-level cases, consultants spend 80% of their time in *licensed* care settings and 20% of their time in *unlicensed* care settings (Key Point 4).

Current reach varies substantially by county, reaching anywhere from zero to 100% of licensed programs. Statewide, 10.6% of licensed providers receive some level of ECMH consultation (child, classroom, and/or program). To maintain the current breadth of reach across the state and scale proportionally, estimates for required FTE are calculated and reported at the county level.[17] Following those, estimates for individual consultants needed to fulfill those resulting FTE estimates were calculated separately for "urban" and "rural" FTE based on county locale. The regional distinction was made to account for documented variations in salary and was critical to cost modeling.

See Appendix A for more information.

Estimated ECMHC Staffing Need and Associated Costs

In SFY23, the state-funded ECMHC Program budget (State General Funds, CCDF Funds, CRRSA/ARP Stimulus Funds) totaled $5.78 million. These funds support 52 FTE, translating to approximately 62 individual consultants. At the current level of funding and staffing, and with non-state-funded consultants also providing services aligned with the Colorado model of consultation, ECMHC serves approximately 10.6% of Colorado's licensed child care providers (1,874 cases in SFY23). The program maintains a statewide wait list of 54 providers as of April 13, 2023.

On June 30, 2024, $3.0 million of current stimulus funding will expire, dropping the state-funded workforce from 52 FTE to approximately 29.75 FTE (36 consultants) and reducing the reach by nearly half.

Funding actions that could be taken and their associated costs are shown in Table 2.[18]

Table 2. Potential Actions, Estimated Impact, Required FTE, and Associated Costs

Action	Estimated Number of Cases Served Annually[19] (Key Point 5)	Additional FTE Funded	Approximate Additional Cost for FTE	Approximate Total Cost for FTE
No action taken	945	0	$0	$2.75 million
Maintain current FTE, replacing temporary relief funds (10.6% reach)	1,652	22.25	$2.09 million	$4.84 million
Increase reach by 10% (~20% reach)	3,105	68.05	$7.78 million	$10.53 million
Reach 35%	5,217	134.52	$15.69 million	$18.44 million
Reach 65%	9,557	271.20	$31.68 million	$34.43 million
Reach 100%	14,635	431.13	$50.59 million	$53.34 million

To maintain the current reach of state-funded consultants beyond June 30, 2024, a minimum additional investment of $2.09 million would be needed, totaling $4.84 million per year for FTE, with additional administrative costs required for state program infrastructure. If the ECMHC Program were to increase its reach by 10%, the associated cost increases to $7.78 million ($10.53 million total for FTE).

Persistent statewide demand for ECMH consultation services exceeds current program capacity, and many consultation sites continue to maintain a waitlist. In SFY23, in an effort to maximize resources and responsively meet growing demand, the program developed and implemented innovative service delivery strategies, including statewide brief consultation.[20] Taken together, the program currently is only reaching 10.6% of licensed child care providers statewide and far fewer unlicensed care settings.[21]

Universal Preschool Program Considerations

In 2022, House Bill 22-1295 created a Universal Preschool Program which is anticipated to launch in fall 2023 and as of June 1, 2023, has received over 30,000 family applications. Approximately 8,600 children and 800-2,000 teachers are estimated to be new to the licensed child care system. These estimates are not included in Table 2 above.

Conclusion

ECMHC services are rooted in the broad body of research evidence demonstrating that positive, secure relationships between caregivers, children, and families are essential to healthy child development. Consultants leverage the consultative stance to cultivate knowledge, skills, and reflective capacity within the adults with whom they partner, empowering caregivers to promote children's healthy social-emotional development and effectively respond to behaviors they find challenging. Statewide demand for ECMHC services consistently exceeds current program capacity, despite additional temporary COVID-19 relief funds for additional consultant FTE and the implementation of innovative service delivery strategies.

To maintain the current reach of state-funded consultants beyond June 30, 2024, a minimum additional investment of $2.09 million would be needed ($4.84 million total for FTE, including existing funding), with additional administrative costs required for state program infrastructure. If the ECMHC Program were to further address excess demand and increase its reach by 10%, the associated cost increases to $7.78 million ($10.53 million total for FTE). Other scaled estimates to reach 35%, 65%, and 100% of licensed child care providers are provided above and would require significantly more investment (for county-level estimates, see Appendix A).

Appendix A: Methodology

Estimating Staffing Needs Based on Current Practice

First, we examined the *estimated Full-time Equivalent (*FTE) needed to serve all cases represented in the state data system in State Fiscal Year (SFY) 2023. This differs from the FTE actually used in the same time period because caseload recommendations represent the upper bound for cases served by a given consultant in a year. Comparing these allowed us to better understand how estimates and projections might relate to on-the-ground staffing needs.

