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Management Strategies for Positive Mental Health Outcomes: What Early Childhood Administrators Need to Know

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April 2004
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Training Objectives

Participants will:

I. Understand principles of “best practices” in delivering early childhood mental health services and why they are important

II. Learn research-based strategies for improving the effectiveness of mental health consultation

III. Understand the role of staff wellness and how to foster it

IV. Learn steps to take as Head Start program leaders to improve the quality of your early childhood mental health program

The focus of this training is on understanding ways to design and implement an overall mental health strategy in your program. We’re not going to talk about specific intervention strategies, such as how to deal with challenging behavior in the classroom, or how to identify and screen children with possible mental health issues. Instead, we are going to talk about how to structure and manage your program’s mental health component, focusing on how to work with mental health professionals or consultants, how to maximize resources, and how to infuse your program with a “mental health perspective” that permeates all aspects of program services.

In the process, we expect that participants will learn about four major topics:

1. Principles and values of “best practices” for children’s mental health. These principles and values form the context for selecting and implementing any specific mental health curricula or strategies that you might have.

2. You will learn about what our research has shown to be most important in creating effective relationships with mental health professionals in the early childhood program context—who should your consultant be? What kinds of expertise are needed? What activities should the consultant perform? How should you structure the ways that consultants or other professionals work with staff and parents?

3. You’ll learn about the role of staff wellness and how you can best support staff to do their best work to support children’s well-being.

4. Finally, you’ll learn about your particular role as program leaders in helping to shape and improve the quality of mental health services in your program—how to build a vision focused on mental health, and the importance of advocacy and leadership support.
Head Start Performance Standards mandate:

- A comprehensive, family-focused approach to delivering mental health services, including screening
- “Sufficient” mental health consultation to meet children’s needs
- In practice: Lots of variability, little federal guidance

See the appendix for detailed Head Start Performance Standards.

“The comprehensive model of Head Start was designed so all the components would work together...mental health, being clearly a part of every component, is a logical place to encourage and practice inter-component coordination.”

--Head Start Training Manual

Revised performance standards reflect an increasing awareness of the importance of promoting positive mental health and providing early intervention and service for children with challenging behaviors. Mental health has been a core component of Head Start since its inception; however, it was only in the late 1990’s that it was explicitly discussed in the performance standards.

However, the performance standards don’t offer much specific guidance around how to choose or work with mental health professionals, or how to understand what strategies or curricula might work best in your program.
Mental Health in Head Start

“The rhetoric of Head Start from day one has talked about integrating mental health into every component of the Head Start program and infusing it into every decision about children, families, and staff. The reality is something quite different. Programs have been accountable for assessing children, identifying them, and making referrals, reflecting a rather narrow definition of mental health.

There are two problems with this. For young children, such referrals may not be the most appropriate intervention. Equally important, it leaves staff without any clinical perspectives to inform their day-to-day interactions with children and families. Nor does it give them any help if it is not one or two children who are manifesting challenging behavior, but virtually all”

--Jane Knitzer (1999)


Jane Knitzer, from the National Center for Children in Poverty, and a national advocate for children’s mental health issues, talks about how Head Start in principle incorporates a holistic, wellness focused vision of children’s mental health, but how the implementation of mental health approaches and strategies falls short of what may be most important for Head Start children and staff.
Why Focus on Early Childhood Mental Health?

- **Mental Health = Social Emotional Development, the essential foundation for early learning**
- **School readiness dialogue provides the link** between Head Start’s early childhood mental health supports and increased likelihood of school success.
  - Entering school means having the behavioral and emotional competencies to succeed in school
  - Easier for everyone to understand that services are needed to help get children “ready to succeed in school” than to help children have “positive mental health”
  - To get support for early childhood mental health services, it makes sense to argue that these services are needed to help prevent behavior problems that K-3 teachers would later have to deal with.

One reason that mental health has not had a central and integral role may have to do with the “mental health language”. The word “mental health” is loaded—we think about people who have serious mental illness, schizophrenia, depression, etc., which doesn’t translate very well when applied to children. One way to get more popular support for the concept of early childhood mental health is to:

1. Broaden the definition and talk about children’s social and emotional development and children with early signs of behavioral problems—challenging behaviors in the classroom. This leads naturally to a discussion of:

2. **School Readiness**: a primary goal of Head Start, especially under current administration policies. Clearly, in order for children to succeed in school, they must be able to have appropriate social and emotional development—they must be able to regulate their emotions; not throw temper tantrums, throw things, or act aggressively; they must be able to interact positively with their peers and with other adults; follow directions; participate in group and classroom activities; and they must know how to share and take turns. If people understand that this is what we mean by “early childhood mental health” --at least for most children-- people will come to better understand why its so important for Head Start and other early childhood programs.
Challenges

- Narrow definition of mental health services as “therapy”
- Reluctance to label children with challenging behaviors
- Lack of understanding of effective, efficient mental health approaches
- Difficulties finding, and paying for, qualified early childhood mental health consultants
- Lack of understanding of how to most effectively use limited resources


The challenges for implementing high quality early childhood mental health services are not insubstantial. Some have to do with the lack of understanding of a more holistic definition and approach to children’s mental health—thinking of children or families with “mental health problems” as the primary focus, thinking of services for mental health in terms of “therapy” or “play therapy.” There is also a historical issue with Head Start programs’ reluctance to address children’s mental health needs for fear that children will be labeled—either diagnosed, or simply labeled “problem children.” This issue may exist among staff and be unknown to program administrators. Mental health in and of itself becomes tied to “diagnosis” and therefore, to “labeling.”

Another set of challenges has to do with lack of knowledge about what works best and how to make the most of limited resources. We will begin to address this today, although we can’t offer specific advice about classroom teacher intervention strategies or curricula (we will provide some resources).

Finally, the most frequently mentioned barrier is simply a lack of resources—can’t find a qualified person, can’t afford a qualified person, would like to spend the money on service with more short-term urgency. We will provide you with some ways to address this challenge today. I’m giving away the bottom line here, but one of the big lessons that we’ve learned from our research is that the amount of consultation, or the amount of money spent on consultation, matters less than the quality of consultation and what the consultant actually does.
The training today is based in large part on a research project funded by the National Institute on Disability Research & Rehabilitation, at the US Department of Education. The purpose of this five-year project, as stated in the grant proposal to the National Institute on Disability & Rehabilitation Research, is:

“To use a research-driven approach to develop, test, and disseminate an integrated strategy for program decision-making aimed at addressing the needs of young children with or at risk of emotional, behavioral, or mental disorders and their families.”

-1999 grant proposal to National Institute on Disability & Rehabilitation Research

In more everyday terms, we hope to provide guidance to early childhood program directors and managers who have said to us:

“I know I have to do ‘it’ (have a mental health program) but I don’t know what “it” is! Why do I want one (a mental health consultant) and what am I going to do with one?”
Research Project Overview

- **Phase 1: Literature Review**
  - Review literature to identify key factors important to children’s positive social-emotional development and mental health
  - Develop conceptual model integrating community, program, staff, family and child characteristics

- **Phase 2: Qualitative Study**
  - To understand “from the field” perspectives on how children’s mental health services are being delivered and what contributes to effectiveness

- **Phase 3: National Program Survey**
  - To conduct a representative survey of Head Start program staff and parents to address the following research question:
    - What features of programs or consulting relationships contribute to implementation of mental health best practices and effective mental health programming?

The first phase of the project was a literature review to identify and integrate information about the key factors that are important to children’s social emotional development. We used this literature review to develop a conceptual model linking community, program, staff, family and child characteristics together and to positive child and other outcomes. See slide #19 for the model.

Second, we did a qualitative research study at three Head Start programs to get a better “on the ground” understanding of how Head Start staff and parents talked about and addressed, children’s mental health issues. We also wanted to “check” some of the issues that had come up in the literature review to see which factors were really most important to classroom behavior and children’s outcomes.

Third, based on what we learned in the qualitative study, we conducted a national survey of 80 Head Start programs to collect more quantitative data that could help us understand how the ways that programs organized their mental health services, and how programs used MHC consultants, was related to how staff behaved and child outcomes.
How Did We Measure MH Best Practices, Services, and Outcomes?

More positive = more staff who “strongly agree”:

- **Best Practices: Strengths-Orientation examples:**
  - “Staff are able to build on family and child strengths even when the family is facing significant challenges”
  - Staff believe that the best way to meet a child’s mental health needs is to identify what is “right” with the child, rather than what is “wrong”

- **Best Practices: Parent Involvement examples:**
  - “When a child has a mental health issue, staff actively involve the child’s family in meeting the child’s needs”
  - “Staff feel comfortable talking with parents about their children’s mental health needs or issues”

Later in this presentation, we will discuss Best Practices in early childhood mental health services more fully. Here we give you an example of the kinds of items we used for two of the key constructs, strengths-orientation and parent involvement.

- A copy of the full survey instrument is included as the last item in the Appendix of this training manual.

All items were answered on a 4 point scale from “strongly agree” to “strongly disagree”.
How Did We Measure MH Best Practices, Services

*More positive = more staff who “strongly agree” that:*

- **Mental Health Consultant (MHC) Characteristics examples:**
  - “The MHC works as a partner with staff to meet children’s mental health needs”
  - “Parents trust the mental health consultant(s).”

- **Leadership for Mental Health examples:**
  - “Program leadership advocates and tries to obtain more resources for children's mental health services”
  - “Program leadership has a clear vision of how children's mental health issues are related to all program components”

How Did We Measure MH Best Practices, Services

*More positive = more staff who “strongly agree” that:*

---

How Did We Measure Outcomes?

*More positive = more staff who indicated that mental health services “helped a lot” to:*

- **Child Behavior Outcomes examples:**
  - *Externalizing behaviors, reduce:*
    - Reduce aggression towards other children
    - Self-destructive behavior
    - Aggression towards adults
  - *Internalizing behaviors, reduce:*
    - Withdrawn/Overly shy behavior
    - Child depression
  - *Pro-Social behaviors, increase:*
    - Positive social interactions between children
    - Non-violent problem solving
How Did We Measure Outcomes?

More positive = more staff who “strongly agree”:

- **Staff Wellness Outcomes examples:**
  - “Our program provides me with the emotional and personal support I need to do my job most effectively”
  - “This program recognizes the good work that I do on behalf of children and families”

- **General Program Outcomes examples:**
  - “Transitions are smoother in my classroom because of our mental health services”
  - “Our program’s mental health services have improved the quality of our classroom environments”
  - “Our mental health services help families learn how to better cope with children’s challenging behaviors.”

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The study involved almost 80 programs, from which we selected a random sample of 8-12 staff, plus the director, mental health coordinator, and one mental health consultant. We got about 63% return rate on our surveys, and respondents represented a good range of core Head Start programs demographically. We also collected about 150 surveys from parents.
Reporting Results

- Each program received their own results compared to national averages
- National averages include only 72 programs that had at least 7 respondents
- For copy of the report, see:
- Results used to develop this training

All of the programs that participated received a report back summarizing their sites’ findings compared to national averages.

One of the primary goals of this project was to provide research-based training and technical assistance. If you know anyone else who would like to receive this manual, please contact: M. Everhart by phone at 503-725-8465 or email at everhartm@pdx.edu
An example of variability in MH services provided by HS mental health professionals:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Rarely/never</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom observations</td>
<td>15%</td>
<td>19%</td>
</tr>
<tr>
<td>Make referrals</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>Attend management team</td>
<td>38%</td>
<td>33%</td>
</tr>
<tr>
<td>Meet with staff</td>
<td>30%</td>
<td>33%</td>
</tr>
<tr>
<td>Train staff</td>
<td>22%</td>
<td>25%</td>
</tr>
<tr>
<td>Meet with parents</td>
<td>27%</td>
<td>38%</td>
</tr>
<tr>
<td>Provide direct therapeutic service</td>
<td>30%</td>
<td>38%</td>
</tr>
</tbody>
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These example activities go back to what we were talking about—that there was a lot of variability in Head Start programs over what they are doing with their MH professionals. Our survey found that consultants in some programs did these things “almost never” while others did them frequently (once per month or more).
The actual amount of consultation that was provided also varied tremendously. Interestingly, amount of consultation per child didn’t vary systematically by size of program: some large programs had very little consultation, others had lots; similarly, some small programs had extensive consultation, others had very little.

