

**Promotion of Mental Health and
Prevention of Mental and
Behavioral Disorders**

2005 Series

Volume 1

*Early Childhood Mental Health
Consultation*



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services

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Early Childhood Mental Health Consultation

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Foreword

We envision a future when everyone with a mental illness will recover, a future when mental illness can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully in the community.

“Vision Statement,” President’s New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.*

We are living in exciting times for the promotion of mental health and the prevention of mental disorders. Prevention science has made enormous strides in advancing the health of those at risk for a number of illnesses, such as cancer and heart disease. The research community is beginning to yield promising results for the mental health field.

In 2005, the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Center for Mental Health Services is launching a series on the *Promotion of Mental Health and Prevention of Mental and Behavioral Disorders*. This series will have six monographs, and each topic conveys the work of national experts in the fields of prevention science and child development. The first two monographs are *Early Childhood Mental Health Consultation* (Volume 1) and *A Training Guide for the Early Childhood Services Community* (Volume 2). This set addresses young children’s mental health.

SAMHSA recognizes the critical role of child care providers in facilitating a young child’s social, emotional, and cognitive development in collaboration with the child’s parent and significant caretakers. Increasingly, child care providers report difficulty working with children who are experiencing multiple challenges. Mental health consultants, trained to work with young children and their families, can serve as important resources to help the child care provider find effective ways to work with these children. *Early Childhood Mental Health Consultation* provides a blueprint for child care providers to use when hiring a mental health consultant. The companion piece to this monograph, *A Training Guide for the Early Childhood Services Community*, offers a guide for trainers to use when teaching the early childhood community how to use the blueprint.

We are very grateful to child care providers for their invaluable work in giving our children a solid foundation for future growth. Please help us create a health care system in which all individuals, including our youngest and most vulnerable, can access quality services to promote mental health and can live quality lives in their community.



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Introduction

The vital public health issue of promoting healthy development and the future well-being of infants, toddlers, and preschool children has important implications for families, businesses, private philanthropy, and government. Investment in fostering mental health in the early childhood years presents a special opportunity to open a door to a child's future; to lessen and, when possible, avoid future developmental and emotional problems; and to prepare a child for school and life.

This monograph had its genesis at the May 1998 "Roundtable on Mental Health Consultation Approaches for Programs/Systems Working with Infants, Toddlers, and Preschoolers, and Their Families." Its goal was to exchange information. The then Georgetown University Child Development Center convened this meeting at the request of and with funding by the Substance Abuse and Mental Health Services (SAMHSA), Center for Mental Health Services (CMHS). The center collaborated with the CMHS Prevention Initiatives Priority and Program Development Branch to conduct the meeting.

Since then, the fields of prevention science and child development have made enormous strides, yet child care providers who could benefit from these advances are often unaware of them. Mental health clinicians, trained to work with infants, toddlers, preschool children, and their families, are in a unique position to help their colleagues in the early childhood community use the latest research in their work with children, especially those with challenging behaviors.

Therefore, SAMHSA's CMHS is launching a series on the Promotion of Mental Health and Prevention of Behavioral and Mental Disorders. This series will have six monographs, and each topic conveys the work of national experts in the fields of prevention science and child development. The series comprises the following monographs:

- Volume 1 (published in July 2005): *Early Childhood Mental Health Consultation*
- Volume 2 (published in July 2005): *A Training Guide for the Early Childhood Services Community*
- Volume 3 (to be published in 2006): *The Study of Implementation in School-Based Preventive Interventions: Theory, Research, and Practice*
- Volume 4 (to be published in 2006): *Reducing Risks for Mental Disorders During the First Five Years of Life: A Review of the Literature*
- Volume 5 (to be published in 2006): *The Prevention of Mental Disorders in School-Aged Children: A Review of the Literature*
- Volume 6 (to be published in 2006): *Becoming a Preventionist: Making Prevention Part of Your Mental Health Practice*

This monograph, Volume 1, *Early Childhood Mental Health Consultation*, addresses young children's mental health by providing a blueprint for child care providers to use when hiring a mental health consultant. This first monograph serves the following purposes:

- broadens the discussion on mental health consultation and presents approaches for early childhood programs;
- facilitates the integration of mental health consultation into Early Head Start and Head Start programs; center-based child care and family child care homes; early intervention, child welfare, family support, and other programs; and other systems of care that serve young children and their families; and
- shares current thinking of program administrators and practitioners from both the public and private sectors on promoting healthy development among the youngest members of our society in early childhood settings through mental health consultation.

The target audience includes early childhood program administrators, supervisors, directors of child care programs, foundations, training organizations, educational institutions, parents, families, and mental health professionals and consultants.

The second monograph, Volume 2, *A Training Guide for the Early Childhood Services Community*, is a companion piece to this monograph. It offers a guide for trainers to use when teaching the early childhood community how to use the blueprint.

BACKGROUND

Brain research conducted over the past decade demonstrates that the way individuals function in their preschool years through adolescence hinges—to a significant extent—on their experiences before age 3 (Carnegie Corporation of New York, 1994). These findings are bolstered by evidence of the long-term effects of comprehensive early childhood programs. These effects include improved educational outcomes, reduced levels of criminal activity, and increased economic self-sufficiency—initially for the parent and later for the child—through greater labor force participation, higher income, and lower welfare use (Gomby, Behrman, Lerner, Lewit, & Stevenson, 1995).

Ideally, a child spends the years between birth and age 6 in close relationships with adult caregivers who offer nurturing love, protection, guidance, stimulation, and support. However, patterns of contact between American children and their adult caregivers have changed significantly during the last couple of decades. More and more infants, toddlers, and preschoolers spend 8 to 10 hours each day in some type of early childhood setting. Seventy-five percent of mothers with children under age 6 and 59 percent of mothers with children under age 3 are in the work force. As a result, about 12 million children under age 6 require some type of child care.

Child care, early childhood education, and early intervention programs for children with special needs are provided in a wide variety of settings. These settings include centers operated on both a for-profit and a not-for-profit basis, such as family child care homes, public and private nursery schools, prekindergartens, and home-visiting programs. The quality of these arrangements varies dramatically. Some factors related to quality of care are regulated by government (for example, child and staff ratio, group size, physical facility features, and minimum caregiver training). But other critical components are more subjective, and their quality cannot be easily regulated. Examples of these components include the nature and frequency of caregiver-child interactions, teaching and learning styles, and sensitivity of programs to the cultures, languages, and preferences of the children and families they serve.

Early childhood providers report that they see increasing numbers of children with special needs (who may or may not meet eligibility criteria under the Individuals with Disabilities Education Act [IDEA], Part B or Part C). Violence, abuse, prenatal substance exposure, losses due to incarceration or death, or residing with multiple caregivers or in foster homes often has significantly affected the lives of children who display severe behavioral and emotional problems (Sameroff & Fiese, 2000). The literature suggests that children who struggle with behavioral and emotional problems at this young age have a 50 percent chance of continuing to struggle into adolescence and adulthood.

The range of challenging behaviors that children demonstrate seems to increase with the complexity of the difficulties that families and communities confront (such as crime, substance abuse, depression, and domestic violence). However, the skills and the resources that families and caregivers need to cope with and manage their children's behaviors often have not met that rising challenge. Caregivers often experience stress and burnout as they deal with many of the same issues (such as poverty, crime, and low wages) as the families of the children they serve ((Bowdish, 1998). Salaries for early childhood caregivers are notoriously low, and caregivers typically work under stressful circumstances. These factors often lead to high staff turnover and low morale, conditions that can seriously compromise providing stable, high-quality, and family-centered early childhood services to children and their families.

Most important, the negative developmental paths predicted for these children and their families are not improving. Child care programs are expelling increasing numbers of "problem children" in a cycle of disruptive transitions that interfere with the children's critical need for stability. The State of Michigan Department of Community Health conducted a series of surveys to assess the prevalence of preschool-age children expelled from child care settings and to determine strategies for retaining them. One survey reported that during 1 year, nearly 2 percent of the children in a single Michigan county had been expelled. It is not surprising that parents whose children have been expelled from child care frequently withhold pertinent information from subsequent potential providers. They do so because they fear rejection, given their desperate need for reliable child care arrangements. But withholding information offers little or no chance for staff of these programs to care successfully for the children (Tableman, 1998; for more information, contact Betty Tableman, University Outreach and Engagement, Michigan State University, East Lansing, MI, 48824).

Despite this bleak picture, positive research findings indicate that prevention and intervention efforts to address mental health problems in early childhood may reduce significant personal and social difficulties in later childhood, adolescence, and adulthood. The earlier the intervention begins, the better the prognosis. Early childhood providers have indicated that the most helpful types of assistance to support them in caring for children with challenging behaviors are:

- on-site consultation with a mental health expert,
- workshops on behavior management strategies, and
- written materials on behavior management strategies (Tableman, 1998).

Directors and administrators of early childhood programs are being challenged to consider and offer creative ways to build their staff's capacity to address the mental health concerns of children and families living with many risks and stressors. They understand that there are no "quick fixes" and that their objective requires attention, time, and resources. However, providing staff support and mental health skill development pays off in "better problem solving skills, greater staff confidence in coping with difficult situations, a wider range of concrete strategies to help children and families, and the provision of a safety valve which enables staff to share their frustrations and to celebrate the victories of their work" (Yoshikawa & Knitzer, 1997).

The Head Start program proactively emphasizes the mental health approach to working with staff, children, and families (Green, Simpson, Everhart, Vale, & Gettman, 2004). Head Start's recently published performance standards stress collaborative relationships between programs and parents to share concerns about children's mental health, to identify appropriate responses to children's behavior, and to help parents understand mental health issues and create supportive environments and relationships in their homes. The performance standards also require that local Head Start programs have mental health professionals on staff and that on-site mental health consultation be available to staff at work.

