The Early Childhood Mental Health Project

Child Care Center Consultation in Action

A Project of
Jewish Family and Children's Services
of San Francisco, the Peninsula, Marin and Sonoma Counties

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Written by Brian Johns and edited by Elisa J. Rassen
Designed by Chana Andler

The Early Childhood Mental Health Project, a collaboration between Parents Place, a non-sectarian program of Jewish Family and Children's services of San Francisco, San Mateo, Santa Clara, Marin and Sonoma Counties, and Day Care Consultants, a program of the Infant-Parent Program of the University of California, San Francisco

Amy G. Rassen, LCSW, Associate Executive Director, Jewish Family and Children's Services of San Francisco, the Peninsula, Marin and Sonoma Counties

Laurel Kloomok, M.Ed, Director, Parents Place, a program of Jewish Family and Children's Services of San Francisco, the Peninsula, Marin and Sonoma Counties

Kadija Johnston, LCSW, Coordinator, Day Care Consultants, a program of the Infant-Parent Program of the University of California, San Francisco

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Jewish Family and Children's Services
of San Francisco, the Peninsula, Marin and Sonoma Counties
2150 Post Street, San Francisco, CA 94115 415/449-1200
admin@jfcs.org ***www.jfcs.org***

"A mental health consultant is extremely useful to a program such as ours. There are times when you need a fresh idea or to talk to someone outside your own work area. Our ECMH consultant has been incredibly helpful with children's observations and getting the proper help needed. She has also done a great deal of work with staff development and communication. This program has proved to be very helpful and I hope that it can expand to all private and public children's centers and secondary schools."

Emily B.
Program Director

Origins of the Early Childhood Mental Health Project

A seismic shift is changing the way America raises its children.

Over the past three decades, the number of youngsters in childcare has jumped 50%. Each day, five million children under the age of three are cared for by adults other than their parents. Meanwhile, 67% of children under the age of five have working parents who leave them for up to 10 hours at a time.

The mounting pressures of modern life have altered teachers' roles and responsibilities. In the face of these pressures, childcare centers must find ways to pool limited resources, often inadequately trained staff, and under-equipped facilities to shepherd an increasingly diverse group of young children. Teachers must be equipped to offer healthy, safe and developmentally appropriate experiences for all children in their care. Yet teachers often lack sufficient knowledge, training and support to respond effectively to children experiencing difficulties in learning or socializing.

Across the country, teachers are asking themselves the same questions: are we providing an environment which effectively nurtures young children into productive, healthy citizens? Is the care we offer sufficient to enable children to enter school ready to learn?

For more than two decades, Jewish Family and Children's Services (JFCS)/Parents Place and Day Care Consultants, a program of the Infant-Parent Program, have provided mental health consultation to schools and childcare centers. As organizations, we emphasize the work of early intervention with challenged children, helping teachers learn about child development and assisting administrators in creating environments that address the social, emotional and learning needs of the children in their care.

In the mid 1980s, backed by foundation funding, JFCS—in partnership with a local university and the San Francisco Unified School District—undertook a four-year service and research project to find out which consultation methods worked best and why. We wanted to investigate how our intervention model helped children and teachers and whether the emotional and academic well being of children could be improved by providing mental health services to elementary school personnel. Our research provided several key insights:

- The support and expertise provided by our on-site mental health consultants enabled teachers to address a wide range of mental health problems facing children and families.
- Teachers' sense of efficacy improved if they had a fuller understanding of the issues facing children. Further, this understanding could translate into more effective classroom interventions.
- As teachers used more mental health consultation and developed a more effective set of classroom interventions, children's self esteem, motivation to learn and academic performance improved.

This strategy for helping children and families by working with primary teachers—in this case, elementary school teachers—prompted more questions. JFCS wondered whether a still earlier mental health consultation intervention at childcare centers would succeed. In theory, such an approach would be even more beneficial because it could address social, developmental and emotional issues during the crucial first five years of life. Meanwhile, the Infant-Parent Program (IPP), a direct service and training program, was established in 1979 by the University of California, San Francisco at San Francisco General Hospital to bring specialized infant mental health services to the Bay Area and provide clinical consultation to a variety of agencies and programs and in-home psychotherapy to parent(s) and children from birth to three whose relationships were troubled. IPP also provided intensive supervision and seminars focused on this particular specialized treatment to a range of mental health professionals. As a corollary to this

"I feel very lucky to have the help I received and feel you are doing a great service to the community."

Kim M.
Parent

work and with foundation support, Day Care Consultants was begun in 1988. Its mission is to provide consultation informed by a mental health perspective, both programmatic and case-centered, to childcare providers. Gradually, therapeutic groups and special access to Infant-Parent Program psychotherapy services were added as well.

Our collective experience, backed by the growing body of brain development and early childhood educational research, supported our hypotheses that promoting the emotional wellness of young children and fostering secure warm relationships with teachers were critical to healthy early development and greater success rates for children once they started attending school.

As a result, JFCS/Parent Place formed a collaboration with the City and County of San Francisco's Community Mental Health Division and Day Care Consultants, and we began the process of recruiting, training and supervising mental health consultants to provide support for childcare center staff. We also partnered with a number of low-income San Francisco centers open to utilizing the services of mental health consultants that gave us the opportunity to study the effects of the intervention strategy on the quality of childcare.

For three years, a six-member team met monthly to oversee the program. JFCS/Parents Place was responsible for coordinating and administering the project, Day Care Consultants developed and implemented a training and supervisory program for mental health consultant staff, and Community Mental Health insured linkages of the project to public resources. Because JFCS operates in five counties, we hoped to replicate the model throughout our service area.

At the same time, the Carnegie Starting Points Initiative—a local collaboration of public and private agencies focusing on the zero to five populations in San Francisco—began to take note of our approach. As more childcare centers sought assistance, the City and County of San Francisco moved to fund mental health consultation through its Department of Public Health, Division of Community Mental Health Services. Consequently, JFCS' initial grant from a San Francisco-based foundation was converted to a municipal contract.

As a result of our work in San Francisco, a similar collaboration was formed in Marin County. Leveraging assistance from two local Marin foundations, the program began receiving Prop 10 Funds in 2001. In Sonoma County, the United Way has funded the model. Similarly, several private and community foundations in San Mateo and Santa Clara Counties provide financial support for the intervention.

Today, JFCS/Parents Place and partner Day Care Consultants serve 46 low-income childcare centers in five counties. We are funded by 15 private and community foundations, two Prop 10 Commissions, the United Way, and the City and County of San Francisco. The project's annual budget is approximately $1.3 million dollars. It includes a training and supervision program for 15 mental health consultants and consultation service to these 46 centers.

Getting where we are today has required enormous institutional commitments from JFCS, Day Care Consultants and all of our collaborative partners. The backbone of the project is the belief of all partners—mental health consultants, childcare staff and administrators—that the best way to help young children is to insure that teachers are provided with the education and support necessary to address the specific needs of each child in their care.

This manuscript tells the story of our organizations' vision for reaching out to children through their teachers, and of creating and implementing a model of service in San Francisco that is intended to improve the long-term prospects for our most vulnerable children and families.

Philosophy of the Early Childhood Mental Health Project

Children develop best in a setting that promotes positive relationships between teacher and parents, among staff, and between the child and his/her teacher. This relationship parallels the potency of the relationship between children and parents. **The quality of childcare is improved as teachers become better able to observe, understand and respond to children's needs. The work of mental health consultation is to help the teachers develop an increased awareness and understanding of the impact of their interactions with children**.

The Early Childhood Mental Health Approach

The Early Childhood Mental Health Project's approach is based upon the following assumptions:

- Learning is a complex process that occurs over time.
- Due to the interpersonal nature of care giving, the teacher's performance will improve as he is better able to recognize, accept and understand his own emotional reactions to children.
- The teacher's emotions are tools for understanding the child's experiences.[1]

From the beginning, Early Childhood Mental Health was designed to improve the overall quality of childcare for the Bay Area's low-income youngsters, specifically addressing the child/teacher relationship, and to promote their mental health by building the community's capacity to provide high-quality childcare and early childhood mental health services. The model seeks to improve overall care, yet targets the developmental needs of individual children.

To achieve this aim, three primary activities are pursued:

- Providing on-site mental health consultation services to childcare teachers, including case and program consultation and didactic training.
- Providing clinical and assessment services to children and families, such as on-site therapeutic groups, neurodevelopmental assessment, and on-site or at-home dyadic child-parent psychotherapy.
- Providing intensive training and supervision for mental health professionals in the provision of consultation and individual/group treatment of young children, their families and teachers.

The success of consultation depends on the consultant's ability to develop an alliance with teachers. Within this alliance, they work to understand what children need and how best to provide it. A hallmark of the effort is respect for teacher, children and families. However, forming an alliance with teachers takes time and depends on the establishment of a predictable, protective atmosphere of learning. Not only must the consultant understand concerns about particular children or programs, she must also strive to understand the childcare teacher's subjective experience and appreciate the stresses experienced by staff members, their readiness to engage in the learning process, and their particular professional and cultural views about childrearing.

The work of mental health consultation is to help the teachers develop an increased awareness and understanding of the impact of their interactions with children.

"She helped me see my son's side of situations and treat him more like a person that needs my help. The best thing briefly is that she became his best friend."

Rhonda W.
Parent

[1] "An Application of Clinical Concepts to Education: A Proposed Model for In-Service Training" by Cozzarelli, Silen, Fields (Reiss-Davis Bulletin, 1975, Volume 12(1), pages 8-21).

Getting Started with Consultation

Preparation

A number of steps are involved in initiating the consultation process. An administrative structure and data tracking systems should be in place before the consultant walks in the door of a childcare center, knowledge and methods in hand.

In order to budget and secure funding for the program, administrators should determine staffing levels and supervisory and administrative support needs. Job descriptions must be prepared and staff hired. Systems to track childcare center information and Early Childhood Mental Health program data and outcomes have to be developed. Recruitment strategies that utilize existing relationships with the childcare licensing community to reach childcare centers need to be outlined, and sources of specialized early childhood assessments and interventions identified so that future needs for specific referrals can be handled promptly and effectively.

These preparations can occur concurrently, so that as staff is being hired and receiving initial training, sites are being recruited and screened for their readiness to benefit from consultation, and site agreements are being drawn up. Relationships with centers should also be developed by management staff so that, once consultants are on board, appropriate matches can be made between consultant staff and childcare sites without delay.

Establishing Relationships

Typically, initial requests for consultation services come when teachers are in crisis about a particular child. **While the ultimate goal of consultation is to improve the overall quality of care for all children in a particular program, the initial step is to respond to a staff's immediate needs.** The basis for a productive long-term relationship will be determined by our response to the initial concern presented. As the teacher begins

to feel that her experience with a difficult child is understood, she will develop trust in the consultant. Eventually, the teacher will come to value the consultant's general expertise about children.

Confidence in the consultant grows as the teacher learns that the consultant understands both the child's and teacher's experiences and feelings. Frequently, teachers are concerned about how other people, including the consultant, will regard their "inability to solve" the problem. As the staff begins to feel the consultant understands and empathizes with these feelings, trust and mutual respect develop. **Without the key element of trust, even the most brilliant advice feels burdensome to an overwhelmed, distraught teacher**. With trust, however, the teacher can put to use the information and understanding a consultant has developed through observations of the child, her work with his family, and her observations of the classroom and program.

Although the aim of consultation is to improve the quality of relationships between children and childcare teachers, the foundation for this improvement is attending to relationships between adults, particularly those between teachers, teachers and parents, and the consultant and consultee. Consequently, from the moment she enters a childcare center, the consultant must attempt to understand the center's unique culture. Through inquiry and observation, she must learn about the program's guiding philosophy, daily routines, bureaucratic structure, and inter-staff and staff-parent relationships, while at the same time learning about the relational styles of individual childcare teachers, the background contributors to these styles, and each teacher's expectations, emotional capacities and beliefs about child development.

Mental health consultation focusing on an individual child is always part of a larger effort to improve a center's overall standard of care. The consultant helps bring this about by establishing a "learning alliance" with the childcare staff, relieving the teachers' anxiety and self-doubt, and providing well-timed didactic information. Through successful consultations, teachers learn that understanding a child's feelings is not limited to specific or isolated "cases." Often, this realization leads to requests for program consultation. The scope of work is then extended as consultants help teachers increase empathy, understanding and overall childcare skills.