<table>
<thead>
<tr>
<th>Amounts of Consultation Also Varied</th>
<th>Half or More Programs Had Lower Levels of Consultation</th>
<th>A Few Programs Had More Extensive Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>*57% (31) report less than 1 hour of consultation per child, per year</td>
<td>*26% (13) report more than 2 hours of consultation per child, per year</td>
<td></td>
</tr>
<tr>
<td>*37% (20) report less than ½ hour per child</td>
<td>*71% (35) report less than a half-time mental health consultant</td>
<td></td>
</tr>
<tr>
<td>*46% (31) have less than a half-time mental health services coordinator</td>
<td>*29% (14) report 1 half-time mental health consultant or more</td>
<td></td>
</tr>
<tr>
<td>*79% relied on external, contracted consultants</td>
<td>*16% (8) report 1 full-time consultant or more</td>
<td></td>
</tr>
<tr>
<td>*21% had salaried, on-staff consultants</td>
<td>*54% (36) have more than a half-time mental health services coordinator</td>
<td></td>
</tr>
<tr>
<td>*18% (12) have a full-time mental health services coordinator</td>
<td></td>
<td></td>
</tr>
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Now you have some understanding of why we were doing this project, and about the research basis for the training. Before going further there are a few key terms that warrant some discussion so that we make sure we are all “on the same page”.
Defining Mental Health

- Mental health in its simplest form is the capacity to “Love, Work, and Play”: Forming relationships
- A holistic or wellness approach to mental health includes attention to:
  - Physical health and self-care
  - Emotional health (feelings, coping strategies, mastery)
  - Social relationships and behavior
  - Cognitive well-being: curiosity, problem solving, interests
  - Spiritual: having internal guides for living, morals, ethics
- Mental health must be understood within a broad context as influenced by biology, relationships, developmental status, cultural context, and other factors.
- “Mental health services” include a wide range of services


First, what is mental health? We take a very broad view of the concept, and encourage you to work with your staff to adopt a holistic understanding of what early childhood mental health is, and what kinds of services might be involved.

From the Head Start Bureau comes this definition:

<table>
<thead>
<tr>
<th>LOVE</th>
<th>WORK</th>
<th>PLAY</th>
</tr>
</thead>
</table>

To form meaningful relationships with others
To have positive self-regard
To feel productive and self-actualized
To play, relax, and have fun

A range of services. From everyday strategies for supporting children’s positive social and emotional development to more focused work identifying and solving early problem behaviors, all the way up through knowing how to meet the needs of children with more extensive or serious behavioral or emotional problems.
This is a model for how programs might think about promoting children’s social emotional development and preventing challenging behavior, from the Center on the Social Emotional Foundations for Early Learning at the University of Illinois in Urbana-Champaign.

The idea is that the basis for all social emotional development is positive relationships between and among children, families and staff. This relationship context sets the stage for everything else that happens.

The next level has to do with the importance of building environments (classroom or home) that support children’s positive behavior through meaningful activities, well-planned and organized to facilitate smooth transitions and routines, and engaging parents and teachers in helping children learn. Preventative classroom strategies have to do with how environments and schedules are put together, working to accommodate all children’s needs, and engaging children in daily activities and routines.

Social and Emotional Teaching Strategies—have to do with specific teaching strategies that promote social emotional competence—teaching problem solving, emotional regulation, how to develop friendships, etc. These apply both to all children as well as to helping children with specific behavioral challenges work through these at their early stages, before they become more serious.

At the top, are those services needed to address specific challenging behavior, including understanding the behavior, developing a plan, and bringing in other resources as needed. As suggested, this is at the top of the triangle, and isn’t needed for all kids, but is for some.

To fully address children’s positive social emotional development and mental health, staff need to understand and provide services within each of these levels.

Describe general model, most services are at the bottom three-fourths.

Give examples of each strategy. Later, we’ll return to this model when we talk about consultation.
Another key term that warrants definition is “Best Practices.” There are lots of different uses of this term, as well as for “Evidence Based Practices.” We define Best Practices as those Principles and Values that guide the work, rather than the specific strategies.

For example, one “best practice principle” is delivering strengths-based, family-focused services.

An evidence-based strategy might be a particular curriculum, such as Incredible Years or Second Step, or a particular technique for promoting positive behavior, such as giving appropriate choices or ample notification of upcoming transitions. These curricula or behavior management tools have been well-researched in comparison designs and had positive outcomes, hence “evidence-based.”

We will talk today about strategies, but for general program design rather than specific classroom or other behavior.
Evidence-Based Intervention Strategies for Early Childhood Mental Health:

Some Examples:

- San Francisco Mental Health Consultation Project
  - www.kluweronline.com/issn/1082-3301/contents

- The Incredible Years
  - www.incredibleyears.com

- Project SUCCEED in Head Start
  - www.rrri.pdx.edu/pgProjectSUCCEED.html

- Positive Behavioral Support
  - www.rtcpbs.org

Supplemental Slide

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This training does not include information about Evidence-Based Strategies for young children, but here are some good resources for identifying specific programs and strategies.

San Francisco's Mental Health Consultation Project involved four agencies providing mental health consultation to more than 40 child care programs serving low-income, ethnically diverse young children. Consultants observed children, consulted with directors and teachers, met with individual families, participated in staff meetings and consulted with groups or teams of staff. Over a year’s time, teachers showed improved understanding of children’s difficult behaviors and social and emotional development, and worked more effectively with parents. Mental health consultation was positively received by staff, and led to lower teacher turnover and improved center quality. See Alkon, A., Ramler, M., MacLennan, K. (2003). Evaluation of mental health consultation in child care centers. Early Childhood Education Journal, 31(2), 91-99. (Downloadable at www.kluweronline.com/issn/1082-3301/contents.)

The Incredible Years is a structured series of parent, teacher and child educational programs with strong evidence of effectiveness in strengthening participants’ parenting skills, increasing children’s social competence, and decreasing children’s misbehavior. Visit www.incredibleyears.com for an overview of the programs, or see Baydar, N., Reid, M., & Webster-Stratton, C. (2003). The role of mental health factors and program engagement in the effectiveness of a preventive parenting program for Head Start mothers. Child Development, 74(5), 1433, for a recent study with particular implications for Head Start programs.

Project SUCCEED in Head Start was an OSEP-funded demonstration project that developed and tested a parent-teacher training curriculum to assist adults working with young children with challenging behavior. While no significant differences were found in young children’s behavior between children whose parents and teachers had received the SUCCEED training and those whose caregivers had not, teachers who received the training reported decreased stress in their teaching role than those who had not, and parents who participated in training reported greater gains on a measure of family empowerment than those who did not. See the website for the project, which includes a downloadable version of the training manual and bilingual handouts, at www.rrri.pdx.edu/pgProjectSUCCEED.shtml.

Positive Behavioral Support is a pragmatic, flexible approach to helping young children with difficult behavior based on instrumental learning theory, functional behavior analysis, and humanistic psychology and philosophy. While stressing the need for understanding the role of the environment in governing children’s behavior, it allows for varied methods of assessment and intervention. See the website for the Research Training Center on Positive Behavioral Support at www.rtcpbs.org
To get more info on evidence-based practices, go to:

- Center for Evidence-Based Practices
  http://challengingbehavior.fmhi.usf.edu

- Rand’s Promising Practices Network
  http://promisingpractices.net

Both of these sites have information and links about evidence-based practices, the first specific to young children. Rand’s Network shows different programs having different “levels” of evidence, and can be searched by “desired outcome” or “social problem”. CEBP website has training and parent and staff resources as well.

Note that these are for classroom and direct service techniques: specific programs or curricula.
What is a Mental Health Consultant?

- We define a Mental Health Consultant as any professional providing mental health services to Head Start children and families, including:
  - Contracted private professionals
  - Other providers who are contracted to provide mental health screening, assessment, training, or service (e.g., public health nurses, social workers, etc.)
  - On-staff or salaried professionals who do more than simply coordinate MH services

“Consultant” in our terminology does not just mean external, contracted mental health professionals.
There are three primary pieces to the rest of today’s training. First, we will briefly review Best Practice Principles, what they are, especially applied to Early Childhood Mental health, and why they are important.

Second, we will talk about Program-Level Strategies for improving ECMH service models. We’ll address issues related to the consultant – what characteristics are important, what activities they should be doing, and how to structure their role in the program. We’ll also address the importance of staff development, training, and wellness.

Finally, we’ll talk about the importance of leadership: what you as program directors and managers can do to build a cohesive shared vision for your program that can guide you as you work to make improvements to your mental health program. Even if you have a great MH component, our assumption is that all programs can always improve, and this will help you think about a process for continual assessment and improvement.
Part I: Best Practices in Early Childhood Mental Health

Principles and Values for Best Practice in Early Childhood Mental Health

- Strengths-based
- Individualized
- Relationship-based
- Family-focused
- Preventative
- Inclusive
- Culturally competent
- Attentive to staff wellness
- Integrated/coordinated with other services
- Linked to community services

Please see detailed notes on the next page.
Principles and Values for Best Practice in Early Childhood Mental Health

**Strengths-based:** Services should build on the strengths, assets and positive attributes of children and families so that they will be empowered to meet their own needs.

*For example:* Staff should work with children with challenging behaviors by pointing out what is good or right, rather than focusing on problem behavior.

**Individualized:** Services should recognize and address the unique needs of an individual child across important life domains.

*For example:* Staff should structure classroom activities so that they meet the needs of different children. Adaptations should be made to reflect different children’s needs and personalities.

**Relationship-based:** “In order to ‘do’ the work involved in promotion of early childhood mental health, everyone connected to the work must themselves be able to engage in healthy relationships with those they seek to serve.” [Early Childhood Mental Health Best Practices Project, 2001]

*For example:* As we’ve stated before, healthy positive relationships are the foundation. Everything staff do should build positive relationships among all players.

**Family focused:** Services should be tailored to families’ strengths, needs, and priorities, and should actively involve parents.

*For example:* Parents should always be invited, and efforts made to ensure their attendance, at any meetings focused on planning for their child. Parents’ input about children’s behavior should be actively solicited.

**Preventative:** The primary strategies for children’s mental health should be focused on prevention of problem behavior through thoughtful planning, active engagement with children, and effective early intervention.

**Inclusive:** Services should be offered in the most ‘regular’ environment possible—rather than moving kids with special needs to “somewhere else”. Therapeutic classrooms present interesting conundrum—great for some kids because they can get specialized individual attention they need; problem is of course, putting all the “problem kids” together—no peers to model appropriate behavior. “Pull out” interventions probably much less effective than interventions that can be delivered in the context of the classroom.

**Culturally Competent:** Services should reflect awareness and respect for the racial, ethnic, and cultural background of families.

*For example:* Culturally appropriate materials, understanding of how topic of “mental health” is viewed differently in different cultures, etc.

**Integrated/COORDINATED WITH OTHER SERVICE COMPONENTS:** Mental health services and activities should be integrated into daily activities, not a “stand alone” component.

**LINKED TO COMMUNITY SERVICES:** A single agency will not be able to meet the diverse and complex needs of children with special needs; therefore successful programs rely on coordination among agencies and disciplines.
Why are Best Practice Principles Important?

- Research base is growing to support the importance of these principles (Simpson, et al, 2001)
- Our survey results found that programs in which staff reported higher levels of best practices consistently and strongly reported more effective mental health services.
- Best Practices contributed independently to outcomes, controlling for what consultants did and the amount of time consultants spent with the program.


Best Practices help to guide everything else a program does. In our research we found extremely strong, consistent relationships between staff and MH professionals level of endorsement of best practices and how effective they felt the programs were. Further, the more staff saw MHCs implementing services consistent with best practice, the more effective the programs seemed to be.
Family-focused: the more staff can involve parents, the more effective services are in reducing externalizing behavior.