ORGANIZATION OF THIS MONOGRAPH

This monograph is presented in six sections and five appendixes:

- I. Mental Health Perspective.** Describes the early childhood mental health perspective and why it is essential to respond effectively to the social, emotional, cognitive, and behavioral needs of young children and their families
- II. Definition and Types of Mental Health Consultation.** Defines early childhood mental health consultation and contrasts it with other problem-solving, capacity-building techniques and with direct mental health services that enhance the well-being of young children, their families, and other caregivers in child care settings. Using an example, this section describes two major types of mental health consultation: child- and family-centered consultation and programmatic consultation
- III. Essential Features of Early Childhood Mental Health Consultation.** Describes the main features of effective early childhood mental health

consultation, including the following: (1) collaborative relationships, (2) problem-solving and capacity-building goals, (3) issue specificity and time limitation, and (4) skills of consultants

- IV. Challenges and Strategies in the Consulting Process.** Discusses critical challenges facing early childhood mental health consultation, as well as strategies to surmount some barriers
- V. Conclusions and Recommendations for Action.** Presents recommendations to program directors, policy makers, educational institutions, and consultants for integrating mental health consultation into early childhood programs
- VI. Selected Resources.** Presents resources that support programs in implementing early childhood mental health strategies

Appendixes

- A. Selected Programs.** Summarizes several early childhood programs that have incorporated mental health consultation as part of the continuum of support provided to staff and families
- B. Assessment in Child- and Family-Centered Consultation.** Presents lists of questions for consultants and staff to consider for case-based consultation
- C. Assessment in Program Consultation.** Presents lists of questions for consultants and staff to consider for program-based consultation
- D. List of Contributors.** Presents a list of professionals whose support and participation were invaluable and essential to the preparation of this monograph

SECTION I ■

Mental Health Perspective

Recent neurobiological research has produced a solid basis for introducing an early childhood mental health perspective into programs and systems that serve young children and their families. Neurobiologists have dramatically increased our understanding of how the brain develops during the first 3 years of life by describing the impact of environmental and biological factors on a child's cognitive, physical, behavioral, and social development. Concurrently, research on child development and clinical practice has shown that nurturing relationships play a crucial role in facilitating young children's social and emotional development. These bodies of knowledge provide a solid basis for introducing the mental health perspective into early childhood programs and systems.

The ultimate goals of this early childhood mental health perspective are to enhance the well-being of *all* children in child care settings and to minimize or avoid behavioral problems in children with special needs (Donohue, Falk, & Provet, 2000). Designing and implementing child care and other programs that emphasize the mental health of the participating children reflect the essence of the mental health perspective.

The mental health perspective holds that the behavior of young children must be understood within the context of:

- an age-appropriate developmental sequence (is the child meeting expected developmental milestones?),
- relationships between children and caregivers in their immediate environment (within the family or in a child care setting), and
- factors in the broader environment that impact child-family relationships (such as extended family, work, and neighborhood).

The adoption of a mental health perspective offers an opportunity for mental health professionals to play a new role in early childhood and family support settings.

Traditionally, when mental health professionals have been involved in early childhood and family support programs, they have directed their efforts toward children who have exhibited the greatest difficulties—the child who hurts herself or others, or the child with difficult-to-manage behaviors. These professionals have generally referred a “problem child” to psychotherapy and the family to counseling. If mental health consultation has been available, it often has been limited to interventions at the time of a crisis.

By contrast, programs that integrate a mental health perspective have a strong focus on prevention.

These programs:

- try to anticipate and promote the well-being of the child, rather than respond exclusively to identified problems;
- reach out to children at risk of developing social, emotional, and behavioral difficulties;
- acknowledge that some young children have identifiable disturbances and are seriously troubled; and
- view parents and other adult caregivers as an integral part of promoting the mental health of all children, but especially those with identified behavioral problems.

VALUES INHERENT IN THE MENTAL HEALTH PERSPECTIVE

The mental health perspective in early childhood programs is based on a set of values that underpin its models and approaches in policy, practice, and attitude (Feinberg & Fenichel, 1996; Stroul & Friedman, 1986; Zero to Three, 1992). These values include the following:

1. All young children deserve to spend their days in a safe, stable, caring, and nurturing environment. In early child care settings, the caregiving environment plays a crucial role in promoting healthy social and emotional growth and resiliency, in protecting young children from psychological harm, and in creating conditions conducive to appropriate social and emotional well-being.
2. To meet the mental health needs of very young children, it is necessary not only to consider the young child and her parents and caregivers as individuals, but also critical to consider the quality of the child's many relationships. Examples are the relationship between the child and her parents, the relationship between the child and other important people in her life, and the relationships among adults within and beyond the family.
3. Families are considered to be full participants in all aspects of the design, implementation, and evaluation of programs and services for their young children.
4. Early childhood mental health services are responsive to the cultural, racial, and ethnic differences of the populations they serve.
5. Practices build on, promote, and enhance individual, family, and child care staff strengths, rather than focus solely on weaknesses or problems.

SECTION II ■

Definition and Description of Types of Mental Health Consultation

This section defines and describes two different types of mental health consultation for young children in child care settings and their families. The two approaches are child- and family-centered and program-centered consultation. A fictional—but typical—example, presented in boxes throughout this section, illustrates how mental health consultation can work in center-based settings.

Mary, the toddler classroom teacher at the Flower Street Child Care Center, has been increasingly concerned about Robert G, a 2-year-old boy who has been in the agency's early childhood education program since he was 2 months old. Robert has always seemed shy and withdrawn, but during the past 3 months—ever since he moved up from the younger group to a new class—he has been having difficulties during nap time. His crying not only reveals his own distress, but also prevents other children from falling asleep. Robert stops crying when the teacher's aide sits by his side, but he begins to scream again the moment she leaves. Mary also has noticed that he has not been eating very much. Empathizing with Mary's concern and frustration, the center supervisor decided to request a mental health consultation on Robert's behavior.

As Mary made plans to ask Robert's parents to consent to the consultation, she realized that no center staff had ever discussed any concerns about Robert with his parents (although it was apparent now that center staff had had several concerns about his behavior). The parents had completed a social services needs assessment some time ago, but neither had ever attended any parent involvement activities.

Robert's father (and sometimes an aunt) brings him to the center in the mornings on the way to work, and his mother picks him up in the afternoons. Although both parents are courteous, Robert's parents and staff have little interaction.

When Mary approached Mr. G to request a meeting with both parents to discuss her concerns about Robert, Mr. G was taken very much by surprise. He responded that because of work responsibilities, he and his wife could not attend a meeting together. He indicated clearly that although he did not really understand what a "mental health consultation" meant, he saw no need for a consultant to observe his child. He seemed angry at Robert when he left the classroom.

The following morning, he deposited Robert's things in his cubby and hurriedly left the center.

Mary discussed the incident with her supervisor. She expressed her angry feelings toward Mr. G and her anxiety about the next steps to take. Mary and her supervisor decided to ask the mental health consultant for assistance in introducing the need for a consultation to Robert's parents.

DEFINITION AND TYPES OF 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 individuals, primarily child care center staff, with other areas of expertise. 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 6 and their families.

The goal of early childhood mental health consultation is neither to “rescue” child care staff (by shifting their responsibility for dealing with difficult situations to a consultant) nor to transform them into mental health professionals. Rather, the goals are to assist staff in understanding the mental health perspective, and incorporating it into their work, and to use their own roles, skills, and experience to:

- foster positive learning and development of each child through careful observation;
- implement strategies that enhance learning experiences;
- promote social, emotional, and behavioral development of each child;
- build relationships and communicate with parents; and
- seek further consultation, when necessary.

Mental health consultation is one of a number of problem-solving and capacity-building interventions useful in improving adults' effectiveness in their interactions with young children. Other common capacity-building interventions include teaching and training, clinical supervision, and psychotherapy. Although a specific mental health consultation may incorporate one or more of these techniques, the consultative approach is distinctly different from that of its three “cousins.” A summary of relationships between these approaches is as follows:

- **Teaching and training.** A traditional teacher or trainer chooses the content and format of the information to be conveyed. By contrast, a mental health consultant to an early childhood program provides information on topics specifically requested by program staff. Teaching is commonly used as a tool in the consultative process, but much of that teaching is informal and involves various forms of modeling, rather than presentations in a typical classroom format.
- **Clinical supervision.** Both clinical supervisors and mental health consultants help program staff improve their skills to understand

and accomplish their work and to increase their capacity to master future problems. A supervisory relationship implies administrative and legal accountability of staff members for following the supervisor's recommendations, but in a consulting relationship, staff take responsibility for deciding whether or not to implement the consultant's recommendations.

- **Psychotherapy.** In therapy, as in consultation, a client seeks assistance (or treatment) to solve a problem. Both therapeutic and consultative relationships are characterized by genuineness and trust, and the goal of each is to foster the client's understanding. Therapists focus on personal problems, but consultants do not. Consultants may look at the factors in a staff member's experience that contribute to his subjective perception of the situation. Sometimes, consultants may suggest that a staff member seek therapeutic services; at other times, the consultation can have coincidental therapeutic results. But consultation is mainly focused on improving the effectiveness of the individual staff member in her specific work.

The important tools of training, clinical supervision, and therapy span a continuum of overlapping supports and processes. Mental health consultants use these strategies often. However, it is important to differentiate between the goals and features of the various strategies to avoid confusing the role of the consultant with the role of other professionals, such as counselors or therapists. The underlying principle is that mental health consultants work directly with staff members, not with children.

A variety of factors enter into choosing the best intervention to address a particular issue. They include the following:

- specific goals of the mental health consultation,
- nature of the issues or concerns,
- setting,
- availability of mental health practitioners and other experts in the field,
- time frame, and
- cost.

The Flower Street Child Care Center decided to enlist a mental health consultant to help Mary develop a strategy regarding Robert for the following reasons:

- The situation required problem solving. The goal of the intervention was to work with Mary to develop a plan to help center staff address more effectively their concerns about Robert's behavior.
- Mary wanted to build her capacity not only to respond more effectively to Robert and his family, but also to master similar problems in the future.
- The goal of this consultation was only indirectly related to the child. The overarching objective was to enhance the staff's and the family's capacity to work together toward the mutual goal of enhancing Robert's emotional development.

TYPES OF EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

Early childhood mental health consultation generally advises programs in one of two approaches. One approach focuses on a particularly challenging child or the family of that child; the other addresses a general program issue that impacts the mental health of staff, children, or families.

Child- and Family-Centered Consultation

Child- and family-centered consultation is the most traditional form of mental health consultation. Staff initially seek the assistance of a mental health consultant because they are worried, alarmed, or frustrated by a particular child's behavior. The primary goal of this type of consultation is to develop a plan to address both the factors that contribute to a child's difficulties in functioning well in the early childhood setting and the family's role.

Like Robert, children who experience difficulties may generate feelings of anxiety, anger, or even guilt in child care staff and families. Moreover, parents and parent-child interactions evoke complex emotions in staff that may make it difficult for them to respond in ways that support the parents and the child, and the relationships between them (Johnston, 1998).