Without the key element of trust, even the most brilliant advice feels burdensome to an overwhelmed, distraught teacher.

"I am glad that Parents Place provides the service to our center. When I have questions, I always go to our ECMH consultant. She makes me have more confidence at work."

Carol T.
Teacher

Initiating Case Consultation

In most cases, a consultant is first called to a childcare center in order to address difficulties the staff is having with a particular child. These difficulties often involve social and emotional development, with behavioral indicators that include aggression toward self or other people, withdrawal or depression, an inability to play, an inability to establish relationships, or specific signs of developmental delays.

The scope of consultation provided is determined by the severity of the problem, the wishes of teacher and family, and the consultant's assessment. Typically this includes meeting with teachers regularly, observing the child in the childcare program and meeting with parents. The consultant makes clear that while she is interested in the teacher's perspective, specific information about a child can be shared only with the knowledge and consent of the child's parent(s) or adult guardian(s).

Case Study: Yury

Not too long ago, the staff of a newly established pre-kindergarten classroom requested consultation regarding Yury (name changed to protect confidentiality), a four-year-old who had attended the center's program the previous year. While Yury's behavior had been perplexing to past teachers, his more recent explosive outbursts were of grave concern to his teachers and the program director.

During the consultant's initial conversations with the director, the consultant learned that the staff and Yury's mother and grandmother had different views about the causes and meaning of his behavior. They also disagreed about what might help him.

Previous attempts to discuss Yury's needs had resulted in antagonism between staff and the parent. The mother, an émigré from the former Soviet Union, viewed her son as exceptionally bright. She and the rest of her extended family, especially his grandmother, attributed his difficulties to his boredom with an unchallenging curriculum.

The blame was mutual. Yury's preschool teachers felt his problems stemmed from his family pampering and their willingness to acquiesce to his every wish. Each party held the other responsible for the boy's difficulties. At the very time they most needed to depend on each other and work together to address Yury's problems, suspicion and blame prevented them from doing so.

No one saw Yury and his struggles in the same way, and in the midst of this mistrust, he was disappearing. Given the tenor of the family-staff relationship, the consultant knew the focus of her efforts would have to be directed at mending the fractured adult relationships. Only then could they begin to see themselves on the same side—Yury's.

When consultation services were first offered to Yury's family, Yury's mother reacted to the idea with ambivalence. How could there be anything wrong with a four-year-old? Being from the former Soviet Union herself, the consultant knew that developing trust with a mental health professional would be challenging for the family. In the former Soviet Union, mental health services were only sought for the most seriously ill individuals, and even then with grave reluctance. There were few genuinely therapeutic services available, and "mental health" services were associated with institutional warehousing, or even worse, with the penal system. The mother wanted only limited involvement with the consultant. She did not want Yury observed and she did not see any benefit to meeting with the consultant herself. However, no other subsidized daycare was available to her, and she feared that if she did not grant permission for the teachers and the consultant to meet, Yury would be asked to leave the program. So she gave permission for the consultant and teachers to work together. After all, they were the ones having difficulty. If the consultant could help them better understand and

"One of the real benefits I've noticed is that my staff is much better at building parent-teacher collaborations—functioning as a team, rather than as adversaries. This allows us to spend our energy on getting the child's needs met, rather than on trying to assign blame."

Mark R.
Director

work with her son in his classroom, she welcomed the consultant's involvement.

A sturdy redhead with thick glasses, Yury was described by all of his teachers as very verbal, inquisitive and imaginative. The staff shared his family's opinion that his cognitive capacities, particularly in the area of science, were extraordinary. He was fascinated by nature and mechanics and would regale anyone who would listen with detailed accounts of his latest theories, using sophisticated vocabulary to do so.

In his enthusiasm, Yury would spew stories—literally spitting—as he spoke. Further, he was rigidly tied to classroom routines, agitated by unexpected change, and fixated on a range of fears, particularly of water sprinklers and television advertisements.

As a three-year-old, Yury had shown little interest in peer interaction. He retreated when confronted by too many other children or too much classroom activity. His preferred refuge had been the uncluttered outdoor space that was attached to the preschool classroom.

As a four-year-old, explosive outbursts replaced his pattern of retreating to the outdoors. Besides heightening his teachers' concerns, his behaviors made classroom management difficult. Yury screamed, threw objects, hit, and spat at his teachers when they tried to calm or redirect him.

The consultant empathized with the teachers' distress and acknowledged how trying Yury's behaviors were. Giving voice and credence to their experiences helped relieve the teachers' self-doubt and defensiveness. They had, they admitted, begun to question their skills. After all, Yury had not been a "problem" to his old teachers. He merely retreated when bothered. Why the disruptive behavior now? Why couldn't they manage him as well as the previous year's teachers?
Attending to the teachers' distress helped create a space within which Yury's teachers and the consultant could consider Yury's own distress and begin to examine antecedents and patterns to the boy's outbursts. They eventually identified several possible connections.

Yury, they noticed, had become interested in peer interaction. If he initiated the overtures and the other child responded without coming too close, there were moments of pleasurable interaction. If he was "caught off guard," or was brushed up against by another child, he screamed and fell into a tantrum.

The teachers also noted previously undetected difficulties in his fine motor ability. His capacity to imagine complex creations was immense. But he had only limited skills using Legos, pencils or scissors to construct his imaginings. This was a tremendous source of frustration for him and would periodically result in full-scale "meltdowns," during which he would throw materials and yell self-derogatory epithets about how stupid he was and how he hated himself.

With the consultant's help, the teachers began developing hypotheses about possible contributing factors to Yury's difficulties. They wondered if some of his behaviors were related to earlier traumatic experiences, including emigration. They also wondered if part of the environment, including social interaction, was over-stimulating to him. They began to consider his behaviors as excessive responses to frustration and irritation. Viewing his behavior less as intentional and under his control, they wondered about constitutional contributors.

As their insights evolved, the absence of Yury's mother from the process became increasingly problematic. As the teachers' interest in Yury's confusing profile grew, so did their desire for pieces of the puzzle that only his mother possessed. This parental portion of the consultation will be explored in the next section: Parental Involvement in Case Consultation.

Key Elements in Beginning Case Consultation

Despite working under devalued conditions, childcare teachers hold a powerful position in children's lives. The information a teacher can provide about a child—whether confirming or disputing a parent's perceptions—is invaluable to understanding the child's experience. It is important that the consultant begins by engaging teachers in thinking about the possible contributors to and the meaning of the child's behavior. Simultaneously, the consultant should elicit the teacher's subjective experience of the situation.

Children experiencing emotional distress can arouse feelings of anxiety, anger and self-blame among teachers. At times like these, the consultant must work to fully understand the teacher's emotions. As the teacher begins to feel the consultant understands and empathizes—and is not condemnatory or judgmental—empathy for the child increases. Meanwhile, trust and mutual respect between consultant and consultee develop. Then, and only then, is the teacher free to begin considering the child's experience.

The consultant proceeds from the premise that the child's behavior has meaning. She endeavors to engage the teachers in the process of deciphering that meaning, as the exact same behavior in any two individuals is not necessarily caused by nor does it mean the same thing. Only as the behavior is understood in this specific context can responses be contemplated and strategies of intervention proposed. From their knowledge of and intensive interaction with a child in their care, teachers are often able to develop accurate hypotheses as to what is influencing a child's behavior. However, a complete understanding depends on the parent's participation in the consultation process.

"When I first talked with the ECMH consultant, I was overwhelmed with relief, for I finally had someone who seemed to understand ALL of the feelings I was having and to help me see more clearly what had occurred over the last few years. When I struggled to explain myself, she would perfectly put into words what I had been feeling and then validate those feelings. Because of her willingness to listen, her validation of my frustration and fears, and especially her understanding of children's feelings and sensitivities (which helped me to understand my child better), I was better able to see ways that I might help."

Barbara D.
Parent

Parental Involvement in Case Consultation

Including Parents

Initially, Yury's mother had refused the offer of the consultant's services, informing the director that neither she nor Yury needed professional help. However, if center staff could get help from "their" consultant, that was fine. From what she and her extended family could tell, the teachers needed all the help they could get.

Despite this inauspicious beginning, the consultant had to keep the ultimate goal of engaging the parent in the consultation process in mind and take steps to achieve it. While working with the teachers, she encouraged them to see the usefulness of involving Yury's mother. And, as the teachers' sense of competence increased, their need to relieve their feelings of responsibility by blaming Yury's family decreased and they no longer accused the mother and grandmother of being "in denial." Instead, they became interested in the data she could provide them to help decipher the puzzle of Yury's behavior.

Initiated by staff, another series of meetings with the mother took place. The first was rocky. Understandably, the mother was guarded and cynical about any good outcomes. Her expectations, based on previous experience, temporarily blinded her to the staff's shifting attitudes. Although discouraged, the director and staff persevered, with the consultant's help. In a second meeting, the consultant again made herself available. Warily, the mother agreed to meet her.

Based on the consultant's suggestion—and with staff agreement—the mother was offered options about who would be involved and where the meeting would take place. The mother opted to meet the consultant alone in her home, under the watchful eye of Yury's grandmother, a doting advocate for Yury. The daycare staff was relieved to not have to be involved at this point, trusting the consultant to help repair the fractured relationship.

During the first few meetings, the consultant worked to convince the family she was not solely allied with the school. Her interest, like everyone's, was to see if they could make school a more pleasurable place for Yury and to ensure his success there. She demonstrated her belief that their knowledge and perspectives were essential to the undertaking, and that she wanted to hear what Yury's family felt was important for her to know. The mother seemed pleased to be asked.

At the end of these conversations, a plan was proposed. Yury's family wanted the consultant to spend time with Yury directly interacting rather than simply observing him, as his mother mistrusted the opinion of anyone who she felt did not know him well. While atypical, the consultant agreed, assuming the teachers were willing. She hoped direct interaction would enhance her credibility with the mother.

Although willing to adapt, the consultant had reservations about the plan. She was concerned about how her interaction with Yury might be experienced by the teachers. She recognized and communicated that Yury's behavior in a group setting would not be replicated in a one-on-one interaction with her. In voicing this concern, she was anticipating that her private interaction with Yury might heighten the teachers' feelings of inadequacy and she wanted to underscore the idea that understanding and change would reside in the caregiver/parent relationship with Yury, not in hers.

Key Elements in a Consultant's Work with Parents

The most salient relationship is between teachers and parents. If a trusting relationship between parents and teachers is already established, introducing consultation is much easier. As a matter of course, teachers and parents should be discuss-

"The consultant has helped us to better interpret and understand our son's non-verbal communication and to respond more appropriately to that communication."

Steve & Susan S.
Parents

ing any worries or concerns that either has about a child. Ideally, teachers work *with* parents to understand the reasons for a child's difficulties. Together, they work collaboratively on behalf of the child. However, such collaboration is sometimes hard to forge or can reach an impasse.

As stated above, if agreement and trust have already been established between teachers and parents, introducing consultation is easy and might begin by having the consultant join a regularly scheduled parent-teacher conference. If, as was the case of Yury, antagonism and suspicion preclude a parent-teacher partnership, the consultant's first steps must often be to establish herself as a non-partisan participant in the process, equally empathetic and available to everyone.

Sometimes, the teacher or administrator is reticent about talking to parents. In these instances, the consultant must first help the teacher examine the nature of the relationship with the family. To do so, the consultant may meet with staff to help identify and overcome the many possible obstacles to communication.

In other cases, staff may consider it difficult to obtain parental consent for consultation. One solution to this problem is for the consultant to be present at the center when parents will also be there to introduce herself and explain her interest in being useful to teachers working with their child.

When she meets with parents, the consultant must convey her interest in their perspective of the child's experience, indicating that she does not rely solely on the center's view. She also wants to communicate that the parents' involvement in the consultation process is vital to understanding the child.

The extent to which the consultant works with a child's parents varies. The interaction between a consultant and a child's family is influenced by several factors, including:

- The extent and nature of the child's difficulties. Are the concerns situational—evidenced only in the childcare setting—or pervasive?
- The degree of dissension or agreement between parents' and teachers' views regarding the child—his development, needs and behaviors and the depth of concern about each.
- The parents' ability and willingness to participate in the consultation and thinking about their child.
- The cultural and/or linguistic match between the consultant and the family.

Each of these factors influences how the consultant and parents interact and how the family experiences the consultant. The consultant must effectively express the importance parental participation holds in this process and communicate that a child's behavior can only be understood in the context of his development, feelings about himself, and his relational history, which can only be acquired from his parents.