![Diagram](image)

This figure shows the results of a typical path model of how our data support principles of best practices. The path between parent involvement and externalizing behavior is very strong, and statistically significant—the highest it could be is 1.0 and it is .75. Amount of MHC consultation is not related to either the level of parent involvement or the success of the program in reducing externalizing behavior. Similar results were found for other areas of best practices and for other child and staff outcomes.
Even programs that generally do a good job implementing services that are consistent with best practices sometimes falter when it comes to children with challenging behavior.

In part this is related to:
Lack of knowledge/skill – simply not understanding how these practices can be translated to problematic situations.

Beliefs and attitudes about MH: having a narrowly defined view of mental health and not being able to see approaches to mental health as family friendly and preventative.

**Lack of resources**—obviously, necessitates an emphasis on “efficient” systems.

Lack of collaborative systems—may not be a lot of other providers out there providing more intensive or alternative kinds of services. This is where open advocacy becomes important, and helping bring to your community the resources that are needed.
We’ll talk more about how to address challenges to implementing good MH practice later, but it is crucial to do this specifically around the issue of Best Practices.

**Lack of Knowledge**
- Improved staff development/training
- Better supervision and mentoring
- Find appropriate consultants

**Beliefs and Attitudes**
- Group discussions and training to identify and challenge negative or uninformed attitudes
- Provide incentives for implementing best practices
- Develop vision and cross-program commitment to change

**Inadequate Fiscal Resources**
- Explore resource sharing: training, curricula, etc.
- Make sure you’re getting “bang for your buck” with consultants
- Explore creative sources for resource expansion (e.g., collaboration with universities)

**Need for Collaborative Systems**
- Identify other providers
- Enlist their help in building a system
- Engage in community-wide MH planning

Identify the challenges specific to your program
- Develop and implement strategies to address these issues
- Provide clear guidance, roles and responsibility for making changes
Self Assessment:

Where is my program in terms of implementing best practices for children’s mental health?

18 questions from the national Head Start MH Services survey become a mini-assessment exercise, found on adjacent page.
Self-Assessment for Best Practices in Early Childhood Mental Health.

**Purpose:** A quick way to assess the extent to which you, as the program director or manager, think that your staff is implementing early childhood mental health services that are consistent with best practice values and principles. This is not a test, but a way to identify whether training or improvement in any of these areas is needed. Questions could also be asked of staff for their own self-assessment. Keep in mind that director’s assessments often differ from those of staff.

Answer the following as honestly as possible. Response categories:

- 2=Always true, no improvement needed.
- 1=Mostly true, some small improvements needed.
- 0=Mostly not true, significant improvements needed.

<table>
<thead>
<tr>
<th></th>
<th>Mostly Not true</th>
<th>Mostly true</th>
<th>Always true</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths-Oriented</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Staff are able to build on family and child strengths even when the family is facing significant challenges (e.g., substance abuse, mental illness, homelessness)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Individualized &amp; Comprehensive</strong></td>
<td></td>
<td></td>
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<tr>
<td>2. Staff are able to structure classroom and other activities to meet the needs of individual children.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Our program is able to provide a comprehensive array of services to support children who need different levels of support.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Relationship-Based</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Staff are able to build caring, nurturing relationships with every child and their family.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Staff use strategies in the classroom to help children to build positive relationships with each other.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Family-Focused</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. Parents of children with special needs regularly attend schoolings or service planning meetings.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. The program has a mechanism for communicating positive behaviors or events to parents.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Preventative</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. Our program focuses on implementing strategies to prevent problem behaviors from developing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. Staff spend more time working with and providing feedback to children who are showing positive behavior than they do dealing with children’s challenging behaviors.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Inclusive</td>
<td>Mostly Not true</td>
<td>Mostly true</td>
<td>Always true</td>
</tr>
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<td>--------------------------------------------------------------------------</td>
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<tr>
<td>10. Our program is able to meet the needs of all children inclusively, without removing children with special needs from the classroom.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11. Staff believe that children with challenging behaviors learn best in a regular classroom setting with age-appropriate peers.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Culturally Competent/Sensitive</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>12. Our program uses materials that provide images of and attention to children from a variety of cultural backgrounds.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13. Staff have an awareness of how their own thinking about “mental health” may differ from those of Head Start families.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Supportive of Staff Wellness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. The program provides staff with the training and professional support they need to do their job well.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15. The program provides staff with the emotional and personal support they need to do their job well.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Integrated</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>16. The program’s mental health curricula or services are integrated into all aspects of classroom activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17. Staff would agree that supporting children’s mental health is a part of everything they do.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Linked to Community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. The program has at least one strong partnership with a community mental health agency or organization.</td>
<td>0</td>
<td>1</td>
<td>2</td>
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</table>
Part II: Strategies to Improve Service Effectiveness

1. Mental Health Consultation
   1. Who should they be?
   2. What should they do?
   3. How should they interact with the program?

2. Staff Development
   1. Training
   2. Wellness

3 primary strategies:
- Work on consultation
- Work on staff
- Work on leadership and overall vision for the program

Improving consultation really means improving the role and function of whatever mental health professionals work with your program.
Strategies we focus on are embedded in an overall model (developed by us and our review of the research literature) that sees mental health outcomes as influenced by many factors, all of which need to be addressed in order to achieve the best outcomes. We only address selected elements of this model.

This training focuses on the “green boxes” --issues related to organization climate, culture, or mental health philosophy; program design; staff training & development; and practitioner characteristics, activities, & roles; all from the management perspective of program design and overall approaches to mental health.

Model visualizes steps to outcomes—to get to the top, you have to take each step and not skip any! If you skip thinking about any of the factors, your results will not be as good. For today, we’re focusing on the middle steps. The first two steps we’re assuming you know about. You also know more about the particular families and their characteristics, so hopefully the middle steps will be the right ones to get you to where you need to be.

This training works backward in this model, starting with consultation. Then, we’ll briefly address staff development issues, and give you resources for where to go for more information about specific staff training and strategies for in-class interventions. Finally, we’ll talk about the importance of leadership and what you as a program leader can do to start effecting change in your mental health program right now.
Outcomes flow from interactions of People X Structure X Activities

Example Head Start


Another way to see the model: programs are part of a larger environment, have a culture of their own, and outcomes flow from interactions between people, structure, and organizational activities.

Animation:
Activities= processes, “how things get done around here”
People= “the cast of characters”
Structure = formal & informal arrangements of people & activities
Describe your own Mental Health Consultant(s):

- What are their characteristics (education, competencies, background)?

- What do they do with or for your program?

- How would you describe their role in your program? How is their relationship to the program, staff, and families created and experienced?

Take a few minutes to think about the mental health professionals that you work with in your program. Jot answers down in the space below. We’ll come back to these lists on slide #90.
Strategy 1: Improve Mental Health Consultation

- Who is your consultant?
- What do they do?
- What is their role in the program?

The first set of strategies that we are going to talk about is focused on improving the quality of mental health professional consultation in your program—remembering that consultants doesn’t have to mean “consultants”!
Surprisingly *un*-important about MH consultation:

- Hours of MH consulting time per child
- Percent of budget spent on MH
- Size of Head Start program
- Urban, suburban, or rural setting
- Ethnicity of families or staff
- Credentials of consultant (type of professional, education completed)

Before we talk about what is important, we want to note what our research found to be solidly, statistically UN-related to reports of program effectiveness!
Who is Your Mental Health Consultant?

“Consultation will be effective in bringing about change only when staff believes that the consultant understands the problem, perceives the need for action, and provides support to staff in carrying out the desired change.” To do this, consultants must have:

– Warmth
– Empathy
– Respect

(from Cohen & Kaufmann, pp. 17-18)

What our research says about who the consultant should be:

– Experienced with young children
– Experienced with Head Start population
– Understands Head Start approach: Integration of service components, parent involvement, family centered, holistic approaches
– Ability to make long-term commitment to working with the program
  – Develop relationships with staff and parents over time
“Key Competencies” for MH Consultants suggested by Cohen & Roxane Kaufmann

- Knowledgeable about a variety of intervention strategies
- Knowledgeable about child development
- Knowledgeable about family systems
- Observation and communication skills
- Organizational skills
- Understands a holistic, best practice approach to children’s mental health
- Able to integrate mental health activities and philosophies with other preschool components
- Understand low-income families, cultural differences, and group dynamics
- Sensitive to community’s attitudes towards mental health issues
- Knowledgeable about community resources
- Able to honor diverse perspectives and facilitate communication

Our list of “what is important” based on our research meshes nicely with lists of key competencies suggested in the literature.

Cohen, E., & Kaufmann, R. (2000). Early Childhood Mental Health Consultation. Washington, DC: Center for Mental Health Services, SAMHSA, US Dept. of HHS. (Available by calling National TA Center for Children’s MH at Georgetown University Child Development Center, phone Mary Deacon at 202-687-8803 or e-mail deaconm@georgetown.edu)
Who the consultant should be, continued

- MHC understands and provides services consistent with “best practices”—able to model and teach this approach
  - Especially important:
    - MHC sensitivity to cultural issues
    - MHC ability to involve parents

- These factors were important to outcomes even controlling for amount of time consultants spent per child.

The extent to which mental health consultants’ were perceived by staff to provide services consistent with best practices was important to outcomes. All best practices were important, but only culturally competent practice and parent involvement contributed variance once the degree of other practices and the type of consultant activities were held constant. [In research speak, these two continued to add additional variance to outcomes after levels of other best practices were controlled.]

We found limited resources and information related to how to develop cultural competency/sensitivity in mental health consultants specifically. Mental Health obviously an issue that carries different significance in different cultures, different behaviors are more or less problematic in different cultures, yet often the literature advocates simplistically that the MHC share the ethnicity of the children.

MHC’s Best Practices and their strong relationships with staff were important OVER AND ABOVE the amount of consultation provided per year or per child.
The more culturally sensitive the MHC is, the more effective services are in increasing positive behavior.

This figure shows the results of another path model. The path between MHC cultural sensitivity and prosocial behavior is very strong, and statistically significant. Amount of MHC consultation is not related to either the level of cultural sensitivity or the success of the program in promoting prosocial behavior.
MHC sensitivity to cultural issues

- Consultants typically are not of the same racial/ethnic or socio-economic background
- MHC could engage in cultural sensitivity/diversity training provided to all staff
- Consultants should make opportunities to talk with teachers & parents about cultural differences as they play out in children’s behavior & its interpretation

Resource: *Cultural Competence in Early Childhood Mental Health* (2002) by Koroloff, Parks, McLeod, and Steltzer at PSU RTC


This report summarizes and synthesizes over 50 articles related to cultural competence in children’s mental health. It is organized as a review and annotated bibliography, and is a great resource for becoming informed with current research and practice related to this issue. In particular, two articles reviewed can be used as tools for a program to conduct an agency-wide cultural competency assessment, one of the first strategies we recommend to program directors.


Particularly Important: MHC must be able to successfully involve parents

- **Research finding:** Having consultants who were seen by staff as better able to involve parents in a child’s MH issues was important to child outcomes

- **Examples of involving parents:**
  - Meet with parents
  - Do home visits
  - Parents know the consultant by name
  - Parents trust the MHC
  - Talk with parents at drop-off and pick-up
  - Attend policy council meetings
  - “for many mental health professionals, this less-confined role can be a welcome break from the more formal constraints of therapy” (Paul Donahue)

- **Resource for improving MHC ability to involve parents:** *Mental Health Consultation in Early Childhood*, by Donahue, Falk & Provet (2000).

This book by Paul Donahue is also a great overall resource for any consultant to own and read. Uses case stories and clinical discussion to describe ideals and achievements in consultative relationships with early childhood programs.