Because they were concerned about Robert's behavior, Mary and other staff became resentful when they felt Mr. G had not "heard" their concerns: They blamed the father for Robert's behavior.

The initial step in the consultation process was for the consultant to understand the staff's feelings toward Robert and his father and to respond to the staff's immediate need to obtain parental consent for the consultation. After listening to and empathizing with staff, the consultant elicited strategies that staff had used successfully in the past to involve parents. As staff and the consultant developed trust and mutual respect, they began to plan nonthreatening strategies to introduce the consultation service to both parents.

In contrast to the approach she had taken with Mr. G, this time Mary asked Mrs. G whether she could remain at the center the following day for several minutes to talk about Robert. Mary also arranged for the teacher's aide to take over her class at the end of the day. In the privacy of the teacher's lounge, Mary initiated the conversation by describing some of Robert's favorite activities, described the friends with whom he played, and talked about his love for finger painting. Mary asked Mrs. G about Robert's favorite activities at home, and she shared with Mrs. G her observations of Robert's strengths and talents at child care. When Mrs. G seemed at ease, Mary asked her about Robert's sleeping and eating habits and learned that he was having many of the same difficulties at home that he was having at the center.

Mary explained to Mrs. G how the mental health consultant could assist both center staff and her family in responding better to Robert's needs. Only then did Mary request and obtain consent for the consultation. Mary told Mrs. G that her husband had said he opposed the consultation, so the mother and teacher discussed ways in which Mr. G could be approached with more success.

Several days later, the mental health consultant helped Mary plan ways to bring Robert's father back into the discussions about Robert, to avoid generating conflict between the two parents.

To assess Robert's abilities, limitations, vulnerabilities, and strengths, the consultant visited the center and observed him at various times during the course of a day. The consultant assessed the quality of the interactions in the room—both those involving Robert and those involving the other children. Child care staff worked attentively at feeding the children, setting up and cleaning up materials, and conducting small-group activities, such as reading books. Staff members responded warmly to the children with verbal expressions that reflected many of the children's activities and behaviors. In the classroom, Robert was observed to be a loner, preferring to play by himself rather than with other children.

After lunch, staff helped all the children go to their cots for nap time and dimmed the lights in the room. All the children, except Robert, fell asleep almost immediately. Robert had started protesting "no sleep" as soon as he realized it was nap time. He cried loudly each time the aide would try to leave his side. During this time, both Mary and her aide shuttled back and forth trying to respond to his requests (water and a book), threatening a "time-out" when nap time was over and, finally, holding his hand until he went to sleep. He did not fall asleep until about 15 minutes before the other children began to awaken.

In a subsequent conversation, Mrs. G told the consultant that after a fight some months ago, during which her husband had physically hurt her, Mrs. G awakened Robert and his 4-year-old brother and took them to her sister's home. They stayed there for about 3 weeks. Mrs. G managed to transport both boys to and from the center every day so that she could work her day job. She also left them at her sister's house during the night and on weekends when she went to her second job.

Although the boys were familiar with their aunt, they both cried every time their mother would leave. During these 3 weeks, the boys had no contact with their father, about whom Robert asked constantly. About 3 weeks later, Mrs. G and the children returned to their home. She stated that there had not been a violent incident since her return.

Then the consultant and Mrs. G discussed possible ways to work with staff, with Robert, and with Mr. G, taking into consideration the new information that Mrs. G had provided.

Mr. G never consented to meet the consultant at the center, but he agreed, warily, to meet her at home. During the home visit, Mr. G spoke in a soft voice and responded to the consultant's questions monosyllabically. He did not discuss the time when his wife and children moved out of the house. Observing the interactions between Mr. G and Robert, the consultant noted that Mr. G understood and responded warmly (and sometimes playfully) to Robert's expressed needs and desires. Mr. G was far more affectionate with Robert than with his elder brother. The consultant later learned that the elder boy was not Mr. G's own son.

Observation of Robert at home and at the center helped expand the consultant's understanding of Robert and his family. In subsequent meetings with center staff (one of which Mrs. G attended), the participants considered the mental health ramifications of Robert's experience. The mental health consultant, with both parents' permission, explained her observations to help staff understand and interact better with Robert.

Initial discussions focused on how Robert might have felt when he abruptly left home in the middle of the night and no longer saw his father—to whom he was very attached—without explanation. Also, despite Mrs. G's efforts to protect her elder son, Mr. G constantly reprimanded or punished him, clearly favoring Robert. Witnessing his father's disparate behavior was very confusing for Robert, who could not account for the difference in treatment, and Robert frequently perceived his mother as taking his elder brother's side.

Mr. and Mrs. G and center staff were better able to understand Robert's reactions to the unpredictability of his abrupt separation from his father and to the confusing behavior of his mother. The consultation increased the staff's understanding of Robert's needs and helped them consider how they might respond to these needs.

With the consultant's assistance, staff developed new strategies to help Robert develop a sense of predictability. For example, the same staff member greeted Robert each morning when he arrived at the center. Staff anticipated the transition to and from nap time, establishing a routine and "rules" under which Robert would always be given the same toy and a book that the teacher's aide would read before he went to sleep. Periodically, Mary asked each parent about Robert's behavior at home.

The mental health consultant met with both Mr. and Mrs. G in their home one additional time and discussed ways to enhance Robert's sense of predictability and stability. The family made the important step of acknowledging the feelings and needs underlying Robert's behavior. However, the family only partially used the mental health consultation, because they did not follow up on the recommendation to obtain family counseling for issues related to domestic violence and the relationship between Mr. G and Robert's elder brother.

Mental health consultation in this case also helped staff consider the need to establish stronger relationships with the children's parents, to be able to share with parents their own observations and understandings of children's experiences at the center. Rather than comply with the agency's requirement of conducting only initial needs assessments, staff decided to communicate informally and regularly with parents, sharing anecdotes that provided parents with opportunities to participate in their children's experiences at the center. As a result, the parents' participation increased, and staff gained a better understanding of the children in their care.

Case consultation around individual children who exhibit difficult behaviors is not always sufficient to solve behavioral or emotional problems. To help those children, some early childhood programs have developed therapeutic groups, such

as the Early Childhood Group Therapy Program (Shahmoon-Shanok, 1998). By their nature, these therapeutic groups involve a disproportionately high percentage of children who exhibit significant behavioral difficulties. Early childhood mental health consultation in such groups is directed toward addressing the needs of staff working with these children. The Day Care Consultants Program of San Francisco, for example, meets with staff regularly to enhance their understanding of children’s individual needs and the skills used to address them (see Appendix A). The consultants sometimes meet with the parents of these children to offer immediate assistance and, when necessary and mutually agreed upon, to provide referrals for mental health treatment and other community-based support services to the families (Johnston, 1998).

Programmatic Mental Health Consultation

Mental health consultation to programs focuses on (1) improving the overall quality of the program or agency and (2) assisting the program in solving a specific issue that affects more than one child, staff member, and family.

Consultation to programs usually takes a preventive perspective. By identifying strategies to improve the overall quality of care, the consultation empowers staff to enhance the healthy social and emotional development of children and the functioning of families—and of staff members, too.

Typically, the mental health consultant in early childhood settings is called on to engage staff and families in assessing a problem and designing a plan to deal with specific issues within the overall program. In programmatic mental health consultation, the consultants usually do not focus on individual children; rather, they facilitate the program’s success in reaching such objectives as:

- developing a mental health approach to strengthen the quality of the program, including a staff development plan;
- developing opportunities for staff to discuss their concerns and to examine how stress affects their work;
- providing a forum to explore cultural differences and workplace conflicts; and
- providing a “safe space” in which staff members can identify, examine, and discuss their feelings about their relationships with children and families.

Initial mental health consultation with Mary regarding Robert expanded to a more programmatic concern: devising better channels of communication between staff and parents. Also, the issues of instability and unpredictability in Robert’s life were seen as relevant to all the children in a number of ways and became an important theme for staff discussion.

Many features of a family- or center-based child care program or a home-visiting program resulting in a request for consultation on particular children can help promote the healthy emotional development of all children or identify early signs of emotional and behavioral difficulties (Johnston, 1998). For example, the specific recommendations and interventions designed to help Robert are generalizable to other aspects of the classroom setting.

Consultation with the goal of improving the overall quality of the program need not always be an expansion of child- or family-centered consultation. Programs also can make specific requests for early childhood mental health consultation to improve their ability to respond to the needs of all young children in their care.

The program consultation in Robert's case ultimately aimed to assist all staff in moving beyond the usual parent involvement activities and their practice of involving families only at times of crisis. The focus of the consultation shifted purposefully to developing collaborative relationships between staff and families to actively promote the emotional well-being of the children.

At the request of staff in this classroom, the mental health consultant and staff of the entire center—having developed a mutually respectful and trusting relationship—held a series of weekly meetings. Through these weekly consultations, staff began to realize their importance to parents, and they discussed ways that they could be supportive to families. For example, staff could help families acknowledge and understand both their child's strengths and the child's areas of difficulty. Also, staff could explain to parents the role of the mental health consultant in helping staff and parents better understand a child's behavior. As staff—and parents—begin to understand a child's behavior more comprehensively, they are better able to respond empathetically and appropriately. Another recommendation that may stem from these discussions is for staff to assist parents in understanding how consultation can help them with child rearing, as well as to ensure that parents are linked with other appropriate supports.

Other related issues that had an impact on the mental health aspects of the program became apparent to the consultant as she worked with Mary and other staff members. In reviewing the way information was shared with Mr. and Mrs. G, the consultant observed the staff's lack of knowledge regarding the cultural background of Robert and his family. Knowing how culture influences communication, behavior, and interactions between staff and families and among staff, she suggested that the program director focus on the staff's cultural competence. She also recommended further consultation with an expert in the field.

In Robert's case, the consultant helped a child care provider develop a specific strategy to engage Robert's parents so that staff and parents together could plan effective ways to help Robert. Child care staff were then able to generalize this strategy and apply it in a programmatic way to all parents. With the consultant's guidance, staff began to examine which interactions between staff and families promoted or inhibited the goal of engaging the parents in working with them to enhance the child's development.

SECTION III ■

Essential Features of Early Childhood Mental Health Consultation

Although great diversity characterizes the disciplines, services, and systems involved in early childhood mental health consultation, its essential features include:

- a collaborative relationship,
- problem-solving and capacity-building goals,
- issue specificity and time limitation, and
- consultants with a set of specific skills.

This section discusses each of these features.