Initially, the parents may not understand why their involvement is necessary. Sometimes past experience with "professionals," especially in the mental health arena, undercuts their willingness to engage with the consultant, as does the tenor of their relationship with teachers. The amount of trust and mutual understanding between the parents and the teachers affects how and what the consultation initially addresses.

There are several important steps that need to happen for a consultant to establish herself as a neutral party working in the best interests of the child. These include:

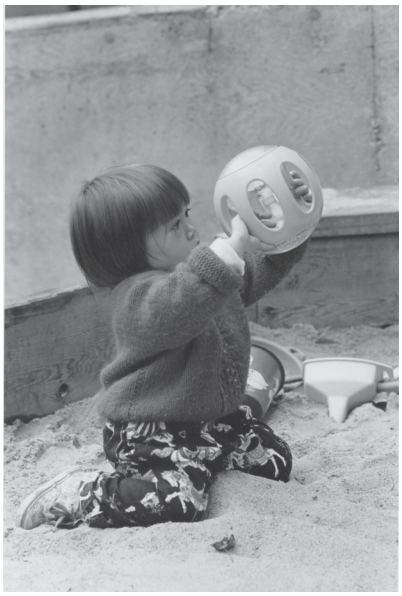
- Introducing herself as someone who is knowledgeable about children but in need of parents' unique knowledge of their particular child. The consultant is enlisted by the childcare center but is not *of* the center.
- Asking parents who they view the consultant to be. The consultant's direction can be determined by their perceptions, since parents help

the consultant elaborate on their ideas of how she might be useful. Conversely, she can dissuade them of grandiose hopes or fears.
- Conveying an understanding of the parents' perspective of the situation. Do they share the teacher's views of how their child is faring in childcare? If their perceptions differ from the staff's, the consultant acknowledges the various points of view.

These inquiries are accompanied by explanations of why and how the consultant thinks the parental information is essential to understanding the child. Such explanations are useful because they increase the likelihood that the consultant's intent will be understood. By clarifying connections between information about the child as presented by the parents and the child's experience in childcare, she promotes the possibility that parents will share—or allow the consultant to share—information with the staff. In addition, they demonstrate her desire to connect and mutually develop hypotheses about the meaning of behavior. As the consultant develops hypotheses, she shares them with parent and teacher.

Factors contributing to the child's difficulties in childcare often predate and extend beyond the childcare setting. Many times, parents identify these contributors during meetings with the consultant. At these times, parents can share information about the child's history and socio-familial stressors that may be affecting the child.

To summarize:
- The consultant must treat parents with respect and be empathetic and non-judgmental. Her understanding of interpersonal behavior and constructs of human motivation guide her interactions.
- Ideally, the consultant should speak the primary language of the family, but at minimum should be knowledgeable about the family's cultural perspective and values.
- It is crucial for the consultant to articulate—first to herself and then to the parents—what roles she can appropriately play in this process.
- The consultant must demonstrate these limits by identifying the factors that she and parents can explore regarding their child's experience in childcare.
- The consultant should maintain a therapeutic orientation toward the parent, but should not engage in a treatment relationship.



"I think the ECMH consultant is terrific. She has a great deal of empathy for children and adults and a great deal of wisdom borne from experience, and, I imagine, a good dose of common sense. She has helped me a great deal."

Michele G.
Teacher

Case Consultation Continued: Turning Hypothesis into Action

Returning to Yury

The consultant's ability to allay the family's suspicions and elicit their involvement greatly enhanced the possibility of her usefulness. The consultant returned to the program to implement a plan about which the adults in Yury's life could all agree. With the plan in place, the consultant began to spend a few hours each week in Yury's classroom. There, she joined in his play and activities. Afterward, she would meet separately with his mother and teachers. Together, they began to unravel the meaning of some of Yury's behavior. He seemed extremely sensitive to stimulation and his overwhelmed, disorganized behaviors appeared to be imbalances in regulation and his unsuccessful attempts to regain it.

As a three-year-old, Yury had avoided such stimuli by retreating to the peace and quiet of the play yard. As he developed more interest in socializing with other children, avoidance no longer worked as a strategy since it precluded social interaction.

In his current classroom, Yury also did not have the luxury of the yard when he felt his space getting "too small." He coped by trying to block out the threatening stimuli with babbles or screeches. Then, he would seek calming, deep sensory input such as pressure, sucking, chewing or running back and forth along the length of the classroom. Of course, what was self-calming to Yury looked disruptive to his teachers.

Simply put, Yury's senses overloaded easily. When the level of environmental stimulation became too much to manage, he could not soothe himself because he did not know how. Neither did the adults in his world. But, with the consultant's help, the causes and meanings of his behavior were becoming clearer to those who cared for him.

The consultant learned that Yury behaved very differently at home. The environment had little noxious stimuli that he had to defend against. Consequently, he exhibited his stress in less dramatic ways. Additionally, his family had also unconsciously accommodated itself to Yury's needs.

The mother's brother knew when Yury needed wrestle-time to provide the deep release he got through pressure. Mom steered him into conversation when she saw his agitation about an inability to produce ideas with paper and pencil. Although they considered it unusual, the grandmother always supplied his favorite bedtime snack of a plate of sliced lemons, accompanied by the reading of two books. The routine was never altered.

The consultant began to interpret the family's intuitive responses in ways that helped them see how these related to and compensated for Yury's vulnerabilities. At the same time, she pointed out that the help they provided—combined with fewer environmental obstacles—might account for his behaving differently in various settings.

Witnessing the disparate behaviors consolidated the consultant's understanding of Yury. It also helped explain how the parent-staff relationship had become so strained. Neither believed the other's characterizations. As the adults became able to trust the consultant's intention to help them all, they were able to trust her observations about how Yury behaved in different settings. This was done without judgment and the result was a clearer picture of Yury and the roles of the adults in his life.

The consultant also helped both sides develop mutual respect and trust. She reported to the mother the methods teachers were using to adapt to Yury's needs, which softened her attitudes. Conversely, she informed staff of the family's efforts to incorporate what they were learning about Yury, as well as their increased appreciation of the staff's attempts to manage him in a stimulating environment.

By interpreting the perspective of one group to another, the consultant facilitated an alliance of the adults in Yury's life. In turn, staff and parents were able to move ahead in a spirit of collaboration on his behalf. They now stood in solidarity.

Everyone entered the effort to develop strategies to help Yury deal with his challenges. The team included teachers, family members, and the consultant. The teachers adapted the classroom environment and instituted certain routines solely for Yury, and, based on the knowledge they had acquired, they adjusted their interactions with him to meet his specific needs.

Acting as a filter, they protected him from overwhelming stimuli. They also acted as translators, interpreting the environment and his responses to it, noting noises that bothered him and approaches he experienced as assaults. Through his teachers, Yury began to develop an awareness of his needs and, as they helped to regulate and soothe him, he began to internalize methods of doing so himself.

These changes in the relationship between Yury and his teachers were monumental. Still, the most significant shift occurred between the adults in his life. As they experienced success, the teachers began to include the family in these moments of pride and acknowledge the parents' positive contributions. Similarly, the mother's appreciation of the teachers' skill and perseverance increased dramatically.

Only when they were able, with the consultant's help, to view one another as allies, could they come to truly see Yury, and only then could they weave together supportive relationships in which he could be held. Through consultation, the web of relationships was strengthened.

Key Elements of Case Consultation

The consultant cultivates relationships with all of the adults in a child's life, conveying the message that everyone's contribution to the process is vital. She then considers all of the information from various sources in order to begin developing hypotheses about the meaning of a child's behavior.

As the behavior becomes more comprehensible, teachers are better able to respond empathetically and effectively. In addition, as teachers recognize the centrality of their relationships with children, their interest in working with the consultant is heightened. It is in this context that the consultant's suggestions and expertise can best be incorporated. The childcare staff and consultant translate a mutually developed understanding of the child's needs into responsive action.

Not surprisingly, how the consultant offers ideas is as important as the ideas themselves. A sensible approach is to inquire about the feasibility of implementing any suggestion and to be open to modifying recommendations based on what is reasonable and realistic for the staff. So simultaneously, the consultant must enthusiastically offer ideas about intervention or interaction based on understanding of the child's needs while remaining aware of what is possible for the teacher to provide.

Staying aware of the constraints that group care or a particular setting impose is an essential part of the process, and the consultant should invite the teachers to express what they feel will or won't work in a given context. The consultant is aware that no matter how well she feels she knows a program, teacher or child, there may be factors of which she is unaware. These factors might make her suggestions inappropriate or unworkable.

Inevitably, the success of consultation depends on the teacher's perception of its usefulness. Even the

most brilliant suggestion is doomed to failure if teachers are not convinced of its merit. Ultimately, involving teachers in the creation of intervention strategies creates the greatest possibility of success.

In the case of Yury, the mental health consultant:

- Formed an alliance with center staff.
- Engaged the mother in a respectful and caring way.
- Was flexible in her approach to working with the family and the teachers.
- Clarified the meaning of Yury's behavior.
- Helped to create an environment that worked for Yury.
- Helped to keep Yury from being removed from the center.
- Helped develop a long-term plan for Yury which could move with him to the next grade, providing future teachers with the insights and tools they will need to work with Yury effectively.

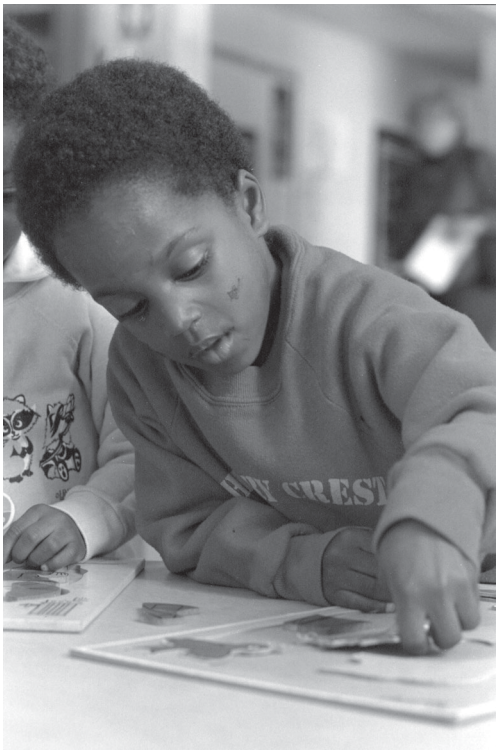
When Consultation Is Not Enough: Direct Intervention

As effective as it can be, consultation is sometimes not enough.

In these circumstances, Early Childhood Mental Health offers individual psychotherapy for the child and family. The parents' relationship with the consultant often influences their willingness to work with other mental health professionals when appropriate. Their experience of receiving help in understanding their child can aid in developing the trust necessary for engaging in further treatment. The consultant does not provide treatment to the child or family, but rather refers the family to a colleague who is part of the Early Childhood Mental Health team of clinicians.

The Early Childhood Mental Health therapists share the consultant's flexible approach to engaging and working with families. She can offer mental health services in a convenient location—on the childcare site or in the family's home— at times that work for the family. Being able to offer this kind of flexibility increases the likelihood that the clinician will be able to see the child and family regularly.

Family involvement in psychotherapy typically coincides with the consultant's work with childcare teachers. With parental permission, the consultant and clinician share information about the child. Each then develops an appreciation of the child's functioning in all arenas, which they can distill and pass along to other adults in the child's life.



"Thank God for services like these that help support families in crisis. The support provided by this on-site service is priceless."

Michael C.
Parent

Program Consultation

The aim of program consultation is to improve the quality of care for all children by improving the quality of relationships within a childcare center's community. Program consultation directly addresses center staff and administrators' concerns about organizational structure and other general programmatic issues that are impacting the quality of their relationships with children.

Consultation around adult relationships, specifically those influencing organizational functioning (inter-staff relationships, communication of role expectations, etc.) is, surprisingly perhaps, a primary focus of Early Childhood Mental Health's program consultation. Attending to how adults within a childcare program treat one another is, we believe, a crucial contributor to the overall quality of care.

The consultant proceeds from the premise that the ways in which people are treated influences, in a parallel fashion, how they will treat others. Therefore, she is committed to understanding the myriad relationships influencing teachers as this directly relates to the quality of their relationships with children. Therefore, the constellation of relationships is carefully considered.