Involving parents provides a holistic, family-centered approach

- Consultants may also provide support to parents in their mental health issues
- Strong links found between parents’ mental health and that of their children
- To get to positive child outcomes, parent mental health must be addressed
- May need different resources/techniques for adult mental health issues—same consultant may not be appropriate

Now we’ve talked about WHO the consultant is and what kinds of expertise s/he should have. Now, let’s talk about WHAT the MHC does. We can distinguish two types of activities.

**MHC Activities: Two Types of Service**

- **Program Level Consultation includes:**
  - Formal and informal training of staff and other staff development activities
  - Meeting with staff
  - Participating in management team processes
  - Supporting staff wellness

  Goal of this kind of consultation is to improve general program quality and/or to help the program address broad issues that affect more than one child, staff, or family member.

- **Individual Level (Child- or Family-Centered) Consultation includes:**
  - Assessment and screening of individual children
  - Direct service to specific children or families to ameliorate specific issues or concerns
  - Working with staff to develop IEPs
  - Making referrals work for family or staff

  Goal of this type of consultation is to develop a plan to address the functioning difficulties of a particular child (and/or family) in home and/or or early childhood setting.
A model for promoting children’s social-emotional development and preventing challenging behavior (adapted from the Center on the Social and Emotional Foundations for Early Learning).

Same model presented before, but the point here is that psychopathology-oriented, individual-level consultation typically only impacts one part of the triangle. Program Level consultation impacts and supports the whole thing.
Programs with higher levels of program-level consultation have more positive staff and child outcomes. Programs with higher levels of individual consulting have more positive child outcomes, but less positive staff outcomes.
Another reason that program level consultation may be important for positive child outcomes is that it may lead to earlier identification and referral for problems—a stronger prevention orientation. As staff become more knowledgeable, they can intervene sooner or seek additional supports sooner.

Staff outcomes include staff wellness and extent to which staff report higher levels of “best practices”.
These are the average scores for the extent to which staff rated the mental health services as helpful in reducing externalizing behavior and supporting staff wellness. As can be seen, the lowest average scores were for programs with low individual and low program level consulting. But for programs Externalizing Behavior, outcomes are equally positive for Externalizing behavior (a child outcome) no matter what other types of consulting the program has. For staff wellness, Individual level consulting has scores equal to programs low in both; programs with high program consulting, regardless of the level of individual consulting, have more positive staff wellness outcomes.
Understanding Pathways to Outcomes

- Why does program level consulting support staff wellness AND individual outcomes?
- Why does individual-level consultation have positive benefits for kids, but fewer benefits for staff?

Program level consultation may also help by enabling staff to do a better job identifying problems early and doing more prevention and early intervention, rather than waiting until serious problems emerge.

Break with self-assessment: What Kinds of Services Does Your MHC Provide?
Working with A Consultant: What is Important?

- Integration of consultant into program functioning is key to effective consultation

- What is an “integrated” MHC?
  - Positive MHC-staff relationships
  - See MHC as ‘part of the team’
  - See MHC as a resource who is available and accessible to answer questions and support staff
  - Integrated consultants reported higher levels of activities of all types compared to consultants who were less well-integrated (even when hours provided were the same) — “get more for your money”
  - Integrated consultants can be on-site salaried staff OR contracted consultants—no one profile
Why is Integration Important?

– “First, it directly helps the children;
– Second, it serves as a quality improvement strategy for the staff;
– Third, it provides a concrete way for Head Start to operationalize its commitment to early intervention and prevention” - Jane Knitzer, NHSA Dialog

- Integration supports all kids, rather than just a few
- Our research suggests that programs with more integrated consultants had:
  1. Higher levels of best practices
  2. More positive outcomes for children
  3. More positive outcomes for staff

MHC-Staff Relationships are KEY

“When the interactions between a mental health consultant and a child care professional are characterized by trust, warmth, and respect, there are opportunities for growth and learning in both individuals. More important, good relationships between providers help to create a positive, supportive environment for all children. This allows the entire group to reap the benefits of a ‘classroom with good mental health’”  Collins et al, 2003

What can you do next week or next fall to support integration of your MHC?
### Do’s and Don’ts for Integrating MHCs

**DO**
- Ask your MHC to provide regular training to staff
- Ask your MHC to visit classrooms frequently
- Provide staff with guidance around how to contact the MHC if needed
- Ask your MHC to meet with staff regularly and informally to provide suggestions about particular children and general strategies for supporting children
- Consider asking your MHC to participate in management team processes

**DON’T**
- Don't put up too many barriers or gatekeepers to staff direct access of MHC
- Don't hire “rotating” MHCs, try to develop a long-term relationship with one or more consultants
- Don't limit your consultants role to providing child-focused direct service (e.g., child or family assessments, therapy).

**DO**
- Involve your MHC in helping to develop a formal mission statement related to children’s mental health
- Involve your MHC in supporting staff wellness
- Make sure parents know the MHC: ask him/her to provide parent trainings & orientation, and having the MHC attend Head Start events, Policy Council meetings, etc.
- Make sure your MHC has an attitude of partnering with staff and families
- Try to have a salaried staff person who provides mental health services

**DON’T**
- Don't assume your MHC knows what is expected of him/her in terms of supporting staff and parents: be clear about roles
- Don't assume staff understand how to interact with the MHC: provide training and guidance
- Don't give up! Remember, relationships and activities matter more than hours and dollars spent!

Use as a checklist. How many of these things does your program currently do? What could you do to implement some of these ideas?
Some Ways to Achieve Integrated Models of Consultation with Efficiency

See also “Lessons from the Field” by Yoshikawa and Knitzer 1997; http://www.nccp.org/pub_mhs97.html

- Entry-level mental health professional provides service with supervision by a licensed professional (e.g. interns, other unlicensed professionals)
- Consultant provides training to all staff members in basic mental health skills (observation, assessment, crisis and other intervention skills, etc)
- Staff do screening and bring in consultant for specific children, work with consultant on overall classroom issues
- “Consultant” is a salaried member of the Head Start staff
- Programs hire “mental health aides” especially for working with minority and non-English speaking families

Supplemental Slide

Collaborating with health care providers to maximize the use of Medicaid funding for mental health consultation, including state-level collaborations:

- In Maine, Head Starts are designated Medicaid-reimbursable preventative health programs
- Collaborate with child-focused mandated programs (IEP, IFSP, IDEA, EPSDT)

- Identify certified and licensed mental health professionals (e.g. American Association for Marriage and Family Therapists) to volunteer to HS program as staff supervisors or MH providers

- Pooling resources across Head Start and EHS programs within communities

- Using well-supervised psychology or social work interns (can have drawbacks in terms of longevity and consistency)

- Work with other early childhood programs and advocates to enhance the early childhood system of supports

Supplemental Slide
Strategy 2: Staff Development

- Training
  - supports more desirable outcomes

- Staff Wellness
Provide both formal and informal training opportunities

- More opportunities for training = more Best Practices, more supported staff, better Child Outcomes
- Formal training opportunities in particular linked to child outcomes
  
  “Manuals alone do not produce positive change unless they are coupled with peer support or consultant strategies to reinforce the lessons…What works best for [HS programs] is having access to ongoing on-site consultation from mental health professionals.

  Further, these consultants have a clear mandate to work with staff, giving them the tools to work more effectively with the full range of young children in the program (and their families).”  

  - J. Knitzer, NHSA Dialog

In our study, staff who reported more total opportunities for training and professional development (whether through formal training or informal conversations and sharing with other staff) reported higher levels of best practices and felt more supported in their work.

However, staff who reported more formal training opportunities also tended to report more positive child outcomes (number of informal training opportunities was not related).

These are the average scores for the extent to which staff rated the mental health services as helpful in reducing externalizing behavior and supporting staff wellness. As can be seen, the lowest average scores were for programs with fewer formal MH training opportunities, both for externalizing behavior and staff wellness. Similar results were found for training’s impact on implementation of best practices, and other child behavior outcomes.
Use your MHC as an in-house training resource

- In our study, 75% of consultants said they provided formal trainings for staff
  - Of these, 2/3 trained 1-2 times per year
  - 1/3 trained monthly or more

- Consultant time supporting staff pays off for staff wellness and child outcomes

- “Consultants provide opportunities for staff to speak together honestly about the problems that they face…Consultants make the hallway conversations and frustrations part of the public dialog about the emotional, mental health, and behavioral needs of children and families, and thereby legitimize the struggles of staff”.  
  - Jane Knitzer, NHSA Dialog

In programs where consultants spent more time providing professional support to staff, staff also reported feeling more supported in their work.

Suggested Training Topics

- **For Direct Service Staff:**
  - Strategies for supporting positive social/emotional development
  - Positive strategies for dealing with challenging behaviors
  - Conducting and using individualized screening tools
  - How to observe children to promote early prevention and intervention for problem behaviors
  - How to talk to families about mental health issues
  - How to collaborate with mental health providers

- **For Mental Health Consultants:**
  - All of the above, plus:
  - Child development, specifically 0-5
  - Parenting and parent involvement
  - How to conduct and use individual and classroom assessments on young children in Head Start environments
  - How to collaborate with early childhood/child care providers
Resources for Staff Training

- “Train the Trainer” guide with all handouts and materials: Promoting the social-emotional competence of young children, available on-line at:
  - [http://csefel.uiuc.edu](http://csefel.uiuc.edu)
  - 4 modules—
    - Classroom preventive practices
    - Social-emotional teaching strategies
    - Individualized intensive interventions
    - Leadership strategies

- Upcoming regional trainings sponsored by the Center for Evidence-Based Practice:
  - [http://challengingbehavior.fmhi.usf.edu](http://challengingbehavior.fmhi.usf.edu)

Upcoming regional trainings sponsored by the Center for Evidence-Based Practice:
http://challengingbehavior.fmhi.usf.edu

With many co-sponsors, the Center For Evidence-Based Practice is conducting a national conference on responding to challenging behavior in Clearwater, Florida on April 1-3, 2004. We believe they will announce on their website more on the regional curriculum and training opportunities after that date.
Consider Gallup’s Q\textsuperscript{12}© to begin. 12 questions in the appendix.

These are an easy, fun way to assess staff involvement and commitment quickly. Each employee is asked to rate their response to each question on a scale of one for “weak” to five for “strong” agreement, then average scores per work team can generate a clear picture of what to work on first. **The beauty of these 12 expectations is that any team of supervisor & staff can remedy them starting immediately.** "We need to incorporate the needs that are expressed in the 12 questions into our personalities as leaders," said one retail chain’s general manager.

Gallup’s researchers interviewed thousands of workers in all kinds of organizations, at all levels, in most industries and in many countries. (3.16 million employee database) From these inquiries researchers pinpointed, out of hundreds of variables, 12 key employee expectations that, when satisfied, form the foundation of strong feelings of engagement.

Results have shown a strong link between high survey scores and worker performance. Of course, this correlation is not new. *It has been discussed in general terms by managers for decades.* The Gallup method differs by creating a methodology that bridges the "soft" values that pertain to worker morale and employee engagement, such as recognition and desire to contribute, with "hard" and measurable outcomes. High scores, in controlled experiments, are strongly predictive of measures of productivity, loyalty, happiness of home life, customer engagement, and other desirable outcomes —talk about evidence-based!
Part III: Leadership Role

- Developing Shared Vision
- Directors: Actions to take
Recipe for Effective MH Program Is *More Than* Assembling Good Ingredients:

- Best Practices
- Qualified MHC
- Well Trained and Supportive Staff
- Involved Families
- Curricula
- Screening and Assessment

Various mental health-related services *may* be part of a great program, but our evidence says they are not enough, in and of themselves, to get positive results.

Instead…

Program recipe “ingredients” must be combined with a *purpose* in mind, envisioning the whole “pie” you are creating all the time.

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**Supplemental Slide**

April 2004
What Supports Strong MH Programs Is:

- Developing a clear mental health vision or planned approach that is shared throughout organization
  - Provides a **purpose** for enlisting services of MH professionals
  - Provides clearly understood goals and outcomes for mental health services and approach.
  - Provides common ground for everyone to see their role in supporting positive outcomes for children and families.

What proportion of your staff would strongly agree?