COLLABORATIVE RELATIONSHIPS

In the consultation process, two (or more) professionals with different areas of expertise usually can solve problems more effectively than if just one works alone to tackle the problem. The mental health consultant and early childhood staff are viewed as experts in their own fields. The consultant has no authority over the early childhood staff, who are free to accept or reject any of the consultant's suggestions. Although the consultant may recommend certain interventions, staff maintain sole responsibility for carrying them out.

In consultation, a productive working relationship is not taken for granted; rather, it develops over time. Strong personal relationships enable a consultant and staff to establish the trust and mutual respect essential to “hearing” each other and being able to discuss issues despite differences of opinion. As the consultant becomes more familiar with the program, she is better able to offer useful ideas. The most effective consultant is on site every week (or day) at an expected time.

The following five principles (Bertacchi, 1996) provide the context for relationship-based work between the consultant and staff members:

1. **Respect for the person.** This principle implies an attitude of positive regard toward individuals, including a recognition of both strengths and vulnerabilities. Respect involves an awareness of differences of opinion and an appreciation for different cultures, perspectives, and areas of expertise. Developing respect makes getting to know the consultant and the staff member a priority in establishing a relationship.
2. **Sensitivity to context.** The staff member and the consultant must understand each other as influencing and being influenced by their

environment. For example, working in a high-risk neighborhood impacts the relationship between consultant and staff, staff and children, and staff and families.

3. **Commitment to evolving growth and change.** Consultants dedicated to promoting the mental health development of young children must be equally committed to acknowledging and promoting development and growth of caregivers (families and staff).
4. **Mutuality of shared goals.** Consultant and staff member relationships are rooted in shared goals for families, children, and the program. Sharing and communicating goals, an ongoing process, occurs throughout the consultation.
5. **Open communication.** At the beginning of a consultation, the consultant clarifies the channels and forums for discussion with staff members and other organization members or the family. They all must communicate regularly, frequently, and consistently.

To initiate a productive working relationship, the consultant and staff members discuss the roles that they both will take in the consultation. This step ensures that both the consultant and early childhood staff have an opportunity to express their preferences and that they both understand and agree on the basic parameters of consultation. In this initial discussion, it is critical for both parties to recognize the importance of a coordinated, nonhierarchical relationship in achieving the mutually agreed-upon goals. When staff members believe they have something important to contribute, they are more likely to avoid the following potential pitfalls:

- taking a less active role in developing a solution to the issue of concern,
- feeling threatened or defensive, and
- feeling reluctant to express disagreement or reservation when problem solving begins.

PROBLEM-SOLVING AND CAPACITY-BUILDING GOALS

The primary role of early childhood mental health consultants is to assist staff working in early childhood programs in addressing concerns and solving problems regarding either specific children and families or certain elements of their program. The underlying—and explicit—goal of the consultation is to help staff members develop attitudes and skills that enable them to function more effectively with specific children, as well as to respond adeptly to similar issues in the future (Parlakian, 2001).

Effective problem solving and capacity building involve three steps: assessment of the problem or issue, selection of the best intervention strategies, and implementation of a jointly developed plan. Each step is described below.

1. **Assessment.** In the assessment stage, the consultant and staff together examine the issues. A wide range of factors may be relevant to a problem and the possible strategies to solve it, including characteristics of the child, the family, and staff, as well as those of the immediate and larger environment. The consultant and staff usually begin their assessment by identifying and considering these factors. (**Appendixes B and C** list questions to consider in child- and family-centered consultations and program-centered consultations, respectively.)

A broad initial assessment is critical, because variables that are ignored during assessment are rarely considered in defining the problem and developing a solution. For example, the consultant and staff members may not be aware of system-level factors (such as lack of a certain type of resources or a culturally specific way to view the problem) that are critical to resolving the issue.

As the consultant and staff examine the issues presented, they better understand the complexities. In many cases, more skilled consultants differ from their less skilled counterparts in the amount of time they spend clarifying and defining the situation. Skilled consultants are less likely to start planning a strategy to cope with an ill-defined problem; they know it is critical to spend sufficient time both to assess the relevant factors and to clarify the goals of the interventions.

During the assessment stage, issues related to the evaluation of the consultation should be considered (see below).

2. **Selection of interventions.** The ultimate decision on which intervention strategy to select must rest with staff. Skilled consultants work with staff members to select interventions that are both effective and doable. In the early stages of strategy selection, the consultant can discuss with early childhood staff the types of interventions that they have found to be successful in the past that would be appropriate to implement in the current situation.

Effective consultation requires the intervention selected to fit within the staff's workload capability. In determining the amount of work involved, consultants and staff must consider the following:

- time needed to design, implement, and monitor the intervention;
- time needed to learn the intervention;
- appropriateness of the intervention to the program philosophy;
- impact on the family and the immediate and larger environment;

- length of time that the intervention is expected to be in place before the natural environment or the staff member assumes maintenance of the change; and
- expected results of the intervention.

Another important consideration in selecting an intervention is cultural competence. Consultants' expertise must include sensitivity to the staff's and families' beliefs about the causes of a problem, and the consultant must try to match treatment rationales to these beliefs. For example, one aspect of the Navajo culture is a holistic approach to mental health wellness. Families may view developmental problems as a result of disharmony within that natural system. Within the Navajo belief system, interventions must be geared to regaining harmony through traditional means rather than through mainstream interventions. Mental health consultants to early childhood programs that serve special populations are more likely to guide the program to success if they acknowledge and respect these beliefs when they design interventions.

3. **Implementation of the plan.** To facilitate the successful implementation of the plan in the early childhood environment, it is important that the consultant consider the staff's level of understanding and skills.

Other factors to be taken into account during the implementation of the plan include:

- arranging opportunities for frequent contact between staff and the consultant,
- providing support to build the staff's capacity to confront similar problems in the future,
- considering cultural issues as the plan is implemented, and
- noting any observations that will be helpful later in evaluating the consultation.

ISSUE SPECIFICITY AND TIME LIMITATION

Mental health consultation usually is requested when in-house expertise is insufficient or unavailable to deal with a specific issue. Usually, mental health consultation supplements other problem-solving strategies within a large agency, but the consultation process unfolds somewhat differently in each service setting. Because the consultant often is constrained by time limitations when assisting program staff in dealing with a specific issue, it is essential that the consultation involve effective entry, contracting, termination, and evaluation processes. Each process is described below.

1. **Entry.** Entry refers to the consultant's introduction into an early childhood program (for example, Head Start, early intervention, or family support). The process, which usually begins with a preliminary exploration of the match between program needs and the consultant's skills, takes various

forms, depending on whether the consultant has been engaged by invitation or secured for the program by an administrator or a monitoring or accrediting agency. During one or more early meetings, the consultant and staff members exchange information. Topics may include basic descriptive information about the program, perceived staff needs, specific precipitating issues (if any), desired outcomes, information on the consultant's skills and working style, and a description of how the consultation might proceed. Fees and time frames also may be discussed.

The entry process involves the formal introduction of the consultant and staff to each other. It often is a good strategy to introduce the consultant during a staff meeting, when he can describe his role and the services to be provided and can answer staff members' questions. This introduction is particularly important for external consultants.

Some agencies use internal consultants who are members of the organization to which they consult; typically, these internal consultants enjoy established relationships of trust with their service-provider colleagues. Internal consultants must take care to avoid ignoring entry issues, because moving immediately into problem-solving aspects of the consultation can lead to later misunderstandings. It is important for an internal consultant to delineate her role and relationship to the administration (for example, the information that will be shared and the confidentiality of her evaluation of staff performance) at the start of each new consultation.

2. **Contracting.** When the consultant and official representatives of the organization reach consensus about the consultant's usefulness to the organization, they move into contracting. Contracting in this context refers to negotiation and agreement between the consultant and the organization regarding the nature of the consultation and the financial arrangements. Although contracting may not involve a formal written contract, particularly when internal consultants are involved, the outcome of the activity is the same as that of negotiating a written contract—clear understanding and agreement by both parties of the responsibilities of each.

Many potential problems about role, termination, method of intervention, and focus of the consultation can be prevented by creating a clearly written letter of agreement between the contracting parties. In addition, documenting understandings is critically important later in assessing the success of the consulting process.

The consultant's and staff's expectations must be aired, agreed on, and documented during the early stages of consultation. These initial agreements often are renegotiated and updated as the consultation progresses, but the expectations developed in the initial stages usually

provide a strong framework for the process. Examples of topics to explore during the contracting stage (in no particular order) follow. (The consultant and staff may discuss some of these topics during the entry stage.)

- goals or intended outcomes of consultation,
- possibility of change in goals and outcomes as consultation proceeds,
- confidentiality of service and the limits of this confidentiality,
- time frames,
- expectations of staff members,
- times when the consultant will be available,
- possibility of contract renegotiation if change is needed,
- consultation fee and duration of consultation,
- consultant's access to sources and types of information within the organization,
- person to whom the consultant is responsible,
- role of families,
- steps to take if the consultant is concerned about the teacher or another staff member, and
- steps to take if staff have concerns about the consultant.

3. Evaluation. The evaluation stage of consultation consists of a series of ongoing consultant-staff interviews to address key issues. The consultant and the staff member meet to determine the following:

- degree of goal attainment,
- nature of consultant-staff relationship,
- effectiveness of implementation of the plan, and
- next steps for the consultation process (continuation, renegotiation, or termination).

Data for making these determinations include primarily observations that begin during the assessment stage and continue throughout the consultation process. During the assessment stage, it is critical to determine who will do the evaluation, who will receive the evaluation, and how to measure the changes.

Two types of evaluation are important in consultation: formative and summative. Formative evaluation occurs during implementation of the plan; summative evaluation occurs after completion of the consultation.

- **Formative evaluation** constitutes a continuous feedback loop that includes all key players, such as families, staff, the consultant, and administrators. They determine how well an intervention strategy is working and whether or not adjustments must be made. One possible outcome of formative evaluation is that the family, the consultant, and the staff member decide that the interventions developed must be reworked, and they return to the strategy-selection stage. Or, a staff member might decide that the original conceptualization of the problem was incorrect, so the consultant and staff might return to the problem-definition stage.
- **Summative evaluation** is generally a more formal process. Although summative evaluation can provide corrective feedback, most frequently it is used to assess overall effectiveness. Summative evaluation often is undertaken to communicate results to funders, policy makers, and other decision makers. But staff also are interested in the effectiveness of consultation relative to the skills and attitudes of individual staff members and the operation of the overall organization, the cost benefits of consultation, and the satisfaction of staff members and families.

