Introduction

As part of a state-wide initiative to find ways to support the emotional health and well-being of young children and their families, the Minnesota Head Start Association (MHSA) is working to build an improved system of promotion, prevention and intervention services integrated within Early Head Start (EHS) and Head Start (HS) programs. While Federal Head Start Performance Standards dictate the inclusion of mental health in provided services, there is considerable variation in the way programs interpret the Performance Standards, and most importantly how they address the social and emotional needs of children in the 15,000 families served. Up until now, directors and program managers have not had the opportunity or format to share information regarding how individual programs address the social, emotional health, and mental health conditions of the children and families served, contract with mental health consultants, or access community-based mental health resources. Furthermore, since the field of early childhood mental health is relatively young and the integration of mental health services into existing early childhood programs is on the best-practice cutting edge, most program administrators and mental health consultants may be experiencing successes and challenges in isolation, without the benefit of system-wide support, consultation, training and evaluation. It is relatively recent in our professional timeline—within the past 20 or 30 years—that the professional field has set about to determine which conditions allow some babies to grow and learn while others are at risk of emotional challenges.

Keys to promotion, prevention and intervention lie in the ability to clearly define early childhood social and emotional health and to develop systems for screening, identifying, and treating emotional difficulties experienced by young children. However, the adolescent or adult treatment models for mental disorders are not conducive to talking about or treating emotional challenges faced by infants, toddlers or preschoolers. Furthermore, we often hope that the child can be flexible and resilient enough to change caregivers multiple times, withstand severe poverty, or ignore domestic violence. In fact, ignoring the impact of early trauma or neglect by holding onto this belief fits our socially-accepted norms. In one school system in a rural community, the superintendent maintained that children in his district could not be considered to have mental health problems until 7th grade. When we look at the disruption in school systems, correctional facilities and within families caused by older children, it is understandable why adults focus heavily on the most problematic children.

Fortunately for very young children experiencing significant trauma, having difficulties in regulating affective experiences, experiencing aberrant caregiving, or living within significant economic hardship, there are excellent data and practice information on how to identify and treat young children in the context of their family, culture and communities. In fact, there is suggestive
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Evidence that young children when compared with older children are more vulnerable to these conditions resulting in lasting developmental consequences (National Research Council, 2000). Guided by scientific evidence from neurobehavioral research, methods for screening, assessment, and intervention have been created. Today there exist valid and reliable social/emotional screening measures and DC0-3R® Diagnostic Manual for use with children under the age of 5.

Given the complexities of the experience of many young children living in poverty, EHS and HS programs are in an excellent position to partner with children and families; however, in order to take full advantage of the opportunities, the state-wide organization, as well as individual agencies, must evaluate current operations in the light of recent developments and opportunities in early childhood mental health. Guiding each program through a process that examines mission and services, screening and referral opportunities, integration of staff support, and education, and engagement of mental health consultants may support quality improvement in promotion, prevention and intervention efforts. In the state of Minnesota, the endeavors by EHS and HS are in tandem with several initiatives by the state departments of Human Services, Health and Education, as well as efforts by the University of Minnesota, Minnesota Association for Children's Mental Health and many foundations, including The Bush Foundation. As a result, this is an excellent opportunity to promote state-of-the-art services.

Method

Through interviews, site visits and group meetings conducted with providers and administrators throughout the state of Minnesota, this report provides a descriptive analysis of the variety of ways mental health services are integrated into day-to-day program practice through promotion, prevention and intervention efforts. The goal is to create a framework for understanding how mental health needs within the Head Start community are being currently addressed and what opportunities, roadblocks, and capacities are necessary to implement best-practice recommendations. This report engaged and combined several complementary approaches.

1. Review of relevant Head Start publications and research findings.
2. Meeting with mental health consultants and administrators to determine current state of affairs including strengths and challenges of the current mental health system and use of consultants.
3. Site visits and interviews designed to provide a “statewide snapshot” of how local Head Start programs meet the mental health needs of the children and families they serve. Site visits and telephone interviews were made with nine of the programs in the state. Those participating in the visit were determined by the local program and ranged from individual meetings with a single administrator to group meetings with teachers, mental health consultants, and administrators.
4. Contract review for mental health consultants.

This process allowed for exploration of three complementary themes:

- How do programs view their mission in addressing social and emotional health of the children and families served?
- How do programs understand mental health problems in young children in the context of development and social systems?
- How are mental health consultants and other mental health services integrated into Head Start programs?