✓ Program leadership has a clear vision of how children’s mental health issues are related to all program components.

✓ Our program has a written philosophy or approach about how to provide children’s mental health services.

After some have ventured a guess, explain that in our study strong agreement with these two statements was the indication of a strong mental health “common vision”, which led to many positive outcomes.
Comparison of Program Findings to National Data

- **Program leadership has a clear vision of how children’s mental health issues are related to all program components.**
  - 53% of staff nationally strongly agree
  - 71% of staff at the strong programs

- **Program has a written philosophy or approach to providing children’s MH services.**
  - 68% of staff nationally strongly agree
  - 80% of staff at the strong programs

Only about half of total staff surveyed strongly agreed with these statements, on average, so don’t despair if you suspect only a small portion of your staff would strongly agree.
Why is shared vision important?

Survey results found that programs with greatest agreement about mental health services and goals and with a shared approach to children’s mental health also had:

- Higher levels of “best practices”
- Better perceived outcomes for children and staff

Statistically significant associations = not just a chance result from variation in program respondents. Small differences in the average level of agreement with various statements for each program, for example an average of 3.2 for 8 people in one program versus another program’s mean of 3.6 from 9 staff, were nevertheless able to be considered significant, when analyzed mathematically, as indicating real differences in the average agreement with various outcome statements in the survey. Stems from sample size of 8 per program and from number of programs over 70.
Before you begin to think about “shared vision” remember: Staff/Management perceptions often diverge

<table>
<thead>
<tr>
<th>“Strongly agree” with items:</th>
<th>ADMIN</th>
<th>DIRECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant is experienced</td>
<td>78%</td>
<td>66%</td>
</tr>
<tr>
<td>MHC has good relationships with staff</td>
<td>73%</td>
<td>56%</td>
</tr>
<tr>
<td>MHC is available</td>
<td>45%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Experienced in this case means experience working with young children ages 3,4,5 and their parents.

While administrators generally view their organizations more positively than direct staff, we had some items when staff were more positive about a program than the administrators. The point here is that each group experiences a different perception, so deciding upon a problem and searching for solutions MUST have full staff involvement or activities won’t match needs.
Our study was certainly not the first to find such a divergence. For even more program-wide examples, look at the adjacent page of graphs from Paula Jorde Bloom’s research at National Louis University’s Center for Early Childhood Leadership.


While next two graphs are from a previously published source, as noted, our source was the book *Circle of Influence*. Many other useful insights are found in *Circle of Influence*, relevant to “how to” undertake some of our leadership recommendations in the area of involving staff in creation of mental health program design and philosophy.
A Comparison of Directors' and Teachers' Perceptions of the Organizational Climate of Their Centers


Agreement with Statements About Decision Making: A Comparison of Directors' and Teachers' Responses

Some signs of a clear, shared vision:

- Written mission or vision statement stresses healthy psychosocial growth
- Phrases from it are used in everyday conversation around the organization
- If an outsider asked what the goals of “the MH program” are, many staff would “talk the talk” and be able to answer

Interactive flip chart exercise: list signs exhibited by different organizations represented in the training. Will learn from each other how to “know” when you have a strong vision.
So, how do I begin to develop a vision and a plan for action?

Step 1:

1. Make the commitment and provide *leadership*

- Set a positive tone about potential
- Support for the MH team – include time, training & TA, $
- Facilitate reinforcing personal experiences for all staff
- Recognize risk-takers, experimenters

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Source was a published training available in .pdf from the Center on the Social and Emotional Foundations for Early Learning – University of Illinois at Urbana/Champaign

csefel.uiuc.edu :

**Promoting the Social-Emotional Competence of Young Children, Facilitator’s Guide**
Module 4: Leadership Strategies for Supporting Children’s Social and Emotional Development and Addressing Challenging Behavior
The Importance of Program Leadership

- Strong mental health leadership. Persons in leadership roles should:
  - Have a clear vision of integrated mental health services
  - Facilitate a shared vision across staff for how to approach mental health issues
  - Facilitate implementation of “best practices” in early childhood mental health
  - Provide support to staff for training re: mental health
  - Advocate for additional resources for MH and seek creative solutions to meet the need for an integrated MH professional

High integration programs were much more likely (27% vs. 37%) to have other sources of their funding for MH, beyond core Head Start funding. They were also more likely to bring their MH consultant in-house, even though they did not spend a higher % of budget on MH component.
This model shows a “mediation” effect in a path model. What this means is that the primary effect of MH Leadership on Reducing Externalizing Behavior is due to its tendency to increase the Level of Integration of the MHC. In other words, leadership that has a strong vision for MH and advocates for good MH practices creates an environment in which the MHC is seen as more a part of a team. That integration, in turn, promotes positive outcomes. These effects were seen for other child outcomes as well. Again, the level of MHC consultation per child was unimportant to outcomes.
Step 2: Broaden Participation in Developing Vision

2. Set up egalitarian **team** of stakeholders

- Small group of teachers, admin, parents, MH professionals etc.
- Collaborative decisions by members who feel **equal**
- Generates wide exploration of new ideas
- Generates **ownership**

Mental Health Is Everyone’s Responsibility (Wide Ownership)

- **Horizontal Management style**: staff members, teachers, directors, support staff work together, with parents, to address children’s needs: more team meetings to share ideas, more inclusion of directors and consultants in supporting individual teachers and children, fewer barriers in teacher access to consultation.

- Lara, McCabe, and Brooks Gunn (2000) report that teachers in Head Start programs reflecting this type of management style cope better with children’s behavior problems.
Resources for collaborative/participatory/consensus management practices

- **Circle of Influence** by Paula Jorde Bloom (2000)
- **Web of Inclusion** by Sally Helgesen (1995)
- **Blueprint For Action** by Bloom, Sheerer, & Britz (1992)

Circle of Influence – Structure and philosophy or management style considerations aimed at managers.
Web of Inclusion – For those who learn well by stories interspersed among key concepts.
Blueprint for Action – Precise actions to take to conduct staff development activities to achieve center-wide change.
Step 3: Stakeholder Training

3. Make sure team is well-trained

- Understands EC Mental Health issues
- Understands Best Practices
- Has Knowledge of Evidence-Based Strategies

Step 4: Develop Agreed Upon Goals & Outcomes

1st team decision = Outcomes to strive for

- Written vision of an imagined future
- Guides work and direction of stakeholder team
How to Begin Talking about “Goals” and “Outcomes”

- How would you know if your MH program was “working” well?
- What changes would you see in children, families, staff, your overall program?
- Don’t worry about “measurable outcomes” at this stage

What indications of success would reveal changes in “how things get done around here”?

Consider List of Better Outcomes from Our Study, When Shared Vision Exists:

- Child & Classrooms:
  - Reduced aggressive behavior
  - Reduced destructive behavior
  - Increased pro-social behavior
  - Increased Positive social interactions between children
  - Increased Age-appropriate emotional regulation
  - Smoother transitions between activities
- Staff:
  - Feel supported in their work
  - Feel less stressed
  - Have access to someone who can help them with specific problems or issues
  - Successfully implement best practices and evidence based strategies

Supplemental Slide
Step 5: Assess Current Situation vs. Ideals

2nd team decision = Assess What Needs to Change

- How well does current situation compare to vision?
- Need for change = discrepancy between desired outcomes & current ones
Compare Actual to Ideal:

- Knowledge/Acceptance of ECMH Best Practices [Based on Self-Assessment]
- Mental Health Consultant: [Go back to slide #35-Describing your MHC]
  - Who are they?
  - *What do they do?
  - *How do they work with the program?
- Staff:
  - Training
  - Wellness
- Program:
  - Cohesive Vision and Understanding of Mental Health Approach
  - Leadership & Advocacy

*We have seen a few MH consultation contracts, and there is little indication of purpose of services—just number of hours, types and timing of reports, on-call availability and rates, contingency if child-emergencies arise. It seems like the contracting process is one place to begin a relationship focused on outcomes and effective activities.

(One of our early training participants immediately said: “I am going to create an IEP for my mental health consultant!”)

Who are they? Checklist of things to look for in a mental health consultant is on page 17 of Cohen & Kaufmann, *ECMH Consultation* (2000) and it can be recommended here.
Step 6: Identify Barriers to Achieving Goals

3rd team decision = Identify Barriers

- Knowledge
- Experience
- Beliefs & Attitudes*
  - (Changed by Learning & Experience)
- Policies
- (Access to resources)
- (Finances)

Even if resources/finances are perennial barriers, don’t assume no improvements can begin. Consider limited resources a fixed reality and begin work there. Stories from low-resource community action program in rural Oregon and others.

*Beliefs and Attitudes: One example—There may be a need to address the self-reliant ethic of preschool teachers, who tend to be resourceful and creative, so “If I need to ask the MH consultant what to try, I must be bad at my job.”
Step 7: Strategize & Plan Next Steps

4th, Team plans around challenges by choosing next steps

- Small steps that are easy to track
  - What can be done to go past barriers? (objectives)
  - What contexts could circumvent challenges? (strategies)
- Measurable goals & objectives (smaller than the ultimate vision)

Step 8: Periodically re-evaluate the changes …

- Are actions planned?
- Is there follow through?
- Do changes lead to the expected outcomes?
- Are there unexpected outcomes (positive or negative)?

...then plan some more action.
Three reasons change fails

- Insufficient staff input into goals and improvements chosen—does not meet needs and beliefs of staff
- Change was viewed too narrowly—didn’t take a systems approach
  - Solely change the MH consultant
  - Simply add more consult hours per year
  - Do “one-shot” trainings
- Didn’t take the long view—change typically happens over time, can’t do everything at once.

--- Parkay & Damico (1989)---

1. Example of first cause of failure: Staff continuing to have unmet problems with individual children will never be interested in a prevention course of action & proactive philosophy until they experience success with that child, so goals and improvements must be incremental and start small.

2. Stress our research again showing that the integration of the MHC leads to staff reporting more positive outcomes consistently.
Summary of Steps for Building and Acting on a MH Vision

1. Make the commitment and provide leadership
2. Set up a team of stakeholders to formulate the vision and plan
3. Make sure the team is well-trained in MH best practice principles & evidence-based strategies
4. Agree on desired outcomes
5. Assess what needs to change
6. Identify barriers to achieving goals
7. Plan strategies to overcome barriers and achieve goals
8. Re-evaluate progress regularly

Source for exercise that follows on next page:

*Blueprint For Action: Achieving Center-Based Change Through Staff Development* by Paula Jorde Bloom, Marilyn Sheerer, & Joan Britz (1998, revised.) New Horizons: Lake Forest, IL (Distributed by Gryphon House, Inc.)
Clarifying a Vision

Write a dozen or so words or phrases that describe your ideal program. Now take those words and phrases and weave them into a short statement of your vision of what you would like to see your program become in three to five years. While your vision statement will have elements of your ideal, it should also be based in reality.

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My vision of what our mental health program could look like…

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____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Adapted from: 

Blueprint For Action: Achieving Center-Based Change Through Staff Development by Paula Jorde Bloom, Marilyn Sheerer, & Joan Britz (1991) New Horizons: Lake Forest, IL (Distributed by Gryphon House, Inc.)
Recommendations & Conclusions

1. Have a vision, and preferably a written vision statement, specific to children’s mental health
   - Reflects best practices
   - Developed with complete staff input
   - Shared and understood by all staff and consultants

Recommendations, continued

2. Ensure Adequate Mental Health Services from a Qualified Professional
   - Experienced with HS populations and well-versed in HS philosophy:
     - Parent Involvement
     - Cultural Sensitivity
   - Understands and implements “best practices” in ECMH
   - Activities and role structured to maximize integration into day-to-day program functioning
   - Have MHC provide “program-level” consultation to support staff and maximize efficiency
Recommendations, continued

3. Provide both formal and informal training opportunities for staff to learn about best practices and evidence-based strategies in ECMH
   – Work collaboratively with other providers to maximize training resources

4. Support staff development and wellness to facilitate child well-being

Recommendations, continued

5. Be a strong leader and advocate for early childhood mental health in your program and community.
   – Focus on importance of ECMH/social emotional development for school readiness
For More Information

- Beth Green: green@npcresearch.com
- RTC website:
- Upcoming article in *National Head Start Association (NHSA) Dialog: A Research to Practice Journal*
- Manual will always be available on RTC website as .pdf file
APPENDIX C

The Head Start Mental Health-Related Performance Standards


Federal Register, Vol. 61, No. 215; Tuesday, November 5, 1996; Rules and Regulations; p. 57212.