Understanding the intricacies of staff relationships as they impact program functioning is possible only over time, and with regular contact. Therefore, the consultant meets with staff regularly, usually weekly, for as long as they find the consultant's involvement useful. This may mean a multiple year involvement with a childcare program.

A consistent and long-standing involvement with a childcare program evolves incrementally. This begins by determining with the staff when and with whom the consultant will meet. Establishing a forum for dialogue is a necessary first step. Within the established forum, the consultant assists staff in being able to convey their perspectives to one another, ensuring that each teacher's perspective is heard. As teachers feel understood and able to understand each other, the quality of their relationships generally improves. In turn, their relationships with children are likely to improve.

The Decision to Work With a Consultant

Three years ago, Michelle came on board as a new director of Redwood Shores Child Development Center (name changed to protect confidentiality). Redwood Shores, a full-day childcare program that has been in operation for 18 years, serves 52 two-to-four-year-olds divided into four groups. The children are primarily from monolingual two-parent Hispanic families who live in the neighborhood and work 10-hour days to make ends meet. The center has nine teachers (two for each group with one floating teacher), an office administrator and a director. Although a long-time childcare professional, this was Michelle's first position as a director. While excited about her new job, Michelle soon realized she had inherited a tangle of complex inter-staff relationships. The problems between the staff members were affecting the children; the classrooms were both disorganized and chaotic. It was clear to Michelle that the inter-staff issues were interfering with the staff's ability to be attentive, caring and effective with the children whom it was their mission to help.

For several months Michelle attempted to intervene on her own to improve staff relations. Her efforts had little impact on the problems among the staff members, however, and Michelle soon realized that she needed a new approach. She decided to seek Early Childhood Mental Health's assistance, requesting program consultation.

The Consultation Process

Early Childhood Mental Health's first step was to match a consultant with the center, based on availability, language capacity and experience providing consultation. At the beginning of the

"Staff morale has greatly improved since we started working with the ECHM consultant. We haven't resolved all our organizational issues yet, but we're much more able to problem solve solutions in a respectful, non-threatening manner."

Lisa K.
Administrator

consultation process, the consultant (Linda, a Spanish-speaking licensed clinician with experience in early childhood education) met with Michelle to learn about the center's history and her experiences. Linda knew it was important for her to gain as complete an understanding as possible of the center and how it worked before she could begin to strategize about how to help the staff with their difficulties. Her first step was to find out as much as she could about Michelle's role in the center and her perspective on the issues the center faced. It became clear that up until this point, Michelle had felt so frustrated and ineffective that she had distanced herself from the unpleasantness of it all. Focusing on her administrative duties, she was rarely a presence on the floor at all.

To complicate the situation at Redwood Shores even further, the center suffered a serious blow when it simultaneously lost three of its valued teachers shortly after the consultation process began. With their departure, Michelle felt they had taken some of her hopes for the program with them. At a time when the center was grieving the loss of three beloved teachers, Michelle was pulling back and leaving the staff without a site supervisor to support them.

Linda's next step was to hear from the staff. With permission from the staff and with Michelle present, she met with the teachers to give them a chance to talk about their histories and experiences. At the end of the meeting, Linda asked the staff how they thought she could be most useful to them. It was important to her to begin the consultation process by soliciting the opinions and desires of the staff members. They said they felt her presence made it easier for them to tell Michelle what was on their minds and to focus on the classroom functioning and on the children. The group decided she would attend their weekly full-staff meetings to help them talk with, and listen to, each other and to problem-solve. Linda hoped that if they felt they could work things out with Michelle, they eventually would believe they could do the same amongst themselves.

With Linda's help in improving communication throughout the center, Michelle soon acknowledged the need for a more attentive presence on the floor and secured board approval to restructure staff and make one of the teachers, Jordan, site supervisor.

After promoting Jordan to site supervisor, Michelle then offered a head teacher position to Denise, a current assistant teacher. Denise, however, declined the offer. Michelle faced a dilemma—Denise did not want the job but there were no other qualified applicants. So she decided to give Jordan a substantial raise and make him site supervisor in addition to his role as head teacher.

Linda worried about Jordan taking on too much. After all, he was inheriting the same difficulties Michelle encountered. Nonetheless, Jordan jumped feet first into the site supervisor's role. As his administrative duties mounted, Jordan shortened his classroom time and, just as Michelle had done before him, became less available to the teachers. He hired substitutes and began relying more and more on Denise. In effect, she became head teacher despite her stated desire not to do so.

As site supervisor, Jordan began feeling as Michelle had. He and Linda met weekly and he talked (and sighed) about his responsibilities and struggles with staff. Meanwhile, Denise saw that Jordan was overloaded. She quietly stepped up and did more, trying to relieve his load by taking care of everything she could manage. She did not have much left for the children.

Consequences for the Children

Shortly thereafter, Michelle called Linda about four boys acting up in Denise's classroom. As Linda discussed the situation with Jordan, Denise stuck her head in and asked if she could speak with Linda when she finished. When they met later behind

closed doors, Denise burst into tears. She told Linda she had been having a terrible time in the classroom but did not want to burden Jordan with it. Not confident about substitutes, she had been dividing the class in half and taking the four "acting up boys" with her. In a moment of intense frustration with one of the boys, she had lost her temper and grabbed at him.

It was clear to Linda that the staff problems at the center were being reflected in the troubles with the children. Michelle's unavailability to Jordan and Jordan's unavailability to Denise had limited Denise's availability to the children. Preoccupied with her overwhelming responsibilities, Denise had been unable to effectively care for the children in her classroom, much like Jordan and Michelle were unable to care for the staff. This was a classic example of parallel process: the children's experience corresponding to the staff's. **The children were not being attended to and therefore, were disorganized and anxious because they didn't know whom to depend on.** Linda understood the children needed more support from Denise, who needed more support from Jordan, who needed more support from Michelle.

The Consultative Process

After extensive discussion with Michelle and the Redwood Shores staff, combined with close and attentive observation, Linda identified the key areas where the center was running into trouble:

- Relationships between staff members.
- A lack of communication between the staff and Michelle.
- A need for clarity in the delegation of responsibility.

After pinpointing these crucial issues, Linda's next task was to strategize with Michelle and the staff members to solve them. She decided in partnership with Michelle to approach the issues from two angles: working individually with Michelle and Denise, and helping Jordan support Denise while asking for support from Michelle.

Linda's first goal with Michelle was to help her empathize with the position Jordan was in while at the same time empathizing with Michelle who felt she was in the same position. Linda shared her worry about Jordan burning out working two jobs. Linda encouraged Michelle to talk with Jordan to explore together how to improve the situation.

Linda's second goal was to have Michelle fully appreciate her staff's need for support. Linda encouraged Michelle to think not that she was dealing with yet another staff "issue," but that she was working to improve the quality of the children's experience. With Linda's help, Michelle came to realize that the teachers needed to have the same experiences of consistency, predictability and support that the center tried to provide for the children. Framed in this way, the unpleasant task of tackling staff relations and communications was transformed into a goal to meet children's needs, something Michelle had always been able to work toward.

Meanwhile, Linda also worked with Denise. Linda said that until Denise was able to talk with Jordan, she would continue to feel bad about her actions and worry about her job. When the three met and finally cleared the air, Denise was heartened by Jordan's reassurances. She finally told Jordan how difficult things had become since he had curtailed his classroom time and admitted she could not handle the four boys by herself.

Linda then turned her attention to Jordan. He said the meeting allowed him to recognize himself in Denise. Her being overworked and unsupported was all too familiar. He also saw that both of them felt unable to tell others about their situations and ask for help.

Unlike a fairy tale, everything did not end "happily ever after" at Redwood Shores. The center

"The ECMH consultant was a great help to me as a teacher and I believe to the parents in our program. She specifically helped me to identify issues concerning a student and she taught our staff what we should watch out for in a child's development."

Chris E.
Teacher

continues to work on improving staff communication and classroom issues. However, Michelle and Jordan have begun meeting regularly with the consultant to problem solve together. In addition, Jordan and Denise developed classroom strategies to separate the four boys. Most importantly, the staff at Redwood Shores Child Development Center is talking, listening, and problem-solving on behalf of the children they care for.

Key Elements in Program Consultation

The consultant has a variety of roles in program consultation, including aspects of being a coach and a facilitator. She also needs a thorough understanding of organizational development in general in order to be effective in helping any one particular organization.

When the consultant comes to a childcare center, she acts as an outside observer, seeking opportunities to see and experience as many aspects of the childcare center as possible in order to develop an in-depth knowledge of the center, its functioning and its problem areas. It is only with a profound understanding of the organization that the consultant, in partnership with the center staff, can identify areas that need improvement and strategies for ways to address them.

Furthermore, the consultant must be able to understand—and communicate the value of—the childcare teacher's view. When the childcare teacher feels both heard and understood, she will not only be able to better hear and understand the children, but will also be more attentive to her communication with fellow staff members and supervisors.

The consultant then works with the director and staff members of the center to develop hypotheses about what is happening at the childcare center and how to deal with the problems, encouraging an atmosphere of exploration and working with the consultee to discover and implement solutions. As a result, the childcare staff becomes the source of ideas and comes to appreciate the mutual nature of the consultative endeavor. Throughout this process, the consultant maintains a position of objectivity, never allying with any individual or faction. She legitimizes each position, without joining or defending a particular perspective.

Lastly, it is crucial that the consultant hold parallel processes as an organizing principal. Her methods stem from the strong conviction that the ways in which people are treated affect how they treat other people. She "does unto others as she would have them do unto others."

Training Mental Health Consultants

Overview

A decade of providing mental health consultation increased the Early Childhood Mental Health's appreciation of its complexity. Meanwhile, requests for consultation outstripped our capacity to respond. Those developments spurred us to develop a concentrated training component for mental health practitioners wishing to expand their clinical expertise to include mental health consultation to childcare facilities, in order to insure a pool of qualified professionals to do this important work.

Other factors convinced us of the need for a comprehensive training program. Paramount among them was a heightened awareness of the special skills a consultant must possess and the lack of higher education and professional training geared directly to this area. Besides having a particular clinical stance, a mental health consultant must have a keen understanding of the varied aspects of group care and an appreciation of how it differs from clinical intervention with children.

In our work, we discovered that a preponderance of issues addressed in program consultation concerned adult interactions. Consequently, consultants must also understand group work with adults and principles of organizational functioning. And, since we knew mental health professionals' training often lacks emphasis on typical child development, didactic training was developed to address these gaps.

Training Mental Health Professionals

Understanding parallel process is the heart of our training approach; consultants learn to treat teachers as they wish teachers to treat the children in their care. We teach that what consultants learn only becomes useful when teachers are approached with empathy and respect. To this end, we emphasize establishing mutuality and collaboration. **Training focuses on listening and "holding" information acquired from a variety of perspectives. Respecting and understanding the teacher's perspectives and feelings about a troubling situation or child is underscored.**

The training component we have developed consists of three parts:

- Didactic training seminar, including written materials and readings.
- Clinical conference.
- Individual clinical supervision.

The didactic seminar is conducted weekly for three hours during the first year of a mental health consultant's employment and once a month thereafter. A new consultant begins with several weeks of observation in a variety of childcare settings. An experienced staff consultant accompanies consultant trainees. Observation corresponds to the focus of the didactic seminar, which begins with a discussion of observation in childcare.

This observational period has several important goals. The first is to expose consultants to a variety of childcare settings, from small family childcare programs to large subsidized centers, so they can begin to appreciate the range of philosophies, environments and perspectives about childcare. Furthermore, it allows the trainees to begin to develop internal questions that will guide them in understanding a unique childcare community's functioning. An additional purpose of the observations is for consultants to begin to consider the meaning of their presence and behavior in the childcare community. For example, they are asked to think about what expectations teachers might project onto them given teachers' past experience with outside experts, mental health professionals, or visitors/evaluators of any kind. These skills are extremely important in a program consultation like Linda's, where she had to develop an in-depth understanding of the Redwood Shores program as a

"I just wanted to say how much I appreciate the ECMH consultant's work. She took time to really involve herself with my son, offer her assistance in his meetings, and help me with any questions I had. She still keeps in touch with us, wanting to know how he's doing. I don't think I can thank her enough for all that she's done, and I'm glad that she's able to help out parents who really need it. It makes a real difference in our lives."

Elena J.
Parent

whole, as well as the perspectives and expectations of Michelle and the other staff members, before she could begin to help them address their particular problems.