Using the recommended caseload and dosage for each case, we assigned each Program, Classroom, and Child case a proportion of FTE required for service. Then, we multiplied that by the number of cases of each with utilizations in the data system to understand the total program-wide FTE required for each case type. In practice, consultants do not serve a single case type, but this allows us to effectively estimate FTE.

Finally, because not all consultants are hired at 1.0 FTE, we calculated the number of consultants needed to meet this FTE amount, using the historical distribution of different levels of FTE (e.g., 80% of FTE will be covered by full-time positions), rounding up where needed. Results of these calculations are shown in Table A-1. Assumptions from the Key Points listed in Table 1 that inform each column are listed in parentheses.

Table A-1. Estimated Share of FTE Required by Case Type

Case Type	**FTE Required per Service Plan** (Key Points 1, 2)	**SFY23 Cases (Actual)** (Key Point 1)	**Total FTE Required (Estimate)**	**Total Consultants Required (Estimate)** (Key Point 3)
Program	0.02	435	10.88	14
Classroom	0.04	442	17.68	23
Child	0.025	997	19.94	25
TOTAL	–	1874	48.5	62

Table A-1 above gives us the lowest amount of FTE and fewest staff required to serve current cases (i.e., those open and served at some point in SFY23) based on caseload recommendations. A comparison to actual practice in SFY23 is presented in Table A-2.

Table A-2. Estimated Consultants Needed for State Fiscal Year 2023 (SFY23)

	Estimate Based on Caseload Recommendations (all consultants carry a maximum caseload, 34 for 1.0 FTE;[22] optimal regional distribution)	**Actual Practice** (mean caseload = 23.2)
FTE Required	48.5	80.75
Consultants Required	62	92

Because of the assumptions made to calculate estimates, it is not surprising that estimates for needed FTE and consultants were lower than the *actual* FTE and consultants in SFY23. Projections in the following section similarly provide a floor for additional FTE required, likely less than the amount needed to account for typical service delivery challenges.

Projecting Future Full-Time Equivalent Totals Associated with Increased Reach

Projections were calculated using the approach described above, under several assumptions:

- Consultants work within caseload recommendations (Key Point 2).
- In program-level cases, consultants spend 80% of their time in *licensed* care settings and 20% of their time in *unlicensed* care settings (Key Point 4).
- In classroom-level cases, consultants spend 100% of their time in *licensed* care settings (Key Point 4).
- In child-level cases, consultants spend 80% of their time in *licensed* care settings and 20% of their time in *unlicensed* care settings (Key Point 4).

Cases that are affiliated with a licensed provider are identified with their licensing number in the data system. We totaled the licensed providers served in SFY23 by county and compared it to the total number of licensed providers in each county to get a percent reach. Statewide, current Early Childhood Mental Health Consultation (ECMHC) Program support and available capacity reaches approximately 10% of licensed care providers.

We then determined the amount of FTE each county would need to achieve various levels of reach: reaching 10% more of the centers in a county; 35% reach; 65% reach; and 100% reach. Gaps between the FTE required at the current service level and what would be additionally required are shown in Table A-3, as well as total FTE needed. Note that unlicensed providers are also included in this projection, with the number of programs projected to be served/FTE required based on licensed provider numbers.

Table A-3. Current Reach and Additional FTE Needed for Expansion, by County

County	Number of Licensed Providers[23]	Current Reach %, based on Licensed Providers (Statewide Average = 10.6%)	Estimated Additional FTE Required, 10% Increase (~20% Reach)	Estimated Additional FTE Required, 35% Reach	Estimated Additional FTE Required, 65% Reach	Estimated Additional FTE Required, 100% Reach
Adams	387	6.72%	3.51	9.92	20.44	32.72
Alamosa	15	33.33%	0.14	0.02	0.43	0.91
Arapahoe	537	8.94%	4.87	12.68	27.28	44.31
Archuleta	12	25%	0.11	0.11	0.44	0.82
Baca	5	20%	0.05	0.07	0.20	0.36
Bent	4	25%	0.04	0.04	0.15	0.27
Boulder	318	11.64%	2.88	6.73	15.38	25.46
Broomfield	65	7.69%	0.59	1.61	3.38	5.44
Chaffee	17	11.76%	0.15	0.36	0.82	1.36
Cheyenne	5	0%	0.05	0.16	0.29	0.45
Clear Creek	10	10%	0.09	0.23	0.50	0.82
Conejos	6	33.33%	0.05	0.01	0.17	0.36
Costilla	3	100%	0.03	0.00	0.00	0.00
Crowley	1	0%	0.01	0.03	0.06	0.09
Custer	6	0%	0.05	0.19	0.35	0.54
Delta	20	10%	0.18	0.45	1.00	1.63
Denver	531	18.27%	4.81	8.05	22.49	39.33