Programs may resist evaluating the consultant-recommended interventions because of the added cost or the difficulty of the evaluation, or both. All parties will gain valuable information, however, by planning for evaluation early in the consultation process; by addressing issues of interest to the consultant, the staff member, and program management; and by defining the goals of consultation in a precise manner to allow measurement (Alkon, Ramler, & MacLennan, 2003).

An example of a summative evaluation is provided by the Miriam and Peter Haas Fund Early Childhood Mental Health Initiative. This initiative assessed the effect of mental health consultation and services on 25 early childhood classrooms in San Francisco serving low-income children ages 2 to 5. The goal of the evaluation was to determine whether and how mental health consultation and services impact child care quality and teachers' self-efficacy and sense of confidence in their ability to manage children with behavioral and emotional difficulties. Selected findings of this evaluation include the following:

- Teacher self-efficacy showed a significant improvement. After a minimum of 1 year of intervention, teachers were far more hopeful about the future of the children in their care and more confident about their ability to make a positive difference.
- Both teachers and directors saw improvement in teachers' understanding of child development and teachers' ability to manage difficult behavior.
- Child care staff felt that the consultation resulted in a center environment that can better include parents as partners.
- Mental health consultation did not have a significant impact on the global quality of centers, as measured by the Early Childhood Environment Rating Scale.

- Mental health consultation did not have an impact on teacher-child interactions in the domains of sensitivity, harshness, or detachment, as measured by the Arnett Caregiver Interaction Scale.
 - Teachers interviewed in focus groups after working with the mental health consultant for a year felt they had a greater capacity for empathy with children, were more curious about the meaning of difficult behavior, and took on more responsibility for changes in the classroom. These teachers also thought they had gained skills in observation and assessment (James Bowman Associates, 1992).
4. **Termination.** Termination of the consultation generally occurs when staff and the consultant agree that the problem that prompted consultation has been resolved, but earlier termination is also an option. The issue of when to terminate the consultation should be addressed early in the consultation.

An important step in the termination process occurs when the consultant gradually begins to withdraw his active support from staff members, who begin autonomously to implement the processes they have learned from the consultant. Consultants should discuss their impending departure openly, validate the staff's success, and encourage staff to continue their efforts on their own.

SKILLS OF CONSULTANTS

Although states license diverse types of professionals as mental health providers, the most commonly licensed specialties are child psychiatry, clinical psychology, clinical social work, marriage and family therapy, counseling, and psychiatric nursing. Roundtable participants recommended that mental health consultants who interact with staff, families, and young children be state-licensed mental health professionals with the following skills and areas of expertise (Hansen & Martner, 1992):

- knowledge of child developmental milestones (the expected characteristics and course of normal growth and development of young children and a basis for identifying atypical behavior in infants, toddlers, and preschoolers);
- understanding of the concepts underlying young children's socio-emotional development, such as attachment, separation, and the ways in which relationships shape development;
- ability to integrate mental health activities and philosophies into group settings;
- observation, listening, interviewing, and assessment skills;
- understanding of cultural differences (cultural competence);
- ability to work with adults and knowledge of adult learning principles;
- sensitivity to the community's attitudes and strengths (including community resistance to mental health services);

- knowledge of alternatives in treatment, including behavioral interventions;
- skills to discern the difference between resistance and culturally appropriate behavior;
- knowledge of family systems;
- ability to recognize the staff's diverse perspectives and to help communicate these perspectives; and
- knowledge of early childhood, child care, family support, and early intervention systems, both public and private.

The consultant must also have specialized knowledge of, and experience related to, the topics of concern to the staff member and issues of relevance to the communities and families that the consultant serves. Examples of such specialized content include, but are not limited to:

- separation and loss;
- substance abuse;
- maternal depression;
- adolescent mothers;
- abuse and neglect issues;
- childhood mental health disorders;
- failure-to-thrive infants;
- children with aggressive behavior;
- low birth-weight infants;
- infants, toddlers, and preschoolers with developmental disabilities; and
- working with fathers.

The consultation process will be effective in bringing about change only when staff believe that the consultant understands the problem, perceives the need for action, and provides support to staff in carrying out the desired change. Therefore, the effective consultant not only has expertise in the particular content area in which she offers assistance, but also has the interpersonal skills to motivate staff to take action. The following interpersonal skills are critically important for entry and building of alliances with families and staff members:

- **Warmth** is the skill of listening to the staff member and the family and of communicating care and commitment.
- **Empathy** is the ability to convey the consultant's understanding of the staff member's subjective experience.
- **Respect** is the ability to suspend judgment and to communicate that the staff member is valued.

SECTION IV ■

Challenges and Strategies in the Consulting Process

Early childhood mental health consultants may encounter critical challenges in their work. This section presents a discussion of the challenges and suggestions for ways to address them. The challenges include:

- difficulty in implementing the intervention plan;
- organizational setting;
- value conflicts;
- racial, ethnic, and socio-economic issues;
- lack of mental health professionals with early childhood consultation experience; and
- funding.

DIFFICULTIES IN IMPLEMENTING THE INTERVENTION PLAN

Staff members may find it difficult to follow through on the plan developed in the consultation process for these reasons:

- **Ambiguity.** The consultant's expectations may not match those of staff. This situation can arise when insufficient structure has been introduced early in the consultation and when staff members do not fully understand the consultation process. The consultant and staff can avoid ambiguity by carefully discussing the consultation process at the outset, by writing a plan with concrete behavioral objectives and outcomes, and by occasionally revisiting the plan as the process continues.
- **Overwork.** Consultants sometimes fail to remember that staff members are involved in a variety of activities. Consultants may take too much of their staff members' time in meetings (especially internal consultants), or they may design interventions that require just too much extra work. Awareness, careful scheduling, and choice of interventions that require less time can reduce the risk of encountering this barrier to effective consultation.
- **Complexity of the intervention.** The design of the intervention is a major determinant of the outcome of the consultant's efforts. Interventions aimed at change must be tailored to the setting, to the provider, and to the power structure. In addition, the consultant should suggest interventions that increase some aspect of the staff member's comfort, require little change in the agency, do not threaten the worker's approach, and can be

communicated easily. Depending on the complexity of the intervention, it may be more difficult for staff members to implement the plan.

For example, consultants sometimes suggest that family child care providers use behavior modification charts to help change the behaviors of young children. This strategy has been found to be successful in some settings, but it is particularly difficult to implement when only one person cares for several children. In addition, the time required to learn and implement this intervention is significant, which may temporarily reduce the child care provider's effectiveness.

- **Entrenched habits.** Individuals, families, groups, and organizations develop traditions in how they function and relate. A tradition, or habit, develops mainly because the practice is both comfortable and successful. The habit also may be continued, even when it is no longer successful, because of concern that new practices may make matters worse. New approaches threaten tradition—the “way we’ve always done it”—and may create ambiguity and even fear related to the staff member's competence in doing his job.

Changing entrenched habits requires first an acknowledgment that fear of the unknown and concern about the consequences of change are normal coping behaviors. Consultants should communicate thoroughly the need for the change, the design of the change strategies, and the implications of the change for the people involved. As noted above, a relationship of mutual trust between those initiating the change and those who will be affected most by it is essential to break through these barriers.

ORGANIZATIONAL SETTING

The setting in which consultation takes place also affects follow-through in the consultation process. Unfortunately, programs sometimes hire mental health consultants who are unfamiliar with the organizational complexities of early childhood and child care centers for young children, or with issues related to quality of care and outcome, or with the challenges of involving parents. Even experienced consultants may find their work complicated by such organizational issues as shoestring budgets, overworked staff, high staff turnover, and low morale. Other barriers may include staff burnout, autocratic decision-making processes, and inadequate community resources.

To deal effectively with organizational variables, consultants must begin the process by defining the organizational structure, by establishing the consultant and staff roles and the boundaries of those roles within the organization, by setting achievable goals, and by establishing accountability. Many other circumstances can facilitate or impede the consultant's work, such as the level of administrative support for consultation and agency change, the level of trust afforded consultants, the agency's process of implementing change, the relationship between staff and administration, the agency consensus about approaches to children with challenging behaviors and their families, and overt and covert agency attitudes toward the families, children, and other agencies.

The consultation process may provide a forum, when appropriate, for developing and implementing such interventions as systems-oriented staffing, staff educational programs, or skill development seminars, which may help address an agency's organizational issues.

VALUE CONFLICTS

The traditional approach to mental health focuses mainly on an individual's problems. The strengths-based approach to mental health (which is increasingly gaining favor in the field) assumes that an individual's strengths and capacities can play an important role in assessing a problem and designing and implementing a treatment plan.

Acknowledging that families and children struggle with mental health issues may seem inconsistent with the strengths-based approach. Rather than focus only on a child's specific emotional, social, or behavioral problems, mental health consultants and child care staff can approach the identified problems within the context of the individual or family strengths and the family's ability to use support services effectively.

Taking the traditional approach may not adequately capitalize on the strengths that families show when they acknowledge the problems they face and seek the support and treatment they need. It is essential to be aware of strengths as mental health consultants address problem areas.

RACIAL, ETHNIC, CULTURAL, AND SOCIO-ECONOMIC ISSUES

Successful consultation requires the consultant to be both culturally empathic and culturally knowledgeable. Cultural empathy requires a rational understanding of cultural differences. It also requires that the consultant understand and appreciate the staff member's culture (and the child and family's culture, if appropriate), view the problem through the staff member's eyes (and the family's eyes), and adapt both style and technique to the cultural perspective of the staff member (and the family). Intolerance in any form from the consultant can give rise to resistance, not only from culturally different families and staff, but also from anyone who is sensitive to and supportive of the special needs of these and other groups.

In addition, consultants working in cross-cultural situations should be aware that cultural differences between the consultant and the staff member may present challenges to the success of the consultation. Addressing these differences openly and nonjudgmentally is essential.

Effective cross-cultural consultants have an awareness of their own personal values, a well-developed awareness of their personal consultation styles, cultural empathy, and the ability to adapt interventions appropriately to meet staff members' needs.

LACK OF MENTAL HEALTH PROFESSIONALS WITH EARLY CHILDHOOD CONSULTATION EXPERIENCE

Agencies, staff, and families who interact with young children may find it difficult to identify local mental health consultants who are trained in both child development and family systems, who understand the complexities of the child care and early childhood education systems, and who have training or experience in working with families and staff facing multiple challenges. In addition, few higher education programs provide mental health training courses that teach students how to be consultants.