Toward the end of this observational period, the didactic seminar focuses on initiating consultation relationships and in particular what elements to consider in the formation of a positive consultation relationship. This translates into intense training focusing on recognizing, empathizing with, and responding non-judgmentally to teachers' particular concerns and their subjective experience. This aspect of training is particularly important in consulting about a child like Yury, where the consultant was given conflicting information about Yury's behavior from the teachers and from his family. Instead of choosing one point of view over another, the consultant in this situation was able to listen to both perspectives and come to understand that Yury truly behaved differently in different environments. By recognizing and not judging the opinions of both the teachers and the family members, the consultant was able to bring together all of the information about the child in order to form a more complete picture of Yury and the possible roots of his problems.

In addition to providing opportunities for observation and reflection, the didactic training seminar also focuses on child development. Our approach is to understand early child development as an interactive phenomenon. We see the adult-child relationship as driven in part by the rapidly emerging cognitive, motor and social-emotional capacities of the young child. Understanding early development demands high levels of responsiveness and flexibility on the part of the adults.

Our training and attention to development concentrates on looking at the child as an active contributor in these relationships, a participant whose patterns and pace and rhythms influence and shape their experience of themselves. It also is based on the idea that any adult brings to the relationship with a child her own personal history, perceptions of childrearing, and ideas about the meaning of development. Since these ideas will inevitably be projected onto and influence the relationship with the child, this aspect of the child-adult relationship receives particular attention in the training. Additionally, consultants receive training from our neurodevelopmental psychologist. This component focuses on development chronologically (birth to five) within discrete domains. The development of play and language are also given specific attention.

The clinical conference is often considered one of the most useful aspects of the training.

Clinical Conference

Like the training seminar, the clinical conference is held in a group format. This takes place two hours each week during the first year and every other week in subsequent years. On a rotating basis, consultants present an aspect of their consultative work. Clinical conferences provide opportunities for trainees to discuss shared issues and to receive collective feedback. While there is no strict formula for presenting, it is the responsibility of the presenter to convey a sense of the situation, the child or the parent, the known history of each, and the focus of the consultation. Usually the group at the initiation of each clinical conference poses a question of particular interest to the presenting consultant for consideration. For example, a consultant-in-training working at Redwood Shores might have asked her group to consider how to make the staff members understand the parallel process that was occurring at the center: Michelle's relationship with Jordan mirrored Jordan's with Denise, which mirrored Denise's with the children.

The clinical conference is often considered one of the most useful aspects of the training. To begin with, the senior staff and supervisors of the consultation program are present and contribute to each clinical conference. They help facilitate the discussion among all of the consultants-in-training and generalize from the specific situation being presented to circumstances

that are similar for all of the consultants. Because the staff members who participate in the clinical conference are also the supervisors of the consultants, they bring into play their intimate familiarity of each of the consultants' styles and struggles.

The clinical conference is also a time when the consultants-in-training have an opportunity to:

- Share clinical perceptions.
- Share information regarding resources, such as useful community organizations, status of school district programs, possible referrals, etc.
- Learn about the experiences of other consultants.

Paramount to this forum's usefulness is that it reinforces to the consultants that they are not alone in their struggles, frustrations, and disappointments. Clinical conferencing diminishes the feelings of isolation which result from the consultants being at the childcare centers or family homes.

Individual Clinical Supervision

Individual clinical supervision, for one hour every week, embodies some of the most important aspects of the consultant's training. It provides a place for learning about the consultant's role in the process of consultation, and it provides the consultant-in-training with an opportunity to reflect, focus on, and understand her particular impact in relation to specific centers, families, clients, and situations.

Early Childhood Mental Health believes the parallel process extends in all directions. In this situation, clinical supervision helps consultants maintain emotional equilibrium as the supervisor understands and empathizes with the supervisee's conflicting emotions and perspectives much as she expects the supervisee will do with childcare staff, families and children. The supervisor also fosters mutual exploration and problem solving. In parallel fashion, these values are passed from consultant to teacher. This mutual exchange supports high-quality attention to teachers, children and families.

Supervision includes a variety of components. Primary among them are the issues of parallel process in three key relationships:

- Between the supervisor and the supervisee.
- Between the supervisee (consultant-in-training) and the consultee/teacher.
- Between the teacher and the children for whom she is caring.

Similar to our view of consultation, the supervisee sets the agenda as to the content of supervision. The supervisor ensures that the supervisee's subjective experiences of situations can be voiced and understood, and helps her to relay the perspectives of all of the other participants. Together the supervisor and the supervisee are partners in constructing the meaning of all of the relationships. They attempt to mutually create meaning that the consultant can then use in her continued understanding of her work.

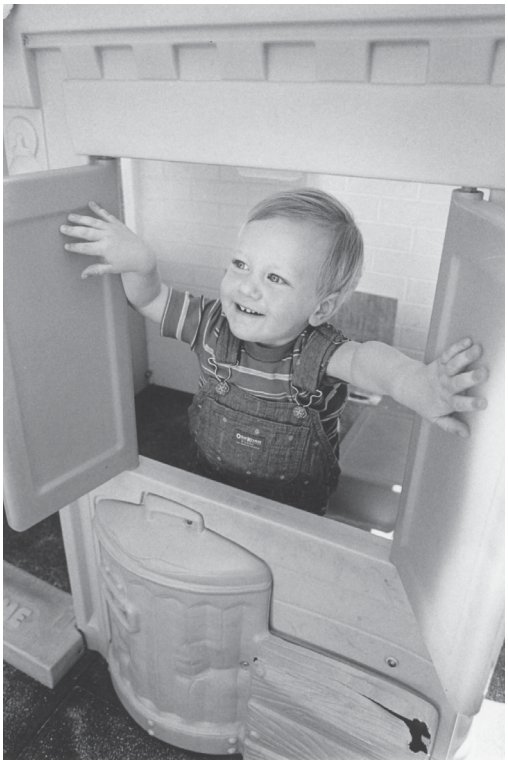
For example, the supervisor may need to assist the consultant-in-training in understanding and including the points of view of all of the contributors to a child's life. In Yury's case, the consultant had to consider the perspective of the mother who initially was resistant to the idea of consultation. By taking into account the mother's cultural background and how it shaped her perceptions of mental health services, the consultant could better aid the mother in overcoming her reluctance to work with the consultant and the teachers.

The supervisor must help the consultant explore and get more information, not just about how a child behaves in the center, but also about their history, their constitutional particularities and their experience at home. In addition, the supervisor may provide guidance by reminding the consultant that her job is in large part to encourage the adults

who are working together to see each other's perspectives; it is not her place to take over either by telling them what to do or doing the work for them, but rather to help them establish an effective working relationship. Once again, both of these skills proved crucial to helping Yury; the consultant brought the adults in Yury's life together so they could share information in order to help solve his problems. Linda's work at Redwood Shores also reflected the importance of these elements of the training process. It was only by helping the adults at the center listen to each other that they began to devise a way to improve the quality of childcare.

While the supervisor's receptivity to the supervisee is important, being able to state one's opinions and needs is equally crucial. By virtue of his/her greater experience and training, the supervisor is the bearer of certain authority, and it must be appropriately and clearly exercised.

Each of the consultants has more than one clinical supervisor with whom they meet. While all of the supervisors are versed in, experienced in, and share the same fundamental theoretical approach, each brings into play his or her unique style. This range of perspectives not only helps the supervisee experience various opinions and styles, but also supports the supervisees in developing their own unique way of being as a consultant.



Evaluation of Effectiveness

Process Evaluation

The quality of the childcare setting has a profound effect on the children in its care. Researchers agree that children who receive high-quality care demonstrate better cognitive, language, emotional and social skills than those who receive low quality care (Scarr, Eisenberg & Deater-Deckard, 1994). Access to quality care helps children become emotionally healthier and better prepared to succeed when they enter school (Cost, Quality & Child Outcomes Study Team, 1995).

Since the mid-1980s, however, there have been a number of indications that childcare programs have actually declined in quality (Howes & Whitebook, 1991) and that more children are entering elementary school unprepared to learn. By the time of a 1995 study, 18 percent of kindergartners were not considered by their teachers to be ready to fully participate in school (Maxwell, Bryant, Peisner-Feinberg & Buysee, 1996).

We believe that the percentage of children not ready for school could be reduced if high quality care were available to all young children who need it. **We also believe the model we have created improves the functioning of childcare centers, enhances teacher knowledge and skills, and ultimately leads to better outcomes for the children**. Increased teacher knowledge and support enables teachers to recognize children for whom specialized testing and possible adjunct services are indicated, and to access special help so that these children do not establish a pattern of failure before reaching school age. To assess whether these outcomes are met, the Early Childhood Mental Health Project has developed a number of evaluative tools to inform consultation practice. These tools also educate current/future funders about the need for and efficacy of consultative efforts.

Evaluative Measures

Childcare Program Functioning

Each consultant uses the Childcare Quality Checklist (an abbreviated adaptation of the ECERS) to gather descriptive data about the overall quality of the childcare center. This tool rates the sites on four criteria:

- Physical space.
- Materials and activities.
- Children's experience.
- Teachers' interactions.

Consultants use the checklist as an observational and informational tool at the onset of their involvement with the center. Consultation targets the fourth criterion: the way teachers treat and interact with children.

Level of Program Improvement

The Problem Statement-Goal form is the measure developed so each consultant may rate program improvement in specific areas. After an initial assessment period, the consultant identifies specific issues to be addressed. During consultation, explicit goals related to these issues are established. The problem statement-goals are rated at three-month intervals. The five assessment areas are:

- Program organizational issues pertaining to inter-staff relationships.
- General programmatic issues.
- Programmatic issues related to individual children.
- Parent/teacher interaction issues.
- Direct interaction with parents/case management.

"We are the parents of a five-year-old boy who attends preschool in San Francisco. The two fulltime teachers at the school are both seasoned experts who care deeply about all the children. But even outstanding professionals such as these occasionally encounter children who are stuck in patterns, which could, if not resolved, evolve into more serious problems. And even teachers like these need the advice of a consultant, who can work with the children, the parents, and the teachers in devising strategies to overcome particular problems."

Richard & Sara P.
Parents

Level of Improvement for Children in Consultation

The *Problem Statement-Goal Form* is the measure developed so that each consultant may rate the level of improvement in areas that are specific to a particular child and program. After an initial assessment period, an evaluation of the most pressing challenges for the child is made and specific goals related to these problems are established. The problem-goal statements are rated for improvement at three-month intervals.

Teacher Interaction with Parents and Children

The Teacher Interaction Scale was adapted to quantify changes in the quality of interaction between the teacher and the child for whom case consultation was requested. The tool is completed during an initial observation and again at the conclusion of case consultation. This tool uses a five-point rating to examine two important relationships: teacher/child and teacher/parent.

Teachers' Satisfaction with Consultation

Childcare center directors and staff complete a Consultation Questionnaire at the end of each service year to assess overall satisfaction with consultation and the degree to which the consultant helped them accomplish their objectives.

Parents' Satisfaction with Consultation/ Education Activities

The satisfaction of parents and the degree to which their needs are met and their knowledge increased are measured through a Parent Response Questionnaire distributed at the end of a case consultation and a Parents' Group Questionnaire distributed at the end of a parent education session.

Comprehensive Program Evaluation

Because the Early Childhood Mental Health Project is largely a prevention model, quantitative evaluation is difficult. Consultation is not a "quick fix." Evidence of its success can be evaluated only over time.

We believe systematic evaluation is a critical element to the eventual nationwide dissemination of the Early Childhood Mental Health model, and we determined that a formal, scholarly evaluation was needed to assess program elements. Emphasis was placed on short- and long-term outcomes of early childhood mental health intervention on concerns such as school readiness.

To accomplish this Early Childhood Mental Health review, JFCS hired Dr. Sharon Lynn Kagan—the Virginia and Leonard Marx Professor of Early Childhood and Family Policy at Teachers College, Columbia University, and a Senior Research Scientist at Yale University's Child Study Center—to consult with project staff in developing an evaluation design.

Dr. Kagan worked with Malia Ramler and other evaluation specialists from James Bowman and Associates to:

- Determine appropriate measurable outcomes.
- Identify/develop tools to measure the short-term impact of the early childhood mental health consultation model on childcare centers and teachers.
- Develop and implement data collection systems.
- Develop methodology to analyze the data.