County	Number of Licensed Providers[23]	Current Reach %, based on Licensed Providers (Statewide Average = 10.6%)	Estimated Additional FTE Required, 10% Increase (~20% Reach)	Estimated Additional FTE Required, 35% Reach	Estimated Additional FTE Required, 65% Reach	Estimated Additional FTE Required, 100% Reach
Dolores	2	0	0.02	0.06	0.12	0.18
Douglas	312	10.26%	2.83	7.00	15.48	25.37
Eagle	66	0%	0.60	2.09	3.89	5.98
El Paso	601	6.32%	5.45	15.62	31.96	51.02
Elbert	13	23.08%	0.12	0.14	0.49	0.91
Fremont	23	26.09%	0.21	0.19	0.81	1.54
Garfield	68	0%	0.62	2.16	4.01	6.16
Gilpin	4	50%	0.04	0.00	0.05	0.18
Grand	22	0%	0.20	0.70	1.30	1.99
Gunnison	22	13.64%	0.20	0.43	1.02	1.72
Hinsdale	3	0%	0.03	0.10	0.18	0.27
Huerfano	6	0%	0.05	0.19	0.35	0.54
Jackson	1	0%	0.01	0.03	0.06	0.09
Jefferson	537	8.19%	4.87	13.05	27.65	44.68
Kiowa	3	0%	0.03	0.10	0.18	0.27
Kit Carson	12	0%	0.11	0.38	0.71	1.09
La Plata	55	38.18%	0.50	0.00	1.34	3.08
Lake	4	50%	0.04	0.00	0.05	0.18

County	Number of Licensed Providers[23]	Current Reach %, based on Licensed Providers (Statewide Average = 10.6%)	Estimated Additional FTE Required, 10% Increase (~20% Reach)	Estimated Additional FTE Required, 35% Reach	Estimated Additional FTE Required, 65% Reach	Estimated Additional FTE Required, 100% Reach
Larimer	381	6.82%	3.45	9.73	20.09	32.17
Las Animas	9	11.11%	0.08	0.19	0.44	0.73
Lincoln	5	40%	0.05	0.00	0.11	0.27
Logan	24	29.17%	0.22	0.13	0.78	1.54
Mesa	135	0%	1.22	4.28	7.95	12.23
Mineral	1	100%	0.01	0.00	0.00	0.00
Moffat	10	30%	0.09	0.05	0.32	0.63
Montezuma	22	4.55%	0.20	0.61	1.21	1.90
Montrose	29	6.9%	0.26	0.74	1.53	2.45
Morgan	29	17.24%	0.26	0.47	1.26	2.18
Otero	16	31.25%	0.15	0.05	0.49	1.00
Ouray	4	0%	0.04	0.13	0.24	0.36
Park	18	16.67%	0.16	0.30	0.79	1.36
Phillips	8	0%	0.07	0.25	0.47	0.73
Pitkin	24	0%	0.22	0.76	1.41	2.18
Prowers	9	22.22%	0.08	0.10	0.35	0.63
Pueblo	124	10.48%	1.12	2.76	6.13	10.06
Rio Blanco	7	28.57%	0.06	0.04	0.23	0.45

County	Number of Licensed Providers[23]	Current Reach %, based on Licensed Providers (Statewide Average = 10.6%)	Estimated Additional FTE Required, 10% Increase (~20% Reach)	Estimated Additional FTE Required, 35% Reach	Estimated Additional FTE Required, 65% Reach	Estimated Additional FTE Required, 100% Reach
Rio Grande	13	23.08%	0.12	0.14	0.49	0.91
Routt	42	19.05%	0.38	0.61	1.75	3.08
Saguache	7	71.43%	0.06	0.00	0.00	0.18
San Juan	1	0%	0.01	0.03	0.06	0.09
San Miguel	14	7.14%	0.13	0.35	0.73	1.18
Sedgwick	4	25%	0.04	0.04	0.15	0.27
Summit	45	22.22%	0.41	0.52	1.74	3.17
Teller	30	16.67%	0.27	0.50	1.31	2.27
Washington	11	18.18%	0.10	0.17	0.47	0.82
Weld	314	13.69%	2.85	6.06	14.60	24.56
Yuma	17	11.76%	0.15	0.36	0.82	1.36
Column Sum:	**5049 Licensed Sites**	**10.6% Statewide**	**45.80 Additional FTE**	**112.24 Additional FTE**	**248.92 Additional FTE**	**408.90 Additional FTE**
Total FTE needed (current + additional):	**–**	**80.75 Current FTE**	**126.55 Total FTE**	**193.02 Total FTE**	**329.70 Total FTE**	**489.63 Total FTE**