On the positive side, Daycare Consultants of San Francisco (see **Appendix A**) and the Institute for Clinical Studies of Infants, Toddlers, and Parents in New York City offer specialized training to mental health professionals in early childhood mental health consultation. For information on this institute, contact Rebecca Shahmoon-Shanok, Child Development Center, Jewish Board of Family and Children's Services, 120 W. 57th Street., New York, NY 10019.

FUNDING

One of the most frequently cited barriers to mental health consultation is lack of funding. Some programs cited in **Appendix A** are funded through grants from private foundations, universities, model demonstration programs, and other time-limited funding sources that may be difficult to sustain.

A number of publicly funded programs address the mental health needs of young children, including:

- Head Start and Early Head Start;
- Individuals with Disabilities Education Act (IDEA; both Part B, Section 619, and Part C);
- Mental Health and Substance Abuse Block Grants;
- Child Care and Development Fund;
- Child welfare funds, such as Title IVE of the Social Security Act;
- Maternal and Child Health Block Grant under Title V of the Social Security Act;
- Temporary Assistance for Needy Families (TANF) program, which has replaced Aid to Families with Dependent Children, used in states to support the inclusion of children with special needs (including mental health needs) in community child care settings; and
- Medicaid.

Federal legislation requires several of these programs to collaborate with other publicly funded programs at the national, state, and local levels. The 1997 reauthorization of IDEA adds stronger requirements for this kind of collaboration to Special Education programs under Part B to match the responsibility for interagency cooperation under the Part C Program for Infants and Toddlers.

A significant source of revenue for many programs receiving mental health consultation services is Medicaid. Medicaid eligibility is highest for young children under age 6, and through its Early and Periodic Screening, Diagnosis, and Treatment program, it must provide or pay for the full range of health and mental health services needed by each Medicaid-enrolled child. This support can include mental health consultation with an enrolled child's teacher or program. This requirement remains in force when a state Medicaid program contracts with managed care programs to deliver Medicaid services to eligible children and their families. In fact, under managed care systems, considerable flexibility and significant incentives have emerged to promote consultative services. In some instances, mental health providers may be able to demonstrate both lower cost of consultation services and potential for improved outcomes.

Obtaining funds for program consultation is much more challenging than paying for child-focused consultation. Head Start is one of the few programs that acknowledge the importance of both child- and program-focused mental health consultation in their performance standards. It is also one of the few sources that provide some funding for these services.

Because child care and other early childhood programs typically are inadequately funded or understaffed, making it difficult to pay for additional services or staff development, interagency collaboration is essential to build the advocacy resources needed to find flexible funds to pay for mental health consultation. Some states and communities are beginning to recognize the benefits of providing mental health services to young children and their families at home, in child care, and in other early childhood programs, and they are using creative approaches to plan, provide, and pay for services (Bazelon Center for Mental Health and the Law, 1998). A few of these initiatives are summarized below. For more information, contact the Georgetown University Center for Child and Human Development (see Section VI, "Selected Resources").

- Vermont is using a statewide planning process to provide regionally driven mental health services and supports to young children with mental health needs and their families. Under the leadership of the state mental health and child welfare agencies, other relevant child-serving programs, agencies, universities, and many family members are involved in the process.
- North Carolina has a special category of Medicaid funding called High Risk funding. Any child under age 3 who is found to have even one risk factor for mental illness is eligible for a broad range of mental health services. North Carolina also has a Smart Start initiative that enhances the ability of child care and Head Start staff to serve children who need specialized interventions.

- Several counties in California are saving money through a reduction in psychiatric hospitalizations for older children and adolescents. The counties then “reinvest” these funds in early intervention.
- Anne Arundel County, Maryland, has implemented an initiative based on a county-wide needs assessment that identifies as its highest priority young children with behavioral problems who are at risk for removal from child care. The county is using county funds to establish a multi-tiered service system that includes a “warm line” for telephone consultation, on-site training and behavioral consultation to child care providers, and behavior management training.

SECTION V ■

Conclusions and Recommendations for Action

The early Roundtable participants recognized that increasing numbers of young children in early childhood, early intervention, child care, and home-visiting programs are at risk for developing mental health problems, and that staff and families often lack the skills and resources to manage and respond effectively to these children. More emphasis must be placed on integrating a mental health perspective into these programs. Ongoing mental health consultation is one pathway to reach this goal.

They agreed on the following guidelines for early childhood mental health consultation:

- Early childhood mental health refers to a comprehensive perspective on social and emotional well-being in young children and on the processes that support it, including family and caregiver functioning and the context of young child-adult relationships.
- To make a difference in the lives of young children and their families, mental health professionals should identify the children's social and emotional disorders, delays, and risk conditions and should design and implement appropriate interventions as early as possible.
- Stable, nurturing, and enduring relationships are basic prerequisites for mental health.
- Programs should be designed to promote staff well-being and functioning through training, supervision, and ongoing consultation and support.

Those participants offered the following recommendations to agencies and systems that seek to create responsive programs and interventions, as well as to individuals who are responsible for funding, educating, or providing early childhood mental health consultation.

ADMINISTRATORS OF COMMUNITY-BASED PROGRAMS

- Operationalize the agency's commitment to integrate a mental health perspective into all parts of the program or system. Several aspects of the agency's administrative, financing, personnel, and compensation infrastructure may require changes to support a mental health perspective. For example, if the consultation process results in the recommendation that a provider have more interaction with family members, the family contacts must be valued and approved by supervisors, counted as in-service hours, and included in the provider's job evaluation.

- Maximize all available sources of funding, not only private funding, but also Medicaid and other public funding sources, strategically and creatively.
- Hold mental health consultants to the highest standards of respect for the early childhood education and child care programs and staff.
- Include managers and supervisors in decision making regarding the mental health consultation process. Develop an infrastructure for open communication among consultants, supervisors, and staff.

POLICY MAKERS AND FUNDERS

- Fund programs that offer or aim to develop a continuum of high-quality mental health services designed to promote the well-being and functioning of early childhood program staff. Such services include training, supervision, and regular long-term consultation and support.
- Assist state agencies (those serving children) that should collaborate to develop an Early Childhood Mental Health Plan for all professionals, providers, and parents involved in such programs as Early Head Start and Head Start, family preservation, TANF, early intervention, health and mental health, child care, and education. Professional provider groups and service delivery systems should address the training and support of staff for early childhood mental health.
- Help sponsor the development of approaches to early childhood mental health consultation that can be adapted for various program settings and populations. An integral part of the development of these models should be the evaluation of their effectiveness with children, families, and staff. Then disseminate information on these approaches.
- Offer financial incentives (or build requirements into current grants) to universities and other mental health programs to train students to provide consultation to early childhood programs and systems.

EDUCATIONAL INSTITUTIONS

- Review pre-service curricula to train early childhood and mental health providers and consultants who have the skills to work with each other, across agencies, and in partnership with families and communities.
- Structure training activities for early childhood and mental health professionals (for example, social workers, counselors, psychologists, and psychiatrists) to recognize the changing milieu in which services are provided. Although managed care settings may provide access to and continuity of services, incentives to reduce such services are encouraged and may compete with mental health professionals' decision-making ability.
- Guide and support faculty members who place students and monitor their field-site (practicum) experiences. Encourage student placement as

consultants in community-based agencies and systems working with young children and their families.

- Develop strategies for recruiting and retaining students from underrepresented groups in mental health disciplines to serve ethnic and linguistic communities and families more effectively.
- Allocate research dollars to demonstrate the efficacy of providing mental health consultation to staff in child care settings for the benefit of young children and their families.

CONSULTANTS

- Work with agencies and systems to develop an ongoing early childhood mental health component and to incorporate it into staff development plans. Relevant, accessible information can help providers understand the mental health context and ways to use consultants to help them do a better job.
- Create forums for community-based agencies; administrators; early childhood, early intervention, and child care providers; support staff; parents; and other service providers to define the specific issues that can be addressed through early mental health consultation.
- Disseminate findings of evaluation studies that demonstrate the efficacy of providing consultation and mental health services to young children and families.

SECTION VI ■

Selected Resources

The following resources support programs in implementing early childhood mental health strategies:

- **Head Start Information and Publications Center Warehouse**

P.O. Box 26417
Alexandria, VA 22313-0417
Telephone: 703-683-5767; 1-866-763-6481
Fax: 703-683-5769
Web site: www.hskids-tmssc.org

- **National Technical Assistance Center for Children's Mental Health**

Georgetown University Center for Child and Human Development
3300 Whitehaven Street, N.W., Suite 3300
Washington, DC 20007
Telephone: 202-687-8807
Fax: 202-687-8899
Web site: www.georgetown.edu/research/gucdc/index.html

- **Zero to Three: National Center for Infants, Toddlers, and Families**

2000 M Street, N.W., Suite 200
Washington, DC 20036-3307
Telephone: 202-638-1144
Fax: 202-638-0851
Web site: www.zerotothree.org

APPENDIX A ■

Selected Programs

Several models of early childhood mental health consultation are described in this section. Contact information is given for each program.

DAYCARE CONSULTANTS, INFANT-PARENT PROGRAM

Daycare Consultants, a component of the Infant-Parent Program (IPP) at the University of California, San Francisco (Johnston, 1998), was founded in 1988 to address the needs of child care providers and to expand the role of mental health professionals within the child care setting. The program provides case-centered and programmatic consultation to caregivers serving children from birth to age 5. Two of the child care sites where Daycare Consultants provides early childhood mental health consultation also have integrated therapeutic playgroups into their regular child care milieus.

Before starting the Daycare Consultants project, the infant-parent psychotherapists in the IPP program were involved with the child care system because child care is frequently prescribed by the same professionals who refer families for infant-parent psychotherapy. The often misplaced hope is that child care, in addition to providing respite for the parents of difficult children, will serve as an intervention for the children. The infant-parent psychotherapists realized that the tasks of child care providers are very challenging. It is especially so for those with limited training and experience, large classrooms, and little or no assistance in understanding the extraordinary expressions of need posed by children whose early relationship experiences have been difficult and, therefore, make them challenging to manage.

Daycare Consultants responds to requests for case consultations on individual children (birth to age 6) who demonstrate behavioral or developmental problems in their child care centers. The consultant observes the child in the program to assess his functioning and the match between the child's needs and the child care program. The goal of the consultation is to enhance the providers' ability to understand, willingness to persevere, and ability to intervene effectively with difficult children.

The consultant meets weekly with child care center staff to interpret the meaning of the child's behavior, to provide ideas on appropriate interactions and interventions in a group setting and, in general, to support staff.