1304.20 Child health and developmental services ....(b)

(b) Developmental, sensory, and behavioral screening. (1) In collaboration with each child’s parent, and within 45 calendar days of the child’s entry into the program, grantee and delegate agencies must perform or obtain linguistically and age appropriate developmental, sensory, and behavioral screenings of motor, language, social, cognitive, perceptual, and emotional skills (see 45 CFR 1308.6(b)(3) for additional information). To the greatest extent possible, these screenings must be sensitive to the child’s cultural background.

(2) Grantee and delegate agencies must obtain direct guidance from a mental health or child development professional on how to use the findings to address identified needs.

(3) Grantee and delegate agencies must utilize multiple sources of information on all aspects of each child’s development and behavior, including input from family members, teachers, and other relevant staff who are familiar with the child’s typical behavior.

Federal Register, Vol. 61, No. 215; Tuesday, November 5, 1996; Rules and Regulations; p. 57216.

1304.24 Child mental health

(a) Mental health services. (1) Grantee and delegate agencies must work collaboratively with parents (see 45 CFR 1304.40(f) for issues related to parent education) by:

(i) Soliciting parental information, observations, and concerns about their child’s mental health;

(ii) Sharing staff observations of their child and discussing and anticipating with parents their child’s behavior and development, including separation and attachment issues;

(iii) Discussing and identifying with parents appropriate responses to their child’s behaviors;

(iv) Discussing how to strengthen nurturing, supportive environments and relationships in the home and at the program;

(v) Helping parents to better understand mental health issues; and

(vi) Supporting parents’ participation in any needed mental health interventions.

(2) Grantee and delegate agencies must secure the service of mental health professionals on schedule of sufficient frequency to enable the timely and effective identification of and intervention in family and staff concerns about a child’s mental health; and

(3) Mental health program services must include a regular schedule of on-site mental health consultation involving the mental health professional, program staff, and parents on how to:

(i) Design and implement program practices responsive to the identified behavioral and mental health concerns of an individual child or group of children;

(ii) Promote children’s mental wellness by providing group and individual staff and parent education on mental health issues;

(iii) Assist in providing special help for children with atypical behavior or development; and

(iv) Utilize other community mental health resources, as needed.
Assessing Staff Involvement in Organizational Life

Q12 ©Gallup Employee Engagement Measure

People who respond to these questions with “yes” or “mostly yes” have been shown, in over 3 million surveys at thousands of organizations, to be more productive, more client-driven, to quit less often, and to be happier and more satisfied in their work and family.

All of these items are within the power of any manager or supervisor and their team to begin improving immediately, once the core problems have been identified. For more information, see: http://gmj.gallup.com/

1. Do you know what is expected of you at work?
2. Do you have the materials and equipment you need to do your work right?
3. At work, do you have the opportunity to do what you do best every day?
4. In the last seven days, have you received recognition or praise for doing good work?
5. Does your supervisor, or someone at work, seem to care about you as a person?
6. Is there someone at work who encourages your development?
7. At work, do your opinions seem to count?
8. Does the mission/purpose of your company make you feel your job is important?
9. Are your associates (fellow employees) committed to doing quality work?
10. Do you have a best friend at work?
11. In the last six months, has someone at work talked to you about your progress?
12. In the last year, have you had opportunities at work to learn and grow?
I believe that the quality of the relationships among all the people involved in an infant/family service is key to its effectiveness. My approach to organizational design is derived from my experience as an administrator in a Family Service Agency, in particular my experience administering a Child Development Center comprised of primary prevention, clinical, and consultative services, including a therapeutic nursery-kindergarten. My experiences as a clinician working with families and their young children, as an educator, and as a consultant have formed the approach which I call Relationship-based Organizational Design.
Much has been written about the content and scope of services for infants, toddlers, and their families, and about the supervision necessary to support infant/family practitioners. This article is about the organizational model best suited to support the provision of relationship-based services to families with very young children. It discusses principles and structural components of relationship-based organizations, stages in the development of an organization's infrastructure, the roles of leaders and supervisors, and the theoretical grounding for relationship-based organizational design.

**Defining principles of relationship-based work**

In my consulting work with organizations, I have identified seven principles of relationship-based work that can be applied to direct service staff, supervision, and the development of an organization. The principles that I enumerate should not be espoused in order to form a more loving work place. The goal is, rather, to make sure that an organization's "way of doing business" supports the smooth and efficient functioning of the services dictated by the organization's mission. There is a definite parallel between the relationships that line staff form with families and their children and the relationships that staff form with administrators and support staff of the organization.

1. **Respect for the person:** This principle implies acceptance of the whole person, with his or her strengths and vulnerabilities. It makes getting to know staff a priority for managers. With respect for the person and for teams of people comes, predictably, awareness of differences of opinion. These are best resolved in a forthright manner, or they fester and undermine service delivery.

2. **Sensitivity to context:** A person must be understood as influencing, and being influenced by, his or her environment. A worker in a high-risk setting, for example, will be affected by the ongoing risk of violence.

3. **Commitment to evolving growth and change:** Organizations dedicated to promoting the healthy development of young children and their families need also to be committed to acknowledging and promoting the development and growth that are possible in staff. A common implementation of this principle occurs in setting and reviewing supervisory goals. Developmental theory is applicable here.

4. **Mutuality of shared goals:** Staff relationships are most profitably rooted in shared goals for families and children, for programs, and for departments and divisions. Sharing and communicating goals is an ongoing process that occurs throughout the organization.

5. **Open communication:** The organization puts in place clear channels and forums for discussion of the work with colleagues and team members. All established arenas for communication are used regularly and consistently.

6. **Commitment to reflecting on the work:** Supervisory time is set aside regularly to discuss the relationships formed with families as well as relationships with colleagues.

7. **Setting standards for staff:** All staff learn and grow. The values and ethics of the various professions involved in the organization's delivery of quality services are modeled, highlighted, and shared with all staff. These standards then become the ideals toward which all staff can strive.

**The mission statement**

A clear mission statement that is understood and accepted by board and staff is a key component of a relationship-based organization. Each organization has its own mission statement, most usually crafted by the organization's founders. Mission statements are most valuable when they articulate clearly the values and purposes of the organization.
It is essential for board, staff, directors, and supervisors of an organization to share an ongoing understanding of and commitment to the mission. Without such ongoing understanding and commitment, the organization is vulnerable to temptations to wander far from its mission. Seductions are frequently related to changes in funding streams (drying up or beginning to flow). An example of this would be a request for proposals for two-year demonstration programs to provide a prescribed set of services to a narrowly defined population of children and families. As a result of such short-term "opportunities" often the result of fairly hasty state or federal legislation organizations and, more importantly, vulnerable families, not infrequently find themselves "seduced" into involvement, only to be "abandoned" when funding is not renewed.

Excitement about a new research finding or intervention approach can also become translated into overly simplistic services for families. (Remember the Doman-Delacato "patterning" techniques to treat young children with brain damage?) An apparently promising "cure" or "quick-fix"(or even "innovative approach") may lift the hopes of staff and families, but if a new approach becomes the only one offered or invested in by staff of the organization, grave harm can be done. The organization can lose its holistic, developmental approach, which understands children and families in the full context of their history, their environment, and their individual needs.

Like the North Star, the organization's mission statement provides a steady guide for everyone. The mission statement should be revisited regularly and must be revisited at times of change.

Stages of organizational development

While an organization's mission may remain steady throughout the life of the organization (unless it is deliberately revised), the infrastructure of an organization necessarily evolves over time. Organizations do not begin with all of their infrastructure in place. Rather, evolution occurs as people and changing times converge to shape the structures that govern service delivery. Eventually, some of these particular ways of operating, solving problem, and using the talents of staff become so characteristic of the organization that they are seen as norms, living "in the bricks" of the organization. These norms often remain in place throughout the organization's lifetime:

The first stage of organizational life typically revolves around the implementation of services to carry out the organization's mission. This stage often involves an intensive focus on the meaning of the relationships formed by staff and families. The second stage usually involves a shift of attention to infrastructure. As leadership and staff find themselves beginning to spend considerable time "putting out fires" rather than reflecting on the quality of services or planning for the future, they recognize the need for institutional support for service delivery. They then begin the process of building and refining the organization's internal systems.

Leaders of organizations whose mission is to serve families with very young children would be wise, when building and refining their organization's infrastructure, to keep in mind the theory of parallel process. Well-elaborated in clinical writing, the theory of parallel process springs from an understanding of the parenting process. The theory suggests that just as parents re-experience—and struggle to master—the emotions and conflicts that surround developmental achievements in their children's earliest years, so do staff who work intimately with the same issues. The intense emotions that staff experience daily in their interactions with families and young children also play out in the interactions that staff have with each other and, exponentially, throughout the organization.

I was impressed once again by the phenomenon of parallel process as I spent time this fall in child care center classrooms and observed several little ones struggling with missing their parents. The classroom "curriculum" consisted, appropriately, of hours of sadness and tears, holding (or deciding not to hold), comforting, and offering oneself to the children and their parents for soothing. Staff working with the youngest children are often operating in the realm of the pre-verbal. They are as much in need of support and "holding" as are the mothers of young infants. Organizations that come to appreciate the demands placed on the direct service staff will ideally respect staff needs when they plan for supervision and professional development.

If the theory of parallel process is kept in mind, it becomes relatively easy to plan for predictable periods of intense feeling, like the beginning and end of the program year. Staff recognize that they will need to soothe and comfort and make decisions about what will be most helpful for particular children and parents in their program. Managers realize that direct service staff may need extra support (or fewer organizational demands) at these times. The theory of parallel process also helps to explain aspects of staff functioning that are less predictable or easy to observe. Tensions and conflicts that arise in collaborations and among team members can often be traced to issues that are taking place within participating families, as the following vignette illustrates.

Although Susie, a social worker, and Laura, a language specialist, have always worked easily together in their early intervention program, lately they have been irritated with each other. They are finding it difficult to discuss their work with the Henderson family. Susie insists that her way of seeing the toddler's needs is the only right way. Laura is convinced that only her view of appropriate goals make sense. So now collaborators who in the past
worked easily and creatively with a number of families find themselves increasingly unable to talk with each other at all about how best to plan with the Hendersons for their child. Moreover, the growing irritation between Susie and Laura is spreading throughout the larger team and jeopardizing planning with other families.

After they have spent several supervisory sessions, individually and together, exploring what is going on, Laura and Susie realize that Mr. and Mrs. Henderson often argue about the right path to take with their child. The parental conflict is intense and quite upsetting to both Laura and Susie. Without being aware of it, they have each selected a different parent to "side with." When their repetition of the parents' conflict is pointed out to Laura and Susie, they are amazed and a bit embarrassed, because this re-enactment was not in their control. It had not occurred to them before that they could be pulled in to the parents' struggles so powerfully.

As families work to accept the unique challenges faced by their child(ren) and themselves, while participating in developing plans that are "doable" their ups and downs, including conflicts over which path to take, are experienced deeply by the staff who share their journey. Supervisors play a critical role in helping staff reflect and slowly come to understand that this is the way that some families allow us to get to know them at a very deep level. Again, if the power of parallel process is understood, the organization can plan an infrastructure that is prepared to deal with it - in this case, through reflective supervision.

Work with infants, toddlers, and their families necessarily engages the heart as well as the mind, the emotions as well as the intellect. In order to be successful, staff, supervisors, managers, and leaders of infant/family organizations must maintain an openness and commitment to examining their reactions and their feelings -both positive and negative -toward participating families and the staff who serve them. Consequently, as an organization gradually develops norms and creates an infrastructure, leaders must ensure that these indeed support open communication and reflective practice.