Design Overview

A one-year evaluation was conducted in forty childcare centers in four greater SF Bay Area counties. Observational data was collected in a subset of twenty centers in the larger sample. Data

was collected only once. Participants in the study included directors of the childcare centers receiving services (n=35 of a possible 40 for a response rate of 88%), and all the teachers working at participating centers (n=135 of a possible 260 for a response rate of 52%). Teachers who responded represent 39 of a possible 40 programs. Observations were made at twenty of the childcare sites by a trained research assistant.

The focus of the evaluation has been on documenting the effect of mental health consultation on the quality of the childcare center and the self-efficacy of teachers. No child-level data has been gathered. While having a positive impact on children is of course a desired outcome, the evaluation design focuses on programmatic and teacher outcomes because the consultation model is primarily programmatic, rather than case based. We believe that if consultants have an impact on the quality of the center and on the knowledge base and self-efficacy of the teachers, the benefits will extend to all children at the site, not just those who may be the focus of individual case consultation.

This evaluation is cross-sectional in design, with only one point in time for data collection. Consequently, the sample has been selected to include programs who are new recipients of consultation (less than one year) and longer term recipients of consultation (two years or more). This will allow us to examine the effect of longer-term mental health consultation. Data has been gathered to allow us to make sure that these two comparison groups are comparable with respect to factors that can impact child care quality outside of those that may be affected by consultation. Data has been collected to allow us to compare both groups with respect to:

- Socioeconomic background of families served.
- Educational backgrounds, qualifications, experience, and level of compensation for teachers.
- Teacher and director turnover in the last several years.
- Age of children served.

In addition to director interviews and teacher focus groups, several evaluation instruments were used:

- Early Childhood Environment Rating Scale revised (ECERS-R).
- Arnett Caregiver Interaction Scale.
- The Teacher Opinion Survey – a standardized measure of self-efficacy.
- A Consultant Effectiveness Survey – a standardized measure of satisfaction with the consulting relationship.
- Self-reports from teachers on their progress toward consultation outcomes.

The research questions are listed below.

- Does the provision of programmatic early childhood mental health consultation improve the quality of childcare and the quality of teacher-child interactions in childcare?
- What is the relationship between intensity and length of mental health consultation to childcare centers and childcare quality?
- What impact does mental health consultation have on teacher self-efficacy and morale?
- What specific activities constitute mental health consultation in childcare?
- What do childcare center directors, teachers, and mental health consultants feel are the key elements of successful working relationships between childcare sites and mental health consultants?

Preliminary Results

- As measured by the Early Childhood Environment Rating Scale–Revised, the **overall quality** of the JFCS observation sample is comparable with centers in a representative California sample and a representative National sample. The mean ECERS-R score for the JFCS sample was 4.96, just below the ECERS-R rating of 5, which indicates good quality. The mean ECERS score for the California sample in the Cost,

"I can't reiterate enough how helpful the Early Childhood Mental Health Services have been to me. My son's life and his chances for success have been greatly increased because of the amount of attention and care given to him from the ECMH program. I find the program consultants to be thoughtful, caring, dedicated individuals whose sole purpose is to see the family unit, and in particular, the children in question, succeed."

Lee H.
Parent

Quality and Child Outcomes in Childcare Centers Study (Cost, Quality and Child Outcomes Study Team, 1991) was 4.49. **There is a higher percentage of programs in the JFCS sample that score in the developmentally appropriate range than in the Cost, Quality and Outcomes California or National samples.**

- **Caregiver interactions** with children were assessed using the Arnett Caregiver Interaction Scale. Scores for teacher sensitivity, harshness and detachment were derived for one teacher at each observation (n=20). **Teachers observed in this evaluation were rated, on average, as more sensitive, less harsh, and about equally detached as compared to teachers in the California sample of the Cost, Quality and Child Outcomes study.**
- The teacher questionnaire contained nine **goal achievement** items. These items were developed for an earlier evaluation of mental health consultation to childcare providers and are based on mental health consultation program managers' statements of desired outcomes. **A large majority of teachers (74%-97%) agree or strongly agree with outcome statements such as** "I try to understand the *meaning* of children's behavior."
- Teacher **self-efficacy** was measured using the Teacher Opinion Survey (Geller and Lynch, 1999). The self-efficacy items were administered as a retrospective pre-test. **There was a statistically significant improvement in teacher self-efficacy based on teachers' responses to the self-efficacy scale "Now" and "Then," with then being before consultation.**
- Ratings on the twelve item Consultant Evaluation Form (CEF) (Erchul, 1987) were derived for all 126 teachers who replied "yes" to the question, "*Think about the mental health consultant providing services to your site right now. Do you have direct experience with the mental health consultant at your center?*" The CEF is designed to measure his/her perceptions of the **consultants' effectiveness.** The mean score for all respondents was 4.35 (on a scale of 1-5), suggesting that teachers evaluate their mental health consultants as very effective. It is worth noting that **almost 90% of the teachers responding agree or strongly agree with the statement, "*I would request services from this consultant again, assuming that other consultants were available.*"**

Results are encouraging. A final report will be available in spring 2003.

Acknowledgments

Decades of work by many people in the field of infant and toddler mental health has culminated in the project described within this manuscript. Foremost among the early childhood mental health pioneers is **Jeree Pawl, Ph.D**., former Director of the Infant-Parent Program in San Francisco and immediate past president of the Board of Directors of Zero to Three: National Center for Infants, Toddlers and Families. As Executive Director of the Infant-Parent Program, Dr. Pawl created Day Care Consultants in 1987 to address the needs of families for quality childcare. She was instrumental in shaping the work described within this manuscript and in creating a body of knowledge and practitioners dedicated to helping families with children under three years old.

Without the backing of **Sai Ling Chan-Sew**, Director, Child, Youth and Family Section, Community Mental Health Services, Department of Public Health, the County of San Francisco would never have considered adopting mental health consultation as its primary model of early intervention at childcare centers. We are grateful to her for her vision, perseverance and belief that early intervention with families of young children is a powerful approach to insuring healthy development.

Foundations that have believed in us and in the outcomes of our work include: The Jenifer Altman Foundation, The California Endowment, Marguerite Casey Foundation, Fireman's Fund Foundation, Gallagher Family Foundation, Gruber Family Foundation, Miriam and Peter Haas Fund, The Larry L. Hillblom Foundation, JoMiJo Foundation, Jewish Community Endowment Kohn Fund, The Lumpkin Family Foundation, Marin Community Foundation, Morris Family Foundation, Peninsula Community Foundation, Pickwick Fund of the San Francisco Foundation, Sequoia Healthcare District, May and Stanley Smith Charitable Foundation, Surdna Foundation, United Way of Sonoma, Mendocino, Lake "Success by Six" Initiative, Marco Vidal Fund of the Marin Community Foundation, Weyerhaeuser Family Fund, Zellerbach Family Fund, and The Harold and Libby Ziff Foundation.

Counties that have been collaborators include Marin County through the Marin Children and Families Commission, Marin Community Mental Health Services, Parent Services Project and Family Services Agency/Pregnancy to Parenthood and San Francisco County through the San Francisco Children and Families Commission, San Francisco Community Mental Health Services, San Francisco Department of Children, Youth and Their Families and San Francisco Department of Human Services. Staff members have been wonderful trainees and even better consultants. They have shown the commitment, dedication and perseverance necessary to "get the job done," and they have been instrumental in implementing the program design and being the experts in this new, burgeoning field.

We would also like to thank the hundreds of childcare teachers, family childcare teachers, and program directors who work daily to support the young children and the families in their care. They have taken the time and made the effort to work with us— during the children's naptime, on the playground or after work, often without compensation—to improve the quality of the care they deliver.

Others to whom JFCS and Day Care Consultants are grateful are our boards of directors and colleagues for their ongoing commitment to ensuring that children and families are strong and healthy and through their willingness to embrace new and creative ways to accomplish this goal.

Consultant's Job Description

Early Childhood Mental Health Project
1710 Scott Street
San Francisco, CA 94115

Contract Job Description

Job Title: Mental Health Consultant

Job Summary: Under the supervision of the Director of Parents Place, the Mental Health Consultant provides consultation to childcare centers as part of a grant-funded project to enhance childcare services for children birth to five years old and their families. The Consultant understands the mission of JFCS and works within the Agency's resources to achieve goals.

Primary Duties and Responsibilities

I. Mental Health Consultation

1. Provides case-centered consultation to teachers with questions or concerns about children at the center.
2. Observes children in the childcare setting to assess functioning, relationships with teachers and other children, and "fit" in the program.
3. Meets on-site or at home with families to complete assessments, provide developmental guidance and referrals, including linkage to clinical services.
4. Meets regularly with childcare staff individually and in groups to discuss individual children.

II. Programmatic Consultation

5. Observes the childcare setting to become familiar with the program offered to children.
6. Meets regularly with the childcare staff and the site director to address programmatic concerns, as requested.
7. Provides consultation to center staff on programmatic issues that affect the quality of care provided to the children, as requested.
8. Discusses effective mechanisms of working with parents, as requested.
9. Assists staff to build and maintain productive collegial relationships with one another, as requested.

III. Clinical Services

10. Provides responsive, clinical services to families, as indicated.
11. Provides case management services as needed and collaborates with schools and community agencies as indicated.
12. Facilitates parenting groups and workshops at childcare centers and at other sites as requested.

IV. Administrative

13. Maintains up-to-date records.
14. Charts regularly and accurately.
15. Participates in the Project evaluation, as requested.
16. Represents the Project in the community, as requested.
17. Complies with all standards of performance set by the Agency of employment and the Training Program.
18. Completes other tasks as assigned.

Qualifications:

1. Masters degree in social work or psychology and license or license-eligible required.
2. Bilingual and/or bicultural, representative of diverse ethnic populations to be served preferred.
3. Experience as a mental health clinician specializing in psychotherapeutic work with young children and their families.
4. Knowledge of early development and work experience in group settings for children.
5. Experience with assessment of young children's social and emotional functioning.
6. Experience with and/or knowledge of group dynamics and intervention with adults.

The above statements are intended to describe the general nature and level of work being performed. They are not intended to be construed as an exhaustive list of all responsibilities, duties and skills required of personnel so classified. JFCS is an Equal Opportunity Employer. This is an exempt position with benefits.

Description of Project Partners

Project Management

The Early Childhood Mental Health Project management team includes the Associate Executive Director of JFCS, the Director of Parents Place/JFCS and the Program Coordinator of IPP's Day Care Consultants. The team meets monthly to discuss progress, develop strategies and identify obstacles and solutions. At least once a week, the Director of Parents Place and the Program Coordinator of Day Care Consultants meet to discuss project implementation. At monthly group supervision sessions, they meet with consultants and clinicians to maintain connections, assist in problem solving, and determine whether project goals are being met.

JFCS acts as fiscal agent/project administrator, reports to the Department of Public Health (DPH), hires and provides administrative supervision for consultants and clinicians, evaluates program performances and outcomes, serves as liaison for other collaborators, and links families to JFCS services.

IPP Day Care Consultants designs, coordinates and implements training programs; places consultants and provides ongoing supervision; organizes centralized intake of childcare centers; provides direct services; and evaluates program performances and outcomes.

Jewish Family and Children's Services/Parents Place

Founded in 1850, JFCS is the largest non-sectarian provider of mental health and social services in the five-county west San Francisco Bay Area. Our mission is to alleviate suffering and help people of all ages develop and maintain their highest level of functioning by providing comprehensive professional and volunteer social services. This year, we will help more than 45,000 people.

JFCS offers more than 40 social service programs. Services include concrete assistance, home care and senior services, parenting programs and consultation to daycare centers and schools, case management, clinical treatment of adults and children, bereavement programs, refugee resettlement and citizenship training, outreach to those with disabilities and HIV/AIDS, social science research, and volunteer services to the isolated and needy.

With a 2001/02 annual operating budget of $22,275,471, JFCS maintains diversified funding. Approximately 33% of revenues come from contributed income, 61% from client fees and other earned income, and 6% from endowment income. The agency has extensive experience managing grant monies and tracking program progress.

Conducting in-depth, long-term research studies to test the efficacy of our practices and to make contributions to the field at large is an ongoing practice at JFCS. The agency is currently completing a multi-year senior care study funded by the Retirement Research Foundation, the California HealthCare Foundation, and the Evelyn and Walter Haas, Jr. Fund.

The Early Childhood Mental Health Project (Early Childhood Mental Health) grew out of an earlier program and study, the Schools Partnership Training Project (1988-1992), a consultation, service and research project in the San Francisco public elementary schools.

