AB 2429

Childcare: Mental Health Consultation Services

Frequently Asked Questions

This document addresses common questions regarding AB 2429 (Rubio), which amends previous legislation (AB 2806) to strengthen and improve the Early Childhood Mental Health Consultation (ECMHC) model in California. If you have additional questions or feedback, please contact Maéva Renaud, VP of Advocacy and Policy at Kidango, (mrenaud@kidango.org).

What is the primary purpose of AB 2429?

The primary purpose of AB 2429 is to amend the previous law (AB 2806) to reduce assessment burdens on child care programs and make the requirements for the Early Childhood Mental Health Consultation (ECMHC) model more flexible. This gives programs the ability to tailor their approach based on their individual context, ultimately helping children thrive and reducing exclusionary discipline practices.

What is the background of legislative efforts on this topic?

AB 2698 (Rubio, 2018) created an adjustment factor of 1.05 (increased to 1.1 in 2022) for children in CSPP, CCTR, or FCCHENs that programs can claim when they implement ECMHC according to specific requirements. AB 2806 (Rubio, 2022) expanded and strengthened ECMHC requirements for claiming that adjustment factor so that services would be guided by best practice to produce desired outcomes for children and providers would have a clearer roadmap on ECMHC implementation.

What is ECMHC?

ECMHC is a research-based approach that builds the capacity and problem-solving skills of early educators and child care providers. It aims to optimize the learning and development of all children within early learning settings.

What are the core aspects of the ECMHC model?

The core aspects of ECMHC are:

- The consultant works with the adults (teachers, providers, families) rather than directly with the child to adjust the caregiving approach and environment.
- The goal is to build the capacity of the adults to meet the varied needs of children as they arise.

- It is collaborative and relationship-based, with the quality of the consultant's "consultative stance" (non-hierarchical, empathetic, & reflective) being crucial.
- It is a prevention model at its core, although it is also used to address challenges as they arise.

What are the benefits of high-quality ECMHC?

Research shows that high-quality ECMHC has a range of positive outcomes, including:

- Increased teacher sensitivity and enhanced classroom management skills.
- Improved social-emotional and mental health climates in classrooms.
- Lower levels of stress for teachers and caregivers.
- Fewer teacher-rated problem behaviors among children.
- Reduced child expulsions from early learning and care settings.

What are the two main changes AB 2429 makes to the ECMHC requirements?

AB 2429 proposes two key adjustments to the ECMHC requirements:

1. **ACEs Screener:** Make the Adverse Childhood Experiences (ACEs) Screener optional for classrooms receiving ECMHC rather than required.
2. **Classroom Observation:** Reduce required classroom observations from twice per program year to once per program year. The selection of an observation tool and the cadence should be decided on in consultation with the classroom team.

What feedback and data are these changes based on?

Through feedback from ECMHC consultants, we heard two main concerns::

- **Observations:** Teachers, directors, and consultants felt the approach was not supportive or tailored enough; there was a desire to have more flexibility to choose an observation cadence and approach that would work best for their specific classroom.
- **ACEs Screener:** The ACEs Screener has proven to be very hard to administer for every child due to substantial barriers in consultant time, training, and parent interview time, given that each consultant handles 10+ classrooms.

After hearing these concerns, we conducted a statewide survey to capture perspectives of other providers. We sent this out via several different listservs and had 36 total responses for ECMHC. The data snapshots and quotes below echo the experience of our team regarding changes to the ECMHC requirements that would make the model easier to implement and therefore be more accessible to more programs:

- Almost 60% of respondents don't claim the adjustment factor for ECMHC, citing among the factors: "Don't know how to make it work", and "don't fulfill all the requirements to be able to claim".
- Only a few organizations do data collection related to ECMHC. With many commenting it is difficult to know what to collect and how to collect it and suggesting that more resources would be needed to support the current data collection requirements.
- "We don't fulfill all the requirements to be able to claim"
- "We are also using the PEARLS, which some families are hesitant to complete and probably aren't always honest."
- "We are not doing ACE's since those were designed for medical professionals."
- "Currently, we are not actively collecting data or using specific screeners such as an ACEs screener or CHILD Assessment as part of our ECMHC work."

CDE and CDSS have also heard this feedback echoed from providers trying to implement ECMHC.

Why is AB 2429 proposing to make the ACEs Screener optional?

While the ACEs Screener is an important tool for identifying individuals at risk for toxic stress, Kidango is proposing to make it optional because:

- The capacity, training, and family interview time to administer the screener for every child is substantial, and ECMHC consultants and other staff often lack the bandwidth.
- While important in its own right, the ACEs screener is not a core component of the ECMHC model itself.
- The requirement could become an impediment to programs implementing ECMHC or be viewed as another administrative requirement on providers.
- The ACEs screener is most often completed in a pediatric primary care setting in California, which is often a more conducive setting for this type of clinical screening.

If we remove the ACEs screening requirement, how do we make sure that the kids who need it are properly assessed or treated?

The ACEs Screener is highly incentivized and standardized as part of routine care with pediatricians in California through Medi-Cal. The American Academy of Pediatrics (AAP) guidelines also recommend "psychosocial/behavioral assessment" at every well-child visit. A health care setting is likely the best setting for this screener, where it is paired with specific reimbursement and protocols.

Importantly, the change to making the ACEs Screener optional rather than a mandate would not prevent programs who want to continue or start implementing it from doing so.

Why are we changing the frequency of classroom observations?

In the initial legislation, two classroom observations were required. This change to **at least once per school year** (in consultation with the classroom team) is in response to feedback from consultants and teachers who found that a less flexible, mandatory twice-a-year schedule was not the right fit for all classrooms and did not always foster a successful collaborative relationship.

The change allows consultants to tailor their support for each classroom, which is essential, as the quality of the relationship between consultants and teachers is the most important factor for a positive impact.

How many observations do programs already have to conduct throughout the year?

California child care programs, specifically California State Preschool Programs (CSPP), are required to complete child assessments using the DRDP (Desired Results Developmental Profile) within 60 days of enrollment and every six months thereafter. Additionally, CLASS is currently being phased in and by July 1, 2028, 100% of the classrooms within an agency's CSPP contract must do at least one CLASS observation annually. In California, child care programs typically conduct **Ages & Stages Questionnaires (ASQ) screenings at least once per school year**, though the exact frequency often depends on the child's age and the specific requirements of the program's funding or quality rating system. Programs may also have additional tools they are using in alignment with their curriculum or other models (for example, the observation tools associated with the Pyramid Model).

As you can see, there is a great deal of information programs already collected that consultants can utilize when working with classrooms to understand their needs. We would advocate for streamlining these efforts and information sharing so as not to over-screen/over-assess and to use time and resources effectively.

What are some examples of an observation tool that would fulfill the requirements in this bill?

Observation tools that providers can utilize to fulfill the requirements of this bill include but are not limited to:

- CLASS: The quality of educator-child interactions across domains like Emotional Support, Classroom Organization, and Instructional Support.
- Teaching Pyramid (TPOT/TPITOS): How well a teacher is implementing the "Pyramid Model" for social-emotional competence. The TPOT identifies "Red Flags" (e.g., a teacher shouting across the room). Coaches use this data to model "Positive Descriptive Feedback"—catching a child being good and describing the specific behavior.
- The CHILD: Specifically measures the "mental health climate" of a classroom—looking at things like adult-to-adult cooperation and the subtle emotional cues between children and staff.