Departments within the organizational infrastructure:

**Touchpoints of a relationship-based system**

To assess the degree to which an organization is in fact relationship-based, one should examine the most important sections or departments of its infrastructure: 1) the executive; 2) the managerial/supervisory structure; 3) the personnel department; 4) accounting/pay- roll/ finances; 5) research; and 6) training.

Each of these departments contributes significantly to the smooth delivery of services. Together, they create not only the context for service delivery, but also the staff's total experience of the work environment.

Consequently, it is important to observe and understand the tenor and tone of each of these elements of the organizational infrastructure. If relationship-based principles are to permeate an organization, then each of its departments must be built on the same principles that guide the direct services to families and children. Again, the relationship of agency structure to staff will parallel the relationships staff will have with families. Although this article pays particular attention to large organizations, the principles are equally applicable to smaller programs. Smaller programs may require a less elaborate infrastructure, or the functions of several "departments" may constitute only part of the job description of a single staff member. Nevertheless, even small service organizations profit from clarity of mission, an investment in supervision, and a well-articulated way of doing business.

In an organization serving families with young children, staff that make up the organizational infrastructure must be as tightly connected as direct service staff to the organization's mission. They must believe in the services that are developed and offered to participating families. When they realize how closely their own work is connected to the services that families and children receive, their sense of pride and commitment to their work can flourish. Orientation for new employees should include discussion of the organization's mission and its implementation through programs and services. Ongoing supervision and training of all staff should be
designed to increase their understanding of the wonders, complexities, and struggles that families with young children and the staff who support them face every day. All staff need to feel and believe that their "backstage" work is a major contribution to the success or failure of the organization's services to families. The touchpoints of any organization are revealed in the day-to-day contacts between the infrastructure, direct service providers, and program participants. Administrators have recognized for some time the powerful messages conveyed to families by an agency's telephone operators, receptionists, and other administrative staff. It is equally important to recognize that what staff members experience in their own interactions with the agency's payroll department or personnel office becomes staff's experience of the organization's values. One Friday morning, Mary, a caregiver in the child care program of a large multiservice agency, goes to the office on her morning break to pick up her paycheck. Sally, the secretary, flips through the checks and sees that Mary's is missing. Sally tells Mary that she will call the payroll department to see what has happened. Mary, meanwhile, goes back to her group of toddlers. At naptime, Mary once again goes to Sally and asks if she has heard from the payroll department. Sally replies casually, "Nope, they haven't called back yet." Mary is quite upset and says, "Please call them immediately and tell them that this is an emergency!" Sally does this but is told, "Mary's paycheck is not an emergency here. Our computer has a glitch that has to be worked out. We'll call you back." Sally repeats this response verbatim to Mary. She is now furious. "What am I supposed to do? I need to get my check to the bank today!" Sally says she doesn't know what to do. Her instructions are to wait for the payroll department to call her back. Mary storms off, goes back to her group, and shares what she has heard with her team colleagues. Everyone tries to think of solutions for Mary and feels less valued by "the agency" than they did this morning. This afternoon, less staff energy is available for the toddlers in the group. If the situation is not rapidly resolved, it would not be surprising to see the upset spilling over into the care of the children and to staff beyond Mary's team. Who can help? Who should be involved? What is the system problem here? What is the solution? A relationship-based organization would work with the payroll department to accept the principle that the staff of a non-profit organization is its primary asset. If the organization's "product" is service to families and children, the staff are the producers and guarantors of that product. The organization would begin to institute a supervisory system within all departments so that staff could experience having their accomplishments, needs, and frustrations listened to and taken seriously. These departments' connections to direct service staff and thus to families would be emphasized in managerial discussions and planning. The goal would be recognition that a financial emergency for Mary (especially one created by the organization itself) is an emergency for the payroll department, one that requires immediate attention. Lack of a solution interferes with production!

The challenges for leadership of relationship-based organizations
Leaders of organizations soon learn that they can expect no absolutely quiet, calm months, weeks, or even days. A leader's first challenge is to understand that she or he will constantly need to adjust priorities and make decisions calmly in an ever-changing context. Once a leader accepts the fact that in organizational life the unpredictable is the predictable, this no longer needs to be resented. A second challenge for leaders is staff resistance to new ideas. Resistance will surface whenever an organization becomes involved in substantive change - like embracing relationship-based principles. Some staff members resist by refusing to see anything new in an idea ("That's not a new idea." "What's the big deal?" "Here we go again!"). Wise leaders will recall that just as a therapist always respects a client's need to resist before change can occur, resistance in an organization can be seen as a form of energy -proof positive that change is in the air and that staff are processing it. It is usually more productive to work with the resistance by opening up discussion and allowing the expression of differences of opinion at every opportunity than to pretend that no differences exist or to ignore the discomfort of staff. A third challenge for leaders is to establish a comprehensive and well-integrated organizational infrastructure. This will become the basis for the solidarity, predictability, and accountability that characterize relationship-based management. With an appropriate infrastructure in place, staff will begin to believe that their needs, as they relate to serving families and children, are of paramount importance to the organization. The infrastructure will, in turn, be able to respond to the flow of the organization's daily demands. Once this stage of organizational development is achieved, leaders will have more time available to set priorities among the opportunities and challenges that come across the desk (or the Internet). A well-functioning internal structure allows the leaders of an organization to be proactive rather than reactive.

Theoretical underpinnings of relationship-based organization
Principles of both human development and management theory support relationship-based organization. Human development theorist Abraham
Maslow, for example, describes a hierarchy of human needs (Maslow, 1954). Once a person meets his most basic needs, he moves up the pyramid to achieve ever-higher levels of personal satisfaction, eventually arriving at the level of "self-actualization." Transferring this paradigm from individuals and families to organizations, we can begin to understand, plan for, and attend to the evolving or developmental needs of staff. Staff whose professional development is attended to are then in a more secure position to foster the development of the families and children they serve.

Maslow's belief in "internal motivators" rests comfortably with contemporary management theorists. Some years ago, Frederick Taylor and other proponents of "Theory X" saw workers as constantly in need of top down control and direction. These theorists did not believe that workers might derive pleasure from work well done and consequently did not trust them. In contrast, Griffiths, Deming and other exponents of "Theory Y" argue that most workers have an innate impetus to "do a good job." In an organization structured to reflect Theory Y, each department must operate to ensure that workers' desire to do well can be fulfilled.

If the wishes of staff to develop professionally and to succeed in their work are truly respected, then it follows that staff should be involved in the processes of organizational decision-making. Among management theorists, Griffiths (1956, 1959) places particular emphasis on this aspect of organizational life, saying, "Show me the decision-making structure of an organization, and I will know all about it." He suggests that the person who controls the decision-making process—that is, creates the arenas for staff input and incorporates staff's experiences and ideas into decision-making—will be the person with the greatest amount of authority in the organization. In other words, leaders who move to a more process mode of decision-making do not relinquish their authority. In fact, they actually become stronger leaders. If leaders can establish an organizational atmosphere in which creativity springs from staff ideas as well as from theory, research, and practice-based experience, then relationship-based work will truly flourish.

Communication and accountability in relationship-based organizations: The supervisory system is key

Including staff in decision-making and valuing the principles of relationship-based work are the responsibility of managers throughout the organization. The organization's leaders must help managers learn to support these principles or risk a dangerous dissonance between the organization's mission and its infrastructure. Once an appropriate infrastructure is in place, establishing mechanisms for ongoing communication and accountability still require considerable energy.

In relationship-based organizations, supervisors are the people who embody and carry out the organization's norms and standards. They are the people who, from experience, can develop the benchmarks that staff strive to achieve. It is within supervisory relationships that principles of communication and accountability are translated into practice. When the principles of regularity, mutuality, and reflection become operative—not only within individual supervisory relationships, but throughout the organization—then and only then will a relationship-based infrastructure be fully in place.

Relationship-based organizations, then, require ongoing communication between administrators and supervisors for purposes of accountability and planning. Program participants will be well served only if program supervisors and staff are at the center of the organization's planning. Program supervisors need support, too. If administrators and managers are isolated from supervisors, gaps in and blockages to communication, commitment, and trust will occur; services to children and families will suffer.

In relationship-based organizations, supervisors become the primary conduit for translating the organization's mission into program practice and for ensuring the quality of the specific services provided. Supervisors are also charged with carrying what they learn from staff about day-to-day issues facing families and children in the community back to leadership or the organization's research department. In smaller organizations, supervisors may lack peers who understand what is involved in the constant balancing of attention between organizational mission and the daily demands of service provision. For supervisors who are thus isolated, links to colleagues, a consultant, or a mentor become absolutely necessary.

Conclusion

Just as there is no perfect family, there is no perfect relationship-based organization. It is the ongoing striving to achieve the organization's mission that is the hallmark of a quality organization. A relationship-based organization will come to accept that staff are its prized possession. Quality service is the end product of staff's efforts. All of the decisions that affect staff will be determined and guided by the very same principles that inform relationship-based services to families and their young children.

References

APPENDIX C:

**Head Start Mental Health Services Survey**

Please answer the following questions about yourself.

1. What is your job title? ______________________________________________________

2. Which of the following best describes your position?
   - Teacher 1
   - Teacher’s assistant 2
   - Manager or coordinator 3
   - Program director/executive director/assistant director 4
   - Family advocate/case manager/family services specialist 5
   - Other staff. Please specify: ____________________________________________ 6

3. How long have you worked for this organization? ____________________________

4. How long have you held your current position? ____________________________

5. What is the highest education level you have obtained?
   - High school diploma 1
   - 2 year degree/certificate 2
   - Child Dev. Assoc. Certificate 3
   - 4 year college degree 4
   - Master’s degree 5
   - Doctoral degree (Ph.D., etc.) 6

6. How would you describe your race/ethnicity? (Check all that apply.)
   - African American
   - Hispanic/Latino(a)
   - Asian/Pacific Islander
   - Caucasian/White
   - Native American
   - Other. Please specify: ____________________________________________

7. What is your gender?  Male 1  Female 0

Please answer the following questions about your program’s approach to children’s mental health promotion.

8. Please rank the following educational objectives for children according to their importance in your program during the next year. Put a “1” by the most important, a “2” by the next most important, and so on until you get to “6” for the least important. Each objective must have only one number next to it.

   In our program, it is important...
   - to help children develop language and problem-solving skills.
   - to help children build strong friendships and learn to share.
   - to help children master concepts needed for reading and arithmetic.
   - to help children develop skill and independence in caring for themselves.
   - to help children develop physical coordination.
   - to help children develop a healthy self-esteem and positive self-concept.

9. Does your program have a *written* philosophy or approach (beyond the performance standards) about how to provide children’s mental health services? This could include a policy or vision statement, set of “guiding principles” or other written documentation about how to approach children’s mental health issues.
   - Yes 1  No 0

10. Does your program have an *unwritten*, but commonly understood, philosophy or approach about how to best provide children’s mental health services.
    - Yes 1  No 0
11. Which of the following led to the development of your program’s mental health approach? Check all that apply.

- [ ] Management team developed the approach.
- [ ] All staff helped to develop the approach.
- [ ] The MHC(s) developed the approach.
- [ ] I don’t know how the approach was developed.

---

### Instructions:

Please answer these questions by circling 1 if you strongly agree with the statement, 2 if you somewhat agree with the statement, 3 if you somewhat disagree with the statement, and 4 if you strongly disagree with the statement.