The consultant works directly with the families of those children for whom case consultations are initiated. The goals of the consultation with families include:

- assessing the impact of the child's past experiences on current functioning,
- providing guidance by suggesting available resources related to parenting practices,
- helping parents explore and implement more appropriate child-rearing practices, and
- promoting better understanding and mutual support between parents and child care staff.

The consultant helps families secure additional, mutually agreed-upon resources for the child. The consultant then acts as a liaison between the child care center and such direct service providers as counselors and family therapists.

Daycare Consultants believes that the usefulness of consultation is not limited to acute situations in which caregivers are especially worried, alarmed, or frustrated by a particular child's behavior. The organization draws a parallel to concerns about the nutritional needs of children in child care only at the point at which signs of malnutrition appear in one child. Through program consultation, staff take a proactive approach to combating the ill effects that poor quality care has on children by creating an atmosphere in which the mental health of all children in programs is protected. This consultation is a preventive strategy designed to ensure the healthy growth and development of children by improving the overall quality of their relationships and their environment. In bi-weekly meetings with the program's staff and director, the consultant assists with all aspects of program planning, that is, from improving communication among staff to implementing developmentally appropriate practices with the children.

The cost of early childhood mental health consultation to a program is \$250 a child. The consultant spends an average of 10 hours a week at the center. Consultation costs usually are covered by special grants, but in some cases, fees are paid by the early childhood programs.

Daycare Consultants' services were evaluated as part of the Miriam and Peter Haas Fund Early Childhood Mental Health Initiative evaluation conducted by James Bowman Associates. This 1-year evaluation assessed the effect of mental health consultation and services on 25 early childhood classrooms serving children ages 2 to 5 (see the evaluation description in Section III, "Essential Features of Early Childhood Mental Health Consultation").

In certain cases, consultants may broaden their primary mandate and advise child care staff to provide direct services to children and their families. For example, Daycare Consultants' therapeutic playgroups are co-led by a mental health professional and a child care provider who is a member of the child care center staff. Six or seven children participate in each of these playgroups three times a week. Within this environment, the co-leaders help the children make choices; organize their experiences; differentiate, label, and cope with emotions;

communicate needs and ideas; and deal with anxieties and conflicts. The consultants meet regularly with both child care staff and the children's families.

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DEVELOPMENTAL TRAINING AND SUPPORT PROGRAM, OUNCE OF PREVENTION FUND

The Chicago-based Ounce of Prevention Fund (OPF) works with community-based programs that support families of adolescent parents (usually mothers) and their children. OPF allocates funding, assists with program design and implementation, and monitors program activities. Although programs vary from community to community, each offers parent education and peer support, plus weekly or biweekly home visiting. Programs also share the common goals of helping teenage parents return to school, obtain vocational training, secure appropriate child care, and provide for the health and safety of their children. The programs aim to reduce subsequent pregnancies, child abuse, and neglect among the families they serve.

The target population of the Developmental Training and Support Program (DTSP) includes pregnant or parenting young mothers ages 13 to 21 and their children. The program provides ongoing training and consultation to home visitors, parent group facilitators, and supervisors for a 2-year period. The aim is to assist program staff in developing supportive, helping relationships with families, so that staff in turn may help teenage parents develop positive relationships with their young children.

The goal of the DTSP is to help programs and staff shift from a parent-centered approach that focuses on parents' crises to a parent-child relationship approach that builds on family strengths to enhance successful family and child development. Through consultation, the program enables home visitors to work through the frustrations of intractable problems and gives supervisors greater structure for overseeing home-visiting staff. It also promotes new standards for interactions between home visitors and parents, and between parents and children.

The following paragraphs describe the key elements of DTSP's intervention.

The main strategy for consultation is the use of home videos as a tool to enhance parent-child communication. The videos, developed by staff, feature parents and young children engaged in daily routines. The production and review of the home videos with staff and parents occur within the context of positive staff-parent relationships. With the consultant's help, the home videos allow parents, home visitors, and executive staff to see for themselves how parents communicate with their children.

Consultants meet with staff (program directors, supervisors, home visitors, and parent group facilitators) in all-day consultation and training sessions once a month for 2 years. The goals of this consultation include learning how to (1) develop positive relationships, (2) observe and interpret parent-child interactions, (3) use these observations with parents to build on strengths present in the teenage parent-child relationship, and (4) use inquiry as an intervention.

Each consultation group has 8 to 10 home visitors (each home visitor serves 15 to 20 families) and about 10 to 15 supervisors and managers.

During the consultation meetings, the home-visiting, supervisory, and executive staff develop new insights into parent-child relationships and learn new ways to bolster relationships within the families they serve and also among program staff. The most critical content of each monthly meeting is distilled from discussions of the work that staff members currently do with families. DTSP facilitators encourage participants to discuss what goes well in their everyday work with families, why it might be happening, and how staff members contribute to the successes they see.

As staff review the home videos of the parents interacting with their children, they learn to look for and support those aspects of the parent-child relationship that have mutual benefits for both parents and children. This model provides the context for building the observation skills of workers. Staff learn to identify positive interactions and to point them out to parents as strengths to build on. When interactions cause concern, staff learn to ask questions, to gather more information, and to clarify what they have seen, rather than to make assumptions or to try to fix a situation or relationship. Supervisors, along with direct service providers, learn the skills of objective observation, inquiry, and supporting strengths.

Another goal of the consultation is for parents to learn to make their daily routines enjoyable rather than burdensome. This goal is accomplished by (1) involving the children during home visits; (2) making home videos of daily routines and reviewing them with the parents, emphasizing the positive interactions; (3) using Parent-Child Observation Guides to increase parents' awareness of their relationships with their children; and (4) conducting developmental demonstrations using parents as co-demonstrators.

This type of early childhood mental health consultation implements a crucial sequence of support: supervisor and staff, staff and parent, and parent and child all learn from and respond to one another. The DTSP calls this sequence a chain of enablement.

The cost of the program ranges from \$500 to \$1,000 a day, depending on the qualifications and experience of the consultant. Average contact between consultant and staff or parents is between ½ day and 1 day a month. The consultation is financed by special grants or from training funds that are part of the regular program budget.

Documented outcomes of the DTSP include the following:

- Staff and parents stay in the program longer.
- Staff develop skills to focus on the parent-child relationship, even in the face of multiple family crises.
- Staff and parents indicate satisfaction with the program.
- Parent-child communication improves over time (as noted on Parent-Child Observation Guides).
- Staff turnover decreases.

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DAY CARE PLUS, A POSITIVE EDUCATION PROGRAM

Day Care Plus is a collaborative effort of the Cuyahoga County Mental Health Board, a children’s mental health agency, and a child care resource and referral organization in Cleveland, Ohio (Bowdish, 1998). The program is designed to meet the needs of children under age 6 at risk, their parents, and staff of the day care centers they attend. The goals of the program are to improve the social, behavioral, and emotional functioning of children in child care at risk, as well as to increase the competencies of the parents and child care staff.

Early identification, screening, and intervention services are provided to child care settings. Parents receive information about intervention strategies to use at home and about appropriate services available in the community. Mental health consultation, training, and crisis intervention services are provided to child care staff, and the project’s interventionists work with staff to develop specific behavioral interventions for children who display signs of emotional or behavioral problems.

Day Care Plus has worked with 22 centers. Fourteen centers receive intensive consultation and 8 centers are on “follow-along” status. Every family with a child under the age of 6 years is eligible to receive services. There are approximately 340 staff and 1,175 children in the 22 centers. Approximately 25 to 30 families receive intensive, individualized services.

The program costs approximately \$20,000 to \$25,000 a center for 1 year. This cost includes the consultant fee, as well as money for other services, such as transportation and resources for families. Each consultant can carry five intensive consultative sites or four intensive sites and three to four follow-along sites.

A research study was designed and is currently being conducted by the Cuyahoga County Community Mental Health Board (the mental health authority), the Positive Education Program (the mental health agency), and the Cuyahoga Mental Health Research Institute. Twenty centers were recruited and paired based on the socio-demographic characteristics of the population served, the composition of staff, and the nature of the program. One member of each matched pair was randomly selected to receive Day Care Plus services. The other sites participate in the control group, with the understanding that they will be among the first sites eligible for expanded Day Care Plus services at the conclusion of the research demonstration phase.

The baseline measures on children, parents, and staff were gathered in spring 1997. Follow-up measures occurred at 12 and 20 months. Both qualitative and quantitative data were gathered.

The objectives for children focus on behaviors. Needs assessment data that led to the development of this project revealed that children often are expelled from child care because their behavioral problems create a risk for themselves and others. The study compares the number of expulsions at the service sites with the number at the control sites. It is hypothesized that, compared with expulsions during an equivalent period before the project's implementation, there will be a greater reduction in the number of expulsions at the experimental service sites than at the control sites.

For parents, the program and research focus is on the ability to manage a child's problematic behaviors. The project also helps parents obtain appropriate community supports to meet their needs and their children's needs. A greater increase in the number of referrals to direct services for the service sites is expected.

The project also is designed to improve the competencies of child care staff. Specific goals include:

- increased ability to identify children who are at risk;
- increased ability to provide appropriate interventions and behavioral strategies;
- improved staff-parent relations; and
- reduction of staff stress, burnout, and turnover.

Focus groups have been held with center staff to gain insight into their ability to identify children at risk and to provide appropriate interventions. Baseline focus groups have identified several primary challenges: poor and insufficient and inconsistent communication among the adults in a child's life, inadequate teacher education and training, and a lack of parent support group meetings. It is expected that the introduction of Day Care Plus services will diminish staff stress and burnout, leading to a reduction in staff turnover. Staff turnover, including information on why staff leave an organization, is monitored throughout the project.

Preliminary outcome data indicate a reduction in expulsion and a high level of participation. Staff and parents expressed the need for creating a follow-along track, through which consultants continue to provide consultation.

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KIDSCOPE

KidSCOPE of Chapel Hill and Hillsborough, North Carolina, provides comprehensive mental health services to young children who experience emotional, social, behavioral, and developmental difficulties (KidSCOPE, 1998). Services are available to all Orange and Chatham County children ages 6 and under. Anyone may refer a child to KidSCOPE, provided that she has the consent of the child's parent or guardian. Services, which include screening, evaluation, intervention planning, and support, are tailored to address the unique needs of each child, his family, and child care center staff. Through home and office visits, and flexible scheduling, counselors make consultation services accessible and convenient for families.