Projecting Costs Associated with Increased Reach

Based on the FTE needs displayed in Table A-3, estimates were made for:

- The number of individual consultants required to reach a 10% increase, and reach 35%, 65%, and 100% of licensed care, under the assumptions described in Table 1.
- The associated costs.

Estimations are grounded in current practice and reflect budget projections currently used for ECMHC Program site contracts. Costs account for consultant salary and fringe, reflective supervision, training and professional development, mileage, and other overhead/indirect costs. It is important to note that cost estimates vary substantially between rural and non-rural contracts due to differences in mileage, cost of living, and average salary expectations. These cost estimates also assume that the number of sites remains static (10 rural, 11 urban) while the staffing at each site increases. The cost estimates by consultant by region are displayed in Table A-4.

Table A-4. Estimated Cost per Consultant by Region

FTE Type	Rural	Urban
0.25	$45,283	$48,600
0.5	$67,723	$74,359
0.75	$90,164	$110,118
1.0	$112,605	$125,875

Note: Cost per consultant includes salary, fringe, reflective supervision/consultation, mileage, and other overhead costs.

Because the method used here to calculate individual consultants involves rounding, examination of the individual county level would result in significant overestimation and is not advised. Instead, the number of consultants needed is examined at the more macro level, either statewide or by rural/urban as appropriate to project budgets. Therefore, to understand the costs associated with scaling to meet the reach described in Table A-3, counties were identified as rural or urban. Estimates for FTE and number of individual consultants required at each FTE level, by rural/urban, are shown in Table A-5. Consultant calculations are rounded up to the nearest individual (for example, 0.4 consultants is rounded to 1).

Table A-5. Consultants Needed to Bridge FTE Gap, by Rural/Urban

Action	Region	FTE Needed[24]	0.25 FTE Consultants Needed (Key Point 3)	0.5 FTE Consultants Needed (Key Point 3)	0.75 FTE Consultants Needed (Key Point 3)	1.0 FTE Consultants Needed (Key Point 3)
Increase reach by 10% (~20% reach)	Rural	6.67	1	1	1	6
	Urban	39.13	1	4	4	32
Reach 35%	Rural	13.61	1	2	2	11
	Urban	98.13	1	9	11	80
Reach 65%	Rural	32.98	1	3	4	27
	Urban	215.97	2	19	23	174
Reach 100%	Rural	55.99	1	5	6	46
	Urban	352.89	3	31	37	285

Each FTE type has a different maximum annual caseload, shown in Table A-6.

Table A-6. Maximum Annual Caseload, by FTE Type

FTE Type	Maximum Annual Caseload
0.25	13
0.5	19
0.75	26
1.0	34

To calculate estimated cases served by a given FTE type, total statewide FTE was multiplied by the estimated amount of statewide FTE served by each FTE type. Those estimates were then multiplied by the maximum caseload for that FTE type (Table A-6). Calculations are shown in Table A-7.

Table A-7. Estimated Cases, by FTE Type

Action	Total FTE Funded	Cases Served by 0.25 FTE Consultants (0.6%*13)	Cases Served by 0.5 FTE Consultants (8.7%*19)	Cases Served by 0.75 FTE Consultants (10.2%*26)	Cases Served by 1.0 FTE Consultants (80.5%*34)	Estimated Number of Cases Served Annually[25]
No action taken	29.75	2.4	49.0	79.1	814.3	945
Maintain state-funded FTE	52.00	4.2	85.7	138.2	1423.2	1,652
Increase reach by 10% (~20% reach)	97.80	7.9	161.1	259.9	2676.8	3,105
Reach 35%	164.27	13.2	270.6	436.5	4496.0	5,217
Reach 65%	300.95	24.3	495.8	799.7	8237.0	9,557
Reach 100%	460.88	37.1	759.2	1224.7	12614.3	14,635

To calculate total estimated costs to the program, consultants required at each FTE level (Table A-5) were multiplied by the cost per consultant in each region (Table A-4). These FTE totals and costs were added to those required to maintain state-funded FTE beyond June 30, 2024: 22.25 FTE at a cost of $2.09 million.