In addition to these methods of gathering information, an instrument developed by JFK Partners at the University of Colorado at Denver and Health Sciences Center under the leadership of Dr. Sarah Hoover was used. EHS and HS administrators, staff, and mental health consultants completed an interview form regarding their impressions of the types of social, emotional and behavioral difficulties children experienced in their classrooms and programs. The original instrument was based on questions that have been developed and asked nationally regarding preschool expulsions and behavioral challenges, and modified to better meet the specific needs of the Minnesota initiative. While this survey was not designed to assess mental health problems in children, it does provide an overview of which behaviors teachers, home visitors, and administrators find challenging to manage in the EHS and HS settings.

The goal of this report is to develop a blueprint of approaches and best practice recommendations based on the specific ways in which Minnesota Head Start can enhance mental health screening, assessment and treatment for the children and families served. The focus of the recommendations is on services with children and partnering with parents. Additional recommendations need to be developed if family mental health services are part of an organization’s mission. Appendix A provides a complete list of the recommendations addressed in this report.

Organizational Mission Regarding Social And Emotional Health

From the beginnings of Head Start nearly 40 years ago, program developers recognized the relationship of children’s health and their ability to learn. However, many researchers and policy analysts in the field have documented tension regarding the recognition of emotional and behavioral difficulties with overriding concerns for the stigmatization of Head Start children. Yoshikawa and Zeigler (2000) detail how mental health has historically had difficulty maintaining equal footing with physical, dental, and nutritional health with regard to prevention and intervention efforts. They noted the lag in the specificity of federal guidelines, training, and
administrative leadership in the area of mental health. Following the evolution of mental health services in Head Start, Yoshikawa and Zeigler observed that the first performance standards to address mental health introduced in 1975 were seen as vague and minimal.

Revisions of the Standards in 1991 increased attention on mental health by focusing on mental wellness and strengths, steering programs away from mental health disorders. To meet the standards programs were to engage a mental health consultant in the promotion of healthy emotional development, family strengths and identifying early signs of behavioral problems. Over the past decade, most programs responded to these mandates by creating and hiring a mental health consultant to conduct observations in the fall and spring of each year for every child in Head Start programs, a practice that continues in many programs today. In the 1990’s consultants and federal administrators worked to provide best practice guidelines and innovative practice descriptions. The advent of Early Head Start helped spur national and statewide Head Start Associations to undertake a variety of mental health training activities and initiatives for teachers and administrators. However, specific trainings or professional standards for mental health consultants were not a central element.

Currently, the U.S. Department of Health and Human Services, Administration for Children and Families (ACF) website states the following overview of mental health within Head Start.

“Head Start programs promote mental health and wellness by supporting the social and emotional development of every child, family, and staff member. Building respectful and responsive relationships with children and their families is key to enhancing the mental health environment within the Head Start community. In order to help children benefit from the relationships and experiences that Head Start offers, families are asked to guide staff in understanding their child’s emotional and social history. Staff have the potential, through their relationships with parents and children, to make a critical difference.” (Eberhardt – Wright, 2002)

In addition, Federal Performance Standards have expanded to include regular contact with a mental health consultant (1304.52), as well as timely and responsive services (1304.24) and family-centered mental health services and education (1304.40). Most programs are also facilitating screenings, assessments, and treatments and provide parents with the information they need to ensure that their children obtain appropriate mental health services. In addition, many outside agencies view Head Start as a preventive or intervention site for children who have experienced a variety of traumas related to living in poverty. In the state of Minnesota, Head Start is often listed as an intervention site for children living in poverty who do not fully meet Part C Early Intervention Service requirements but are in need of emotional and behavioral support services or for children who have been in child protective services or who have experienced other significant life events.
Given the federal backdrop, it was important to determine how individual programs view mission and responsibility for the social and emotional health of the children and families served. At each site visit, one of the first questions asked was: “What is your mission with regard to the social and emotional health of the children and families served?” A sample of responses:

“Ensuring family mental health, central to good outcomes.”
“Follow Head Start Standards.”
“Create secure attachments between classroom teachers and children.”
“Complete and comprehensive services.”
“Support families to know what mental health is and to seek their own services.”
“Provide earliest interventions to families and children.”

The vast majority of programs expressed their surprise to discover that their organization had never before discussed a specific mission for mental health. And while all could quickly develop a statement, these spontaneous responses failed to include a complete description of who is served, how, and why. Not having a well articulated mission decreases the opportunities to create staff and program uniformity regarding promotion, prevention and intervention efforts; make decisions regard which services to offer; and establish how best to implement goals and objectives. Moreover, several of the stated mission were quite grand and if realized would require vast financial and professional resources. While these visions are admirable, without sufficient support, they may create expectations for staff and families beyond the capacities of the program. Conversely, a narrow mission may not recognize the unique position of EHS and HS in promotion, prevention, and intervention of early social and emotional difficulties in children.