<table>
<thead>
<tr>
<th>I learned about this approach:</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. By reading about it in a training manual.</td>
</tr>
<tr>
<td>13. Because it was part of my initial training when I was hired.</td>
</tr>
<tr>
<td>14. Through informal conversations or meetings with staff.</td>
</tr>
<tr>
<td>15. Through our program’s regular pre-service/in-service training.</td>
</tr>
<tr>
<td>16. Through informal conversations or meetings with the mental health consultant.</td>
</tr>
<tr>
<td>17. By observing or watching other staff.</td>
</tr>
<tr>
<td>18. Just by being part of the program.</td>
</tr>
<tr>
<td>19. I understood this approach before I started working with this program.</td>
</tr>
</tbody>
</table>

---

### The following groups understand and share the program’s approach to mental health services:

| 20. Administrators/managers/coordinators/management team | 1 2 3 4 |
| 21. Classroom teachers | 1 2 3 4 |
| 22. Assistant teachers | 1 2 3 4 |
| 23. Family advocates/family services staff | 1 2 3 4 |
| 24. Support staff (secretaries, bus drivers, cooks, etc.) | 1 2 3 4 |
| 25. Head Start parents | 1 2 3 4 |
| 26. Mental health consultants | 1 2 3 4 |

---

Questions 28–63 ask about your program's mental health consultant(s) (MHC). If you work with more than one consultant, please think about their overall characteristics and how the consultants, on average, work with you and your program. (See next page.)
<table>
<thead>
<tr>
<th>Question</th>
<th>Rarely or Never</th>
<th>1-2 Times per Year</th>
<th>Every Other Month</th>
<th>Monthly</th>
<th>Weekly or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. The MHC(s) conducts group (classroom) screenings and observations.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. The MHC(s) conducts individual screenings of children.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. The MHC(s) conducts more in-depth assessments of children after they have been screened.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. The MHC(s) does planning for children with special needs (e.g., IEPs).</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. The MHC(s) makes referrals for children or families to community services.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. The MHC(s) attends management team meetings.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. The MHC(s) meets with staff teams to discuss children or families.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. The MHC(s) provides direct therapeutic/counseling service to families and children.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. The MHC(s) provides formal training to teachers.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. The MHC(s) talks and meets with parents.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. The MHC(s) provides support to staff for their own well-being.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. a. Other activities of the MHC(s). Please specify:</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. b.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>41. c.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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</tbody>
</table>

**Instructions:** Please answer these questions by circling 1 if you strongly agree with the statement, 2 if you somewhat agree with the statement, 3 if you somewhat disagree with the statement, and 4 if you strongly disagree with the statement. If you work with more than one MHC, think about what they do, overall, in general. Answer these questions to the best of your knowledge.
**Instructions:** Please answer these questions by circling 1 if you strongly agree with the statement, 2 if you somewhat agree with the statement, 3 if you somewhat disagree with the statement, and 4 if you strongly disagree with the statement. If you work with more than one MHC, think about what they do, overall, in general. **Answer these questions to the best of your knowledge.**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>54.</td>
<td>The MHC(s) has experience working with young children.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>55.</td>
<td>The MHC(s) respects staff’s perspectives on children’s issues.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>56.</td>
<td>The MHC(s) is “part of the team” trying to help families.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>57.</td>
<td>The MHC(s) provides services in a way consistent with the HS philosophy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>58.</td>
<td>Parents trust the MHC(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>59.</td>
<td>Parents of children with special needs know the MHC(s) by name.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>60.</td>
<td>The MHC(s) is available when I need him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>61.</td>
<td>The MHC(s) talks with staff about the ways in which understandings of mental health and related concepts (self-esteem, discipline, etc.) may differ for children based on culture.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>62.</td>
<td>When talking with families about their children, the MHC(s) demonstrates an awareness of each family’s unique cultural characteristics and preferences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>63.</td>
<td>Dollars spent on mental health consultation would be better spent on other areas of the program.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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Please answer the following questions about your program’s mental health activities.

**Instructions:** Please answer these questions by circling 1 if you strongly agree with the statement, 2 if you somewhat agree with the statement, 3 if you somewhat disagree with the statement, and 4 if you strongly disagree with the statement. **Although different staff may think or behave differently, consider how program staff overall, in general, behave. Think about the program staff that you know.**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>64.</td>
<td>Program leadership has a clear vision of how children’s mental health issues are related to all program components.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>65.</td>
<td>Program leadership (e.g., managers, directors, coordinators) supports staff to learn more about children’s mental health needs and how to address them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>66.</td>
<td>Program leadership advocates and tries to obtain more resources for children’s mental health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>67.</td>
<td>Staff in our program disagree on what mental health services should be provided to which children.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>68.</td>
<td>Our mental health services and approach are well-integrated into all program components.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>69.</td>
<td>Staff would like to see therapeutic classrooms for all children with behavioral health challenges.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>70.</td>
<td>Our program’s mental health services focus more on children with special needs than on preventing mental health problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>71.</td>
<td>Families in our program who need therapeutic/counseling services have problems accessing these through community-based programs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>72.</td>
<td>Staff believe that the best way to meet children’s mental health needs is to identify what is “right” with the child, not what is “wrong.”</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>73.</td>
<td>Parents of children with special needs regularly attend staffings or service planning meetings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>74.</td>
<td>This Head Start program has effective ways of involving parents in the management of problem behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Instructions: Please answer these questions by circling 1 if you strongly agree with the statement, 2 if you somewhat agree with the statement, 3 if you somewhat disagree with the statement, and 4 if you strongly disagree with the statement. Although different staff may think or behave differently, consider how program staff overall, in general, behave. Think about the program staff that you know.</td>
<td></td>
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</tr>
<tr>
<td>75.</td>
<td>When a child has a mental health issue, staff actively involve the child’s family in meeting this child’s needs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>76.</td>
<td>Staff work actively to identify and facilitate services for adult mental health issues.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>77.</td>
<td>When talking with families about children’s mental health issues, staff demonstrate an awareness of each family’s unique cultural characteristics and preferences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>78.</td>
<td>Our Head Start program uses curricula that provide images of and attention to children and families from a variety of cultural backgrounds.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>79.</td>
<td>Our Head Start program offers effective trainings on racial/ethnic, social/economic, religious and other cultural differences among children and families.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>80.</td>
<td>Our program’s approach to mental health focuses extensively on classroom curriculum.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>81.</td>
<td>Staff in this program see mental health as part of everything they do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>82.</td>
<td>Staff believe that children with significant behavioral challenges are best served by programs other than Head Start.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>83.</td>
<td>When a few children have significant behavioral challenges, staff find it difficult to spend time with any of the other children in the classroom.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>84.</td>
<td>Our program has a strong partnership with at least one community-based mental health provider.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>85.</td>
<td>Staff are able to build on family and child strengths even when the family is facing significant challenges (e.g., substance abuse, mental illness, homelessness, etc.).</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>86.</td>
<td>Parents of children with special needs are invited to attend staffings or service planning meetings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>87.</td>
<td>Staff feel comfortable talking with parents about their children’s mental health needs or issues.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>88.</td>
<td>This HS program has a mechanism for communicating positive behaviors or events to parents.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>89.</td>
<td>Staff believe that family participation is essential to improving a child’s well-being.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>90.</td>
<td>Staff have an awareness of how their own cultural norms and expectations may differ from the cultural experiences of Head Start children and their families.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>91.</td>
<td>Our program has staff who feel comfortable talking to non-English speaking families about mental health issues in their own language.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>92.</td>
<td>In their interactions with children and families, staff regularly demonstrate an appreciation for cultural norms and expectations different from their own.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>93.</td>
<td>Our program’s approach to mental health includes a strong focus on staff wellness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>94.</td>
<td>Our program’s approach to mental health focuses exclusively on how to manage children’s behavior in the classroom.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>95.</td>
<td>I have a good understanding of “best practices” in children’s mental health.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>96.</td>
<td>I have a clear understanding of my role in supporting children’s mental health in our program.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>97.</td>
<td>Our program provides me with the training and professional support I need to do my job most effectively.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>98.</td>
<td>This program recognizes the good work that I do on behalf of children and families.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>99.</td>
<td>Transitions are smoother in my classroom (or classrooms I know about) because of our mental health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>100.</td>
<td>Our mental health services help all children in our program.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>101.</td>
<td>Staff have a hard time knowing what to do to help children with challenging behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>102.</td>
<td>Classroom staff do their jobs better because of our mental health consultant.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Head Start Mental Health Services Survey
### Instructions:
Please answer these questions by circling 1 if you strongly agree with the statement, 2 if you somewhat agree with the statement, 3 if you somewhat disagree with the statement, and 4 if you strongly disagree with the statement. Although different staff may think or behave differently, consider how program staff overall, in general, behave. Think about the program staff that you know.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>103.</td>
<td>Our program’s mental health services and approach are sufficient to meet the needs of children and families.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>104.</td>
<td>This HS program has a plan for dealing with children who may have a situational crisis.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>105.</td>
<td>I consistently use best practices in children’s mental health in my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>106.</td>
<td>I feel I do a good job in supporting children’s mental health within our program context.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>107.</td>
<td>Our program provides me with the emotional and personal support I need to do my job most effectively.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>108.</td>
<td>Our program’s mental health services have improved the quality of our classroom environments.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>109.</td>
<td>Our mental health services help children with challenging behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>110.</td>
<td>Our mental health services help families know how to cope with children’s challenging behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>111.</td>
<td>Our mental health services and approach help staff to feel less stress.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>112.</td>
<td>Our mental health services and approach are in need of improvement.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

113. How many children are there in your classroom or caseload? __________

114. How many children in your classroom or caseload received a group (classroom) screening? __________

115. How many children in your classroom or caseload received an individual assessment? __________

116. How many children in your classroom or caseload have been identified as needing mental health services? __________

**Of those children who were identified as needing mental health services**, how many have received the following (provided by either Head Start or by another service):

117. Individual therapeutic services (counseling, play therapy, etc.) __________

118. Family therapeutic services (counseling, etc.) __________

119. Medication only __________

120. Medication plus therapeutic services __________

121. Other mental health services __________

Please describe: __________

122. How many adult family members of children in your classroom, or on your caseload, have been identified as needing mental health services? __________

**Of those adults who were identified as needing mental health services**, how many have received the following (provided by either Head Start or by another service):

123. Individual therapeutic services (counseling, individual treatment, etc.) __________

124. Group counseling/group therapy (support groups, etc.) __________

125. Family therapeutic services (counseling, parent education, etc.) __________

126. Medication only __________

127. Medication plus therapeutic services __________

128. Other services __________ Please describe: __________

---

Head Start Mental Health Services Survey
Instructions: To what extent do you think your mental health services, including prevention and classroom activities, as well as direct mental health services, have helped each of the following? Circle 1 if it has helped a lot, 2 if it has helped somewhat, 3 if it has helped a little, and 4 if it hasn’t helped.

<table>
<thead>
<tr>
<th></th>
<th>Helped a lot</th>
<th>Helped somewhat</th>
<th>Helped a little</th>
<th>Hasn’t Helped</th>
</tr>
</thead>
<tbody>
<tr>
<td>129. Aggression towards other children</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>130. Aggression towards adults</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>131. Self-destructive behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>132. Extreme temper tantrums</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>133. Withdrawn/overly shy behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>134. Extreme moodiness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>135. Child depression</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>136. Speech/language problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>137. Problems concentrating</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>138. Positive social interactions between children</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>139. Smooth transitions between activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>140. Prosocial behavior (e.g., helping, sharing)</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>141. Age-appropriate emotional regulation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>142. Non-violent problem solving</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

143. At this Head Start, if a teacher requested mental health services for a child, how long would the child have to wait for an evaluation if it is not a crisis?

- 1 week
- 1–2 wks
- 2–4 wks
- 1–2 months
- More than 2 months

144. Sometimes Head Start is unable to meet the needs of children with particular issues or problems. In your program, what issues most frequently lead to children being referred to another program or service instead of Head Start? That is, what issues or problems do children have who cannot be served in the Head Start classroom?

145. What do you believe is the most outstanding part of your mental health services? That is, what makes your mental health services most effective?

146. What do you believe is the most unsatisfactory part of your mental health services? That is, what prevents your mental health services from being as effective as they could be?

Thank you very much for your valuable time. Now just fold, tape and place this survey in outgoing mail. You will be entered in the cash drawing, and we look forward to sending your program’s report.

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