KidSCOPE's five counselors provide consultation in approximately 40 programs every year. The cost of each counselor is about \$40,000 a year. Costs are covered by grants from public and private foundations, local and state moneys, and Medicaid funds.

Consultants are mental health professionals trained to address the emotional and social issues unique to very young children. Areas of staff expertise include child development, family relationships and processes, early care and educational practices, and behavioral and therapeutic interventions.

KidSCOPE counselors provide consultation to families and child care staff to assist them in addressing the difficulties experienced by the referred children through the following continuum of services (from least intensive to most intensive):

- information and referral,
- workshops for child care providers and parents,
- child care consultation (not child specific),
- child and family screening,
- child-specific consultation,
- home visiting,
- parent counseling,
- service coordination, and
- Family Transitional Learning Classroom.

The Family Transitional Learning Classroom program is a family-focused early intervention and prevention program offered by KidSCOPE. It provides an alternative therapeutic classroom setting for preschoolers who have had long-standing emotional and behavioral difficulties. It offers family education and support, in addition to information and consultation to the child's mainstream child care setting about child management and special behavior techniques.

During the 1997–98 school year, 100 percent of the children in Chatham County programs served by KidSCOPE maintained their enrollment. In Orange County, 95 percent of the children in KidSCOPE programs maintained their enrollment.

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APPENDIX B ■

Assessment in Child- and Family-Centered Consultation

The following questions are important for the the consultant and center staff member to consider:

Child

- What is the history of this child in this setting?
- What are the behaviors of concern?
- When do the behaviors tend to occur?
- What are the child's strengths and abilities?
- What are the developmental issues to be considered?
- How does the child interact with staff? the family? other children?
- What cultural factors must be considered?
- What feelings does the child elicit from the staff?

Family

- How does the family view the situation? Is this view similar to the staff's view?
- What are the family's expectations for the child and the program?
- What are the family's strengths and resources?
- What types of interventions are acceptable to the family?
- What constraints in the family must be considered?

Staff Member

- How does the staff member view the issues?
- What are the staff member's expectations for self, family, and child?
- What intervention skills does the staff member possess?
- What types of interventions are acceptable to the staff member?

- Does the staff member have the necessary knowledge, skills, objectivity, and confidence to respond to the particular concerns raised?

Immediate Environment

- What are the philosophies of the classroom, program, and organization, and how do they influence the consultant and the staff member?
- What aspects of the environment contribute to, influence, reinforce, or maintain the child's behavior?
- What external resources may be available (for example, extended family and a smaller group in the center)?
- What constraints in the immediate environment must be considered?

Larger Environment

- What larger environmental (community) characteristics contribute to the problem?
- What factors outside of the immediate environment affect the child's behavior?
- Are the changes proposed for the child or staff member consistent with family, agency, and community norms and expectations?
- Are the proposed changes and change strategies culturally appropriate for this child and this staff member?

APPENDIX C ■

Assessment in Program Consultation

The following questions are important for the consultant and staff members to consider in program consultation:

- What is most important about this agency?
- For what does the agency most want to be known?
- How are decisions made or policies changed?
- How does each staff member understand the program’s “mandate”?
- How is the program or agency regarded by staff, families, and other agencies?
- How is the agency regarded by the general public?
- How do staff explain the situation that prompted the consultation?
- What do staff think needs to change in order for the concern to be addressed?
- Do staff view their relationships with clients as positive or negative, as generally successful or failing, or as accomplishing the agency’s mandate or not?
- Do staff feel a sense of satisfaction from their work with children and families?
- Do staff feel angry with families, with children, or with other staff members? If so, why?
- Do staff appear interested in gaining new skills for working with young children and their families?
- What is the quality of the early childhood program?

The following questions relate to content-based program consultation (which is different from general staff development training):

- What is the agency’s treatment regarding the presenting consultation issue?
- What actions has the agency taken to address the concern?
- What human, financial, and program resources can the agency use to address the presenting consultation issue?

- Can any program models or agency interventions be applied to the consultation issue?
- What are the organization's covert and overt expectations of the consultant?

The following questions relate to inter-staff relationship consultation (for example, staff do not get along with one another, a high degree of conflict exists between two staff members, or a fierce split occurs between a staff member and a manager):

- Who defined the problem as requiring a consultation?
- For whom is it a problem?
- For whom is it *not* a problem?
- Who first identified the problem?
- Who talks to whom about it?
- Do some people identify other problems as more pressing?
- How has the system solved similar problems?

APPENDIX D ■

List of Contributors

- Anne Mathews-Younes, Ed.D., Director, Division of Prevention, Traumatic Stress, and Special Programs (DPTSSP), and Gail F. Ritchie, M.S.W., Prevention Initiatives and Priority Programs Development Branch/DPTSSP/Center for Mental Health Services, SAMHSA, provided invaluable support throughout the duration of the project.
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REFERENCES ■

- Alkon, A., Ramler, M., & MacLennan, K. (2003). Evaluation of mental health consultation in child care centers. *Early Childhood Education Journal, 31*(2), 91–99.
- Bazelon Center for Mental Health and the Law. (1998). *A blueprint for coalition building to address the needs of very young children and their families with mental health and/or substance abuse issues*. Washington, DC: Author.
- Bertacchi, J. (1996). Relationship-based organizations. *Zero to Three, 17*(2) 1–7.
- Bowdish, A. (1998, July). Incorporating mental health services and consultation into child care settings. Presentation at *Training Institutes: Developing local systems of care for children and adolescents with serious emotional disturbances and their families in a managed care environment*, Georgetown Child Development Center, Washington, DC.
- Carnegie Corporation of New York. (1994). *Starting points: Meeting the needs of our youngest children*. New York: Author.
- Donohue, P., Falk, B., & Provet, A. G. (2000). *Mental health consultation in early childhood*. Baltimore: Brookes.
- Feinberg, E., & Fenichel, E. (1996). *Who will bear my cry? Developing a system of care to meet the mental health needs of infants, toddlers, preschoolers and their families*. Washington, DC: Georgetown University Child Development Center.
- Feinberg, E., & Fenichel, E. (1997). *Who will bear my cry? Summary of an invitational conference*. Washington, DC: Georgetown University Child Development Center.
- Fenichel, E. (1992). *Learning through supervision and mentorship to support the development of infants, toddlers, and their families: A source book*. Washington, DC: Zero to Three.
- Georgetown University Child Development Center. (1998). *Roundtable on mental health consultation approaches for programs/systems working with infants, toddlers, and preschoolers and their families*. Washington, DC: Author.
- Gomby, D., Behrman, R., Larner, M., Lewit, E., & Stevenson, C. (1995, Winter). Long-term outcomes of early childhood programs: Analysis and recommendations. *The Future of Children, 5*(3), 6–24.
- Green, B. L., Simpson, J., Everhart, M. C., Vale, E., & Gettman, M. G. (2004). Understanding integrated mental health services in Head Start: Staff perspectives on mental health consultation. *NHSA Dialog, 7*(1), 35–60.

- Hansen, K., & Martner, J. (1992). *Mental health in Head Start: A wellness approach*. Washington, DC: Department of Health and Human Services.
- Hirshberg, L. M. (1997–1998). Infant mental health consultation to early intervention programs. *Zero to Three*, 18(3), 19–23.
- James Bowman Associates. (1999). *The Miriam and Peter Haas Fund Early Childhood Mental Health Initiative*. Unpublished manuscript.
- Johnston, K. (1990). Mental health consultation to day care providers: The San Francisco Day Care Consultants Program. *Zero to Three*, 10(3), 7–13.
- Johnston, K. (1998, May). Mental health consultation and therapeutic groups in child care settings. *Roundtable on mental health consultation approaches for programs/systems working with infants, toddlers, and preschoolers and their families*, Georgetown Child Development Center, Washington, DC.
- Kaufmann, R. K., & Dodge, J. M. (1996). *Prevention and early intervention for young children at risk for mental health and substance abuse problems and their families*. Washington, DC: National Technical Assistance Center for Children's Mental Health.
- Kaufmann, R., & Wischman, E. (1999). Communities supporting the mental health of young children and their families. In R. R. Roberts and P. R. Magrab (Eds.), *Where children live: Solutions for serving young children and their families*. Norwood, NJ: Ablex.
- KidSCOpe. (1998, July). KidSCOpe Outreach Services. Presentation at *Training Institutes: Developing local systems of care for children and adolescents with serious emotional disturbances and their families in a managed care environment*, Georgetown Child Development Center, Washington, DC.
- Klass, C. S., Guskin, K. A., and Thomas, J. M. (1995). The early childhood program: Promoting children's development through and within relationships. *Zero to Three*, 16(2), 9–17.
- Lieberman, A. F. (1998–1999). The trials and rewards of being a clinical consultant to Child Protective Services. *Zero to Three*, 19(3), 14–18.
- Parlakian, R. (2001). *Look, listen, and learn: reflective supervision and relationship-based work*. Washington, DC: Zero to Three Press.
- Salazar, R. M. (1995). Consultation is relationship: A clinician's approach to the collaborative relationship in consultation. *Zero to Three*, 16(2), 25–32
- Sameroff, A. J., & Fiese, B. (2000). Models of development and developmental risk. In: C. H. Zeanah (Ed.), *Handbook of infant mental health* (pp. 3–19). New York: Guilford Press.
- Shahmoon-Shanok, R. (1998, May). *Memorandum to the participants in the roundtable on mental health consultation approaches for programs/*

systems working with infants, toddlers, and preschoolers and their families, Georgetown Child Development Center, Washington, DC.

Stroul, B., & Friedman, R. M. (1986). *A system of care for children and youth with severe emotional disturbances*. Georgetown University Child Development Center, Washington, DC.

Tableman, B. (1998). *Keeping early education positive (KEEP) survey review*. Unpublished manuscript.

U.S. Department of Health and Human Services, Administration for Children and Families, Head Start Bureau. (1980). *Mental health in Head Start: It's everybody's business* [multimedia kit]. Washington, DC: Author.

U.S. Department of Health and Human Services, Administration for Children and Families, Head Start Bureau. (1994). *Responding to children under stress: A skill-based training guide for classroom teams*. Washington, DC: Author.

U.S. Department of Health and Human Services, Administration for Children and Families, Head Start Bureau. (1996). *Promoting mental health*. Washington, DC: Author.

Yoshikawa, H., & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs*. New York: National Center for Children in Poverty.

Zero to Three. (1992). *Heart start: The emotional foundations of school readiness*. Washington, DC: Author