In addition to the creation of a mission statement, site visits in which many staff members participated resulted in a conversation regarding mental health, which participants identified as unique, many wondering why they had not previously engaged in such a discussion. Most commented about the value of having the opportunity to analyze current practice rationale and discuss possible ways to improve current efforts. The lack of a specific mission or detailed conversation regarding the mental health program is not surprising and may reflect a general uneasiness with the concepts surrounding early childhood mental health, screening, assessment and diagnoses. In efforts across the state to enhance professional knowledge of early childhood mental health, it is quite common, even among the mental health professionals, to voice concerns regarding the diagnoses of infants and toddlers, worries about the lack of availability of providers, and concerns about the reactions of families. Allowing for full discussion of these issues is instrumental to the success of mental health promotion, prevention and intervention efforts.
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Best Practice Recommendation

**Goal:** Create a feasible, outcome-based mental health mission statement.

**Rational:** Because a mission statement typically includes the reason that a service or program exists—who it serves, what it contributes, what it delivers—it provides structure for determining the methods and values for the program, helping to inform programs, policy, and financial decisions. For example, if the organization’s mission is to ensure the mental wellness of all children and families served through providing comprehensive mental health prevention and intervention services to children and their families, the necessary resources, expertise, and financial structure necessary to fulfill mission can be clearly defined and supported at all levels of the organization.

**Suggested Action Steps:**
1. Dedicate leadership to early childhood mental health from the top of the organization.
2. Create opportunities to explore reaction to the terms and concepts of early childhood “mental health” for all members of the organization.
3. Establish the particular needs of the children and families served.
4. Determine the range of services to be provided within the organization and those services to be provided through referral to outside agencies.
6. Redirect licensed clinical social workers who maybe providing universal services (2 x per year) to targeted services.
7. Determine measurable outcomes.
8. Calculate cost and funding structure necessary to meet mission.
9. Promote and communicate social/emotional health mission throughout programs and the children and families served.

Theme 2: Responding To Federal Performance Standards

**Topic 1: Standardized Screening and Referral**

One of the main features of the Health Services requirement is for programs to promote typical growth and development by assuring that children receive screenings and engaging parents in seeking appropriate treatment services for their children. To successfully meet these requirements in mental health, MSHA embarked on an initiative to have all Minnesota organizations use the same, validated screening tool. The Ages & Stages Questionnaire Social-Emotional (ASQ-SE, 2002) measure provides a method for determining if further assessment
is necessary. Much as a child tugging at his ear is a symptom of a possible underlying medical problem, difficult sleeping or crying may be symptoms, which may or may not be related to an emotional health problem. By using this screening tool, a parent's complaint about her child's behavior or problems with sleeping and eating can be compared with children of the same age to determine if the parent’s concerns warrant professional attention. According to the authors of the instrument, the ASQ-SE allows programs to “identify infants and young children whose social and emotional development requires further evaluation to determine whether referral for intervention is necessary.” Overall, screening provides a brief opportunity for parents to identify concerns and for practitioners to be able to recommend which children and families would benefit from further evaluation. Furthermore, by asking parents with children as young as 6 months of age to complete the questionnaires, early challenges in forming relationships, regulating emotions and learning and exploring the environment can be caught, allowing for appropriate diagnosis and services directed towards helping the child return as quickly as possible to typical pathways of emotional development.

Over the last two years, EHS and HS agencies have integrated ASQ-SE as part of standard screening efforts. While programs are using the ASQ-SE, there exists considerable variability in administration and follow-up on elevated scores. When the measure is introduced and by whom, may significantly impact the results. For example, if the screening measure is used in the first home visit with the teacher, a parent may be concerned about the teacher's response and edit her response to the questions. In other settings, it may be used in an interview format with the purpose of establishing relationships between parent and teacher. However, using a validated tool requires following a specific protocol, administering the measure in the manner in which norms were determined. While other administrative methods may be beneficial for broader goals, deviating from standard protocol invalidates the tool. Furthermore, the standardized protocol for ASQ-SE calls for the completion of the form by a parent or primary caregiver, however, in some settings, with the pressure of reporting and the difficulties in getting parental cooperation, teachers complete the questionnaires. While teacher report is valuable, it results in a different kind of data than parental responses. It is the parent’s perspective of her child’s social and emotional development that is most essential to the everyday moments of the child and family.

Following the collection of screening data, sites use differing criteria for determining who within the organization contacts the parents, under which conditions, and providing what resources. The standardized procedure allows for a para-professional who has been trained not to add her own interpretations or guess on behalf of the parent when scoring
the results. However, determination of next steps should involve staff who have knowledge and relationships with the family, as well as staff or mental health consultants with clinical expertise in social and emotional development. In some cases, treatments (e.g. parenting services) were being offered without the benefit of an appropriate assessment.

Illustration:

Jana, a well organized and competent teacher, scores the ASQ-SE questionnaire completed by the parents of Jason, a 3-year old child in her class. Although Jana views Jason as