Parents Place Family Resource Center, part of the JFCS organization, started in 1975 as a San Francisco-based mother-infant support group. It grew gradually, group by group, service by service. Today, Parents Place is a nationally recognized, full-service resource center for families with children of all ages.

Parents Place offers an array of services to help build strong, effective families. Its community-based programs emphasize a family-focused, proactive approach to achieving positive long-term outcomes and self-sufficiency. Comprehensive support services include a drop-in play center, parenting education workshops and support groups, individual, couple and family therapy, therapeutic play activity groups, mental health consultation programs, a father support project, and programs for youth that include tutoring/mentoring, internships, and community service. Extensive referral networks and collaborative working relationships with service, policy and advocacy organizations have been in place for many years. They are well utilized to benefit children and their families.

Day Care Consultants, A Program of the Infant-Parent Program

The Infant-Parent Program is a direct service and training organization, established in 1979 at San Francisco General Hospital in an effort to bring specialized infant mental health services to the Bay Area. IPP provides clinical consultation and training and in-home dyadic psychotherapy with parents and children from birth to age three whose relationships are in serious trouble. Each year, IPP provides intensive supervision and training to 10-15 graduate and post-graduate level interns who are developing a practice specialty in the mental health treatment of young children and their families.

Day Care Consultants, a program of the IPP with an exclusive mission of integrating mental health services within childcare programs, is in its 14th year of providing mental health consultation services to childcare teachers. DCC has taken a lead role in organizing a collaboration of childcare teachers across the geographic, cultural and economic breadth of San Francisco to improve the quality of care and promote awareness of childcare as a potential site for prevention of emotional and developmental difficulties and mental health intervention. DCC has organized and implemented groups for Latino and African-American Family Childcare Teachers, facilitates an ongoing group for childcare directors and has designed and taught early childhood education courses for childcare teachers. The Day Care Consultants' approach is presented both locally and nationally and is described and referenced in numerous publications.

Initially funded by foundation grants, DCC is currently supported almost entirely by public funds. Foundation funding afforded the first opportunity for childcare programs to receive consultation. After years of working with DCC, many childcare center directors began advocating for continued expanded funding. When San Francisco voters in 1991 passed legislation diverting a portion of property taxes to children's services, DCC was among the initial funding recipients. This funding, from the San Francisco Children's Amendment, continues to support a significant portion of DCC's efforts.

In summary, funding sources include monies from the previously mentioned Children's Amendment, the Department of Human Services and Community Mental Health Services (through the Department of Public Health), and most recently, Proposition 10 tobacco tax fund dollars. The latter funding are state funds administered by San Francisco County. The DHS and CMH funds are allocated for improvement in childcare. As our receiving these indicates, mental health consultation is seen as an effort impacting the overall duality of childcare.

Costs

The cost per site for the Early Childhood Mental Health Project intervention ranges from $17,000 to $22,000, depending on the size of the site and the experience level of the mental health consultant.

Funding social service programs and mental health services in particular is always a challenge. In our case we decided in the beginning to seek grant funding from one source to initiate the project and to then use our hoped-for success to leverage other foundation public support for our efforts on behalf of the children and families in our community.

In the mid-1990s, a seed grant from the Miriam and Peter Haas Fund made it possible for Parents Place, a non-sectarian program of Jewish Family and Children's Services, to collaborate with San Francisco County Mental Health Division and Day Care Consultants of the University of California at San Francisco on the Early Childhood Mental Health Project. As this project gained momentum, research was published on brain development and the effects of quality childcare on the optimal growth of young children. More foundations adopted "prevention" and childcare improvement as their strategies for preparing young children for school. At the same time, Californians decided to invest "tobacco tax" money in young children, also with the hopes of enabling children to get a better start in life.

Our collaborative began first in San Francisco County and then moved into Marin, San Mateo, Santa Clara and Sonoma Counties. We worked with foundations, county offices of mental health and Proposition 10 Commissions to expand the services provided to 46 childcare centers and family childcare homes. Working throughout the San Francisco Bay Area, we have been able to assist more than 2,000 ethnically diverse and economically disadvantaged children, their teachers, and families.

Current funders include a variety of private foundations and public entities. The Early Childhood Mental Health service model continues to receive national attention. Our intent is to continue leveraging local foundation funds to secure additional support from state or national sources. We also plan to keep utilizing MediCal funding for services to low-income children with special needs.

Supporters of the Early Childhood Mental Health Project

- The Jenifer Altman Foundation
- The California Endowment
- Marguerite Casey Foundation
- Fireman's Fund Foundation
- Gallagher Family Foundation
- Gruber Family Foundation
- Miriam and Peter Haas Fund
- The Larry L. Hillblom Foundation
- JoMiJo Foundation
- Jewish Community Endowment Kohn Fund
- The Lumpkin Family Foundation
- Marin Children and Families Commission
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- Morris Family Foundation
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- Pickwick Fund of the San Francisco Foundation
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- Sequoia Healthcare District
- May and Stanley Smith Charitable Foundation
- Surdna Foundation
- United Way of Sonoma, Mendocino, Lake "Success by Six" Initiative
- Marco Vidal Fund of the Marin Community Foundation
- Weyerhaeuser Family Fund
- Zellerbach Family Fund
- The Harold and Libby Ziff Foundation

Seminar Topics and Corresponding Bibliography

I. Watching and Wondering – Observation of Childcare Program – Areas for Exploration and Consideration

II. Introduction to and Overview of Childcare – Historical Perspective and Current Condition

III. Getting Started – Initiating Consultation

IV. Forming a Consultation Relationship – with Director, Staff, Parent

V. Case Consultation – Understanding the Adults' Perspectives – Both Parents and Providers

VI. Child Observation – How and What is the Consultant Observing?

VII. Contribution of Early Experience and Temperament to the Young Child's Sense of Self and Other

VIII. Development – Birth to Three Years of Age

IX. Development – in the Third Year of Life

X. Development – in the Fourth Year of Life

XI. Development – in the Fifth Year of Life

XII. Play – Developmental Contributors and Understanding its Meaning

XIII. Language Development

XIV. Case Consultation – Translating One's Understanding of the Child in Ways that are Useful in a Group Setting

XV. Disorders of Early Childhood – Disturbances in Social and Emotional Domains; Attachment Disorders; Serious Difficulties in Communicating and Relating (PDD/Autism)

Seminar Bibliography

Berlin, I.N. (1969). Mental health consultation for school workers: A conceptual model. Community Mental Health Journal, 5 (4), 280-288.

Caplan, G. (1970). The theory and practice of mental health consultation. New York: Basic Books.

Cohen, E. & Kaufmann, R. (2000, April). Early childhood mental health consultation. (CMHS & SAMHSA Publication). Washington, D.C.: U.S. Department of Health and Human Services.

Donahue, P.J., Falk, B. & Provet, A.G. (2000). Mental health consultation in early childhood. Baltimore, MD: Paul H. Brookes Publishing Co.

Furman, R. (1966). Experiences in nursery school consultation. Young children, 22 (2), 94-95.

Greenspan, S.I., Nover, R.A., & Brunt, C.H. (1976). The child psychiatrist and day care. Journal of Child Psychiatry, 15. 108-130.

Johnston, K. & Browning, E. (1994). Mental health consultation in HeadStart. National HeadStart Bulletin, 49. 10-14.

Johnston, K (1999, February). Attending to the emotional well-being of children, families and caregivers: Contributions of infant mental health specialists to childcare. Zero to Three: National Center for Infant Programs, 10. (3), 7-10.

Knitzer, J. (1996). Meeting the mental health needs of young children and their families. In B.A. Stroul (Ed.), Children's mental health: Creating systems of care in a changing society (pp. 553-572). Baltimore, MD: Paul H. Brookes Publishing Co.

Knitzer, J. (in press). Early childhood mental health services: Through a policy and systems perspective. In J.P. Shonkoff & S.J. Meisels (Eds.), Handbook of early childhood intervention (2nd ed.). New York: Cambridge University Press.

Osterweil, Z. & Plotnik, P. (1989). Mental health consultation; an evaluation of the issue-focused model. School Psychology International, 10. 239-299.

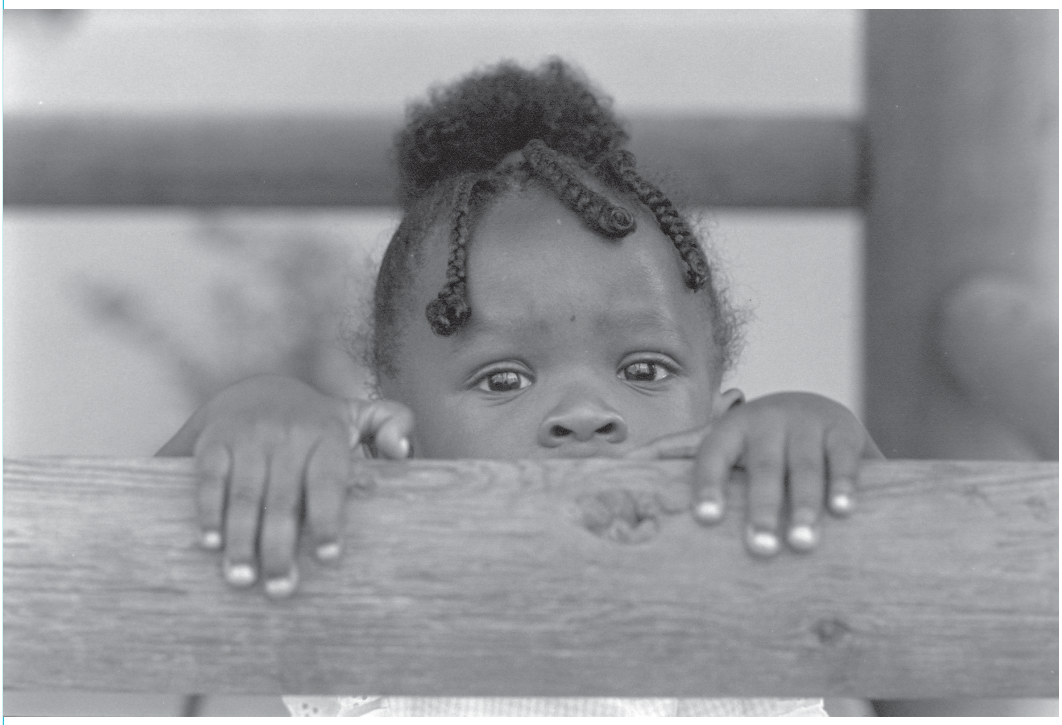
Pawl, J.H., Ahern, C.A., Grandison, C., Johnston, K., St.John, M., & Waldstein, A. (2000). Responding to infants and parents: Inclusive interaction in assessment, consultation, and

treatment in infant/family practice. Washington, D.C.: Zero to Three: National Center for Infants, Toddlers and Families.

Ramler, M., Alkon, A., Sokal-Gutierrez, K., & MacLennan, K.H. (2002, December). Early childhood mental health initiative final evaluation report. San Francisco, CA: James Bowman and Associates.

Smith, K. (1984). A heart with skill to listen: Consultation to a child-minding project. Journal of Social Work Practice. (November), 55-60.

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



Case-Centered Consultation (Caregiver Interaction Scale)

Date_____ **Child** _____
Caregiver _____ **Observer** _____
Program _____

Observer: To what extent are each of the following statements characteristic of this caregiver's relationship with and understanding of the particular child about whom case consultation is being provided. For each item, circle one:

1= not characteristic, **2=** somewhat characteristic, **3=** quite characteristic, **4=** very characteristic,
X= not enough information to evaluate.