Potential actions and their implications for required FTE and associated costs are displayed in Table 2 above.

Assumptions

Our estimation methodology assumes that all staff are operating at full capacity (no new consultants are being onboarded or using the "New Hire" caseload recommendations); those staff are operating at maximum caseload recommendations; the time required for actual cases average out to the time used to calculate caseload recommendations (no attrition); there is no additional time granted for cases based on consultant requests for service plan extensions; consultants are optimally distributed across the state; consultants utilized the data system consistently, accurately, and in accordance with program guidance; and all licensed/unlicensed providers remain in the same county for the entire year.

Limitations

There are several limitations to our estimation methodology.

- Share of licensed/unlicensed providers served and proportions of each case type within consultant caseload differs slightly from current practice and is based on desired proportions.
- Data used are from SFY23 and only span 11 months of the program year. Based on previous year case totals and the cadence of case opening, the estimate used here should capture the vast majority of cases that will be opened in SFY23.
- Calculations are based on utilizations from all consultants entering data into the state data system. Our estimates for reach require that the reach of all non-state-funded consultants remains constant.

Endnotes

[1] Brodsky, A. (2019, October). *Colorado Early Childhood Mental Health Consultation: Statewide cost estimation results.*

[2] Colorado Department of Human Services, Office of Early Childhood. (2019, December). *Colorado shines brighter: Opportunities for Colorado's early childhood system.* https://dcfs.my.salesforce.com/sfc/p/#410000012srR/a/4N000000AGxx/QPNqI9n15kNbYRhObm7zKcWoPajUElvqWkrdaeSJdHY

[3] Colorado Department of Human Services, Office of Early Childhood. (2022, March). *Early childhood mental health consultation: ECMHC workforce, recipients, and reach.* https://drive.google.com/file/d/1Ok_OehDmX-m70t86hk13CKiYEvPfQmud/view]

[4] See MentalHealthStartsEarly.com. Additional information on the services provided by ECMH consultants can be found in videos describing the family experience and the early childhood director and teacher experience of consultation.

[5] Shonkoff, J.P., Garner, A.S., The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1). https://doi.org/10.1542/peds.2011-2663

[6] Elango, S., Garcia, J.L, Heckman, J.J., & Hojman, A. (December 2015). *Early childhood education* (Working Paper 21766). National Bureau of Economic Research. https://www.nber.org/papers/w21766

[7] National Scientific Council on the Developing Child. (2004). *Young children develop in an environment of relationships* (Working Paper 1). Center on the Developing Child, Harvard University. http://developingchild.harvard.edu/wp-content/uploads/2004/04/Young-Children-Develop-in-an-Environment-of-Relationships.pdf.

[8] In the Theory of Change visual, abbreviations used include:

MH = mental health

SE = social-emotional

ECE = early childhood education

[9] HB20-1053 authorizes the state to serve children through age eight. Because of limited resources and the value of earlier intervention, the program focuses on birth to age 6.

[10] Given data limitations, this potentially overcounts the actual FTE because consultants are included as if they were employed for the full year, whether or not they actually were.

[11] Because many teams did not have the capacity to hire and onboard new consultants, and due to hiring challenges, only 10 of the 15 FTE were filled with CARES.

[12] Read more about Statewide Brief Consultation here: https://drive.google.com/file/d/1q4ShN5zCDgwKUbB42QSkFc8DZy4guvqP/view

[13] See Assumptions for further explanation.

[14] These dosage requirements are detailed in *Early Childhood Mental Health Consultation: Stakeholder-Informed Recommendations for Service Delivery in Early Care and Education Settings*.

[15] See Table 8 for maximum caseload by FTE type.

[16] "Unlicensed care" for the purposes of this report encompasses all forms of care provided to young children in places where they learn and grow, such as elementary schools, home visitation, child welfare, public health, and health care.

[17] See Table 5 for details of current reach by county.

[18] These are a lower bound because estimates assume that FTE is optimally allocated across regions and that consultants are operating at maximum caseload.

[19] By state-funded consultants only.

[20] Read more about Statewide Brief Consultation here: https://drive.google.com/file/d/1q4ShN5zCDgwKUbB42QSkFc8DZy4guvqP/view

[21] "Unlicensed care" for the purposes of this report encompasses all forms of care provided to young children in places where they learn and grow, such as elementary schools, home visitation, child welfare, public health, and health care.

[22] See Table 8 for maximum caseload by FTE type.

[23] Based on data pulled on June 27, 2023. This count does not include the anticipated increase in providers due to UPK.

[24] In addition to current funding in SFY23.

[25] By state-funded consultants only.