I.	**Caregiver-Child Relationship**					
1.	Anticipates situations in which this child might begin to have difficulty.	**1**	**2**	**3**	**4**	**X**
2.	Able to read child's cues as a way of anticipating that s/he is going to have difficulty.	**1**	**2**	**3**	**4**	**X**
3.	Avoids engaging with this child until s/he is distressed or having serious difficulty.	**1**	**2**	**3**	**4**	**X**
4.	Gives evidence that she understands the needs/feelings underlying the child's behavior.	**1**	**2**	**3**	**4**	**X**
5.	Is able to use herself and her relationship with this child to prevent him/her from having difficulties.	**1**	**2**	**3**	**4**	**X**
6.	When the child is having difficulty, the caregiver's ways of intervening are useful to the child.	**1**	**2**	**3**	**4**	**X**
7.	When the child is having difficulty, the caregiver attempts to ignore the problem.	**1**	**2**	**3**	**4**	**X**
8.	When the child is having difficulty, caregiver intervenes by using punishment, shouting or shaming.	**1**	**2**	**3**	**4**	**X**
9.	Caregiver's expectations of this particular child are realistic.	**1**	**2**	**3**	**4**	**X**
10.	Even when limiting this child's behavior, caregiver lets the child know that she is sensitive to her/his distress.	**1**	**2**	**3**	**4**	**X**
11.	Actively lets child know of her (caregiver's) availability (to help).	**1**	**2**	**3**	**4**	**X**
12.	When appropriate, helps child understand the feelings underlying her/his difficulty.	**1**	**2**	**3**	**4**	**X**
13.	Helps child express feelings in acceptable ways.	**1**	**2**	**3**	**4**	**X**
14.	Seems frustrated or exasperated with this child.	**1**	**2**	**3**	**4**	**X**
15.	After child has had difficulty in some situation, caregiver offers child ways to re-engage (with caregiver, activity or peer).	**1**	**2**	**3**	**4**	**X**
16.	Expectations of this child give evidence that caregiver is sensitive to this child's limitations.	**1**	**2**	**3**	**4**	**X**
17.	Is aware of the times when this child is in need of the adult's physical proximity and physical assistance.	**1**	**2**	**3**	**4**	**X**
18.	Takes pleasure in and demonstrates that she likes this child.	**1**	**2**	**3**	**4**	**X**
19.	Sustains one type of intervention for an amount of time adequate enough to assess its usefulness to this child.	**1**	**2**	**3**	**4**	**X**

II.	**Caregiver-Parent Relationship**					
1.	Sustains one type of intervention for an amount of time adequate enough to assess its usefulness to this child.	**1**	**2**	**3**	**4**	**X**
2.	Respects and tries to understand the parents' view of their child.	**1**	**2**	**3**	**4**	**X**
3.	Blames or resents parents for child's difficulties.	**1**	**2**	**3**	**4**	**X**
4.	Exchanges information regularly with parents about child's life at home and in the center.	**1**	**2**	**3**	**4**	**X**

Child Care Quality Checklist

Date_____ **Total Observation Time**_____
Program _____**Group**_____
Consultant_____

Rating Scale: Each statement below describes a quality or characteristic that might be present in the day care setting or the persons there. The anchors for this rating scale, presented below, are phrased in the terms of degree of applicability or descriptiveness: to what extent does the statement describe the child care setting?

- **5** Very descriptive; very much like this place/setting
- **4** Quite characteristic or salient
- **3** Fairly descriptive
- **2** Somewhat descriptive; not a major quality
- **1** Does not apply; quality or characteristic is not present.

For each statement, circle the appropriate rating:

Physical Space

5 4 3 2 1	There is individual space (locker, drawer, cubicle) for each child to store belongings. Personal space is accessible to child, easily identified, and in good condition.
5 4 3 2 1	Storage space is available for children to return toys and equipment to after use (e.g., shelves). It is readily accessible to children, low enough and open to promote independent use by children.
5 4 3 2 1	Windows are large and low enough for children (with clear glass) so children can see outside.
5 4 3 2 1	Space is colorful, e.g., colorful pictures, posters, and/or mobiles in view.
5 4 3 2 1	Children's work is plentiful and displayed at their eye level.
5 4 3 2 1	There is adequate indoor and outdoor space for group size. There are not too many children. Equipment is neither too large nor too much for space. Limited space indoors may be offset by a greater usable and accessible outdoor space, and vice versa.
5 4 3 2 1	Activity areas are defined clearly by spatial arrangement. Space is arranged so that children can work individually, together in small groups, or in a large group. Space is arranged to provide clear pathways for children to move from one area to another and minimize distractions.
5 4 3 2 1	Private areas are available for children to have solitude (book corners, pillows in corners).
5 4 3 2 1	Indoor play area has soft surfaces (pillows, cushions, rugs, easy chairs, couches).
5 4 3 2 1	The outdoor area includes a variety of surfaces such as soil, sand, grass, hills, flat sections, and hard areas for wheel toys. It includes shade, open space, digging space, and a variety of equipment.

Materials, Equipment, and Activities

5 4 3 2 1	There is a full range of activities accessible to both boys and girls with materials (dress-up clothes, wheel toys, tools, dolls, etc.) in reasonably good condition.
5 4 3 2 1	Children have a choice of several activities (story, music, painting, puzzles) much of the time except during naps, mealtime, or lessons.
5 4 3 2 1	Materials are available (accessible and in reasonably good condition) for quiet play (books, puzzles) and active play (riding toys, climbing structures).
5 4 3 2 1	The following kinds of materials are available: paints, crayons, pencils, paste, clay or dough, sand, water, scissors, paper, buttons, string.
5 4 3 2 1	Building and construction materials are available (cardboard, boxes, blocks, building toys).

5 4 3 2 1 Attractive and well-written story and picture books are available.

5 4 3 2 1 The outdoor play area offers two or more of the following: blocks, cartons or boards for building, sandbox and sandtoys, slides, riding toys, see-saw, balance beam, tires.

5 4 3 2 1 Enough materials and equipment are accessible and in reasonably good condition so that children do not have to wait more than a few minutes to use them.

Children

5 4 3 2 1 Children appear happy (laughing, joking) around adults.

5 4 3 2 1 Children are busy and involved (not wandering aimlessly, just sitting and staring blankly, waiting for a long time).

5 4 3 2 1 Children seem to enjoy one another (help, smile, show approval, cooperate). Little fighting is seen (hitting, grabbing toys, pinching, kicking).

Caregivers

5 4 3 2 1 Adults are observed to teach children sometimes, but not all the time (teaching may be informal, explaining, labeling, reading). There is a balance of structure and flexibility, with smooth transitions between activities.

5 4 3 2 1 Adults interact frequently with children. They are available (accessible) and responsive to all children.

5 4 3 2 1 Adults use positive approaches (encouragement, modeling) to help children behave constructively. Consistent, clear rules are explained to children. They do not use physical punishment or other negative discipline methods that frighten or humiliate children.

5 4 3 2 1 The sound of the environment is primarily friendly, positive, courteous, rather than harsh, stressful, noisy, or enforced quiet. Conversation is encouraged. Adult voices do not predominate.

Group Size

Infant-Toddler Group: (0 through 24 months)
Check group size:
_____ Fewer than 6 children How many adults for this group?
_____ 6 to 12 children _____ Number
_____ 13 to 20 children
_____ Over 20 children

Preschool Group: (25 months through 5 years)
_____ Fewer than 6 children How many adults for this group?
_____ 6 to 12 children _____ Number
_____ 13 to 20 children
_____ Over 20 children

Family Day Care Group: (mixed age)
_____ Number of adult caregivers
_____ Number of infants / toddlers (0 - 24 mos.)
_____ Number of preschool aged (25 mos. through 5 yrs.)
_____ Number of school aged (over 5 yrs.)

Staff Meetings:

_____ No _____ Yes, monthly _____ Yes, weekly _____ Yes, daily

Problem Statement / Goals

SCHOOL: _____ **CASE NAME:** _____

CLASSROOM: _____ **KEY= Amount of Improvement:**

1 2 3 4 5

None Moderate Adequate

DESCRIBE ISSUE / PROBLEM

1) Date _____ GOAL:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

DATE: 3 MOS | 6 MOS | 9 MOS | 12 MOS

DESCRIBE ISSUE / PROBLEM

2) Date _____ GOAL:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

DATE: 3 MOS | 6 MOS | 9 MOS | 12 MOS

DESCRIBE ISSUE / PROBLEM

3) Date _____ GOAL:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

DATE: 3 MOS | 6 MOS | 9 MOS | 12 MOS

Parents' Response Questionnaire

School Site_____ Date_____
Consultant_____

A. To what extent do you agree with these statements? For each item circle one:
1=Strongly Agree, **2**=Mostly Agree, **3**=Neutral, **4**=Mostly Disagree, **5**=Strongly Disagree, **6**=Not Applicable

1 2 3 4 5 6 The consultant has been helpful to me in my relationship with my child.

1 2 3 4 5 6 The consultant has been helpful to me in better understanding my child.

1 2 3 4 5 6 The consultant has been helpful to me in thinking about my child's experience in daycare.

1 2 3 4 5 6 The consultant has been helpful to me in assisting the teachers and/or responding to my child.

Yes No Need The consultant was involved in finding additional services for me or my child. If Yes, were securing these services helpful?

_____
_____
_____
_____

B. Are there other ways consulting has been helpful to you and your family? How?

_____
_____
_____
_____
_____

C. Are there ways in which our services could have been more useful? How?

_____
_____
_____
_____
_____

D. Any additional comments?

_____
_____
_____
_____
_____

Consultation Questionnaire

Your responses will be kept confidential and should be returned unsigned.

I. **Overall level of satisfaction with consultation services:**

1. In your meetings with the consultant, has the consultant helped you accomplish what you wanted?

A. Yes, mostly
B. Yes, somewhat
C. Made no progress
D. Too soon to assess

II. **Please answer the following only if the consultant was involved in discussion about a particular child:**

1. Did the consultation increase your understanding of the child's experience and feelings?

A. Yes, very much
B. Yes, somewhat
C. No, not much
D. No, not at all

2. Do you feel better able to handle this child's behavior?

A. Yes, very much
B. Yes, somewhat
C. No, not much
D. No, not at all

3. Did consultation contribute to your ability or willingness to continue caring for the child?

A. Yes, very much
B. Yes, somewhat
C. No, not much
D. No, not at all
E. Continuing was not a concern

4. Did the consultation help you in your relationship with this child's family?

A. Yes, very much
B. Yes, somewhat
C. No, not much
D. No, not at all
E. This was not a concern

5. Did the consultant's direct involvement with the child's family help you in any of the following ways:

_____Helped me understand child's history and its effect on current behavior
_____Helped me understand family's situation
_____Helped by relieving some of the pressure on me to respond to the family's needs
_____Helped by finding services that the child and family needed

6. Did the way the consultant helped you in thinking about this child seem useful in thinking about other children?

A. Yes, very much
B. Yes, somewhat
C. No, not much
D. No, not at all

III. **Please answer the following if the consultant was involved with you in thinking about your program:**

1. Did the consultant offer useful ideas about children's development and behavior?

A. Yes, very useful
B. Yes, somewhat useful
C. Not really useful
D. No, not at all

2. Has consultation influenced your thinking about program planning for children?

A. Yes, very much
B. Yes, somewhat
C. No, not really
D. No, not at all

3. Did the consultant help you think about the ways that staff relationships influence your program and the children?

A. Yes, very much
B. Yes, somewhat
C. No, not much
D. No, not at all

IV. **As someone who has used Early Childhood Mental Health Services:**

1. Do you think that consultation such as you've received is useful to providers like yourself?

A. Yes, very useful
B. Yes, somewhat useful
C. Not really useful
D. No, not at all

2. Would you recommend Early Childhood Mental Health Services to others who needed help with similar concerns?

A. Definitely yes
B. Probably yes
C. Probably not
D. Definitely not

3. Had you received consultation services before you used the services of Early Childhood Mental Health Services consultants?

A. Yes ____ B. No ____

If yes, please describe:

Please comment on the a) need for, b) usefulness of, c) quality of service and any suggestions or recommendations you have that might help us to evaluate and further improve our service.

Your responses will be kept confidential and should be returned unsigned.

Parents' Questionnaire

1. **Did attending the parents' group help you to understand your child's behavior better?**

   A. Yes, very much
   B. No, not much
   C. Yes, somewhat
   D. No, not at all

2. **Did participation in the group help you to develop successful way of responding to your child?**

   A. Yes, very much
   B. No, not much
   C. Yes, somewhat
   D. No, not at all

3. **Were the issues discussed in the group relevant to your experience with your child?**

   A. Yes, very much
   B. No, not much
   C. Yes, somewhat
   D. No, not at all

4. **Was the format of the group satisfactory to your needs?**

   A. Yes, very much
   B. No, not much
   C. Yes, somewhat
   D. No, not at all

5. **Was it sometimes difficult for you to attend the group?**

   A. Yes, very much
   B. No, not much
   C. Yes, somewhat
   D. No, not at all

6. **Has the group met frequently enough for you?**

   A. Yes, very much
   B. No, not much
   C. Yes, somewhat
   D. No, not at all

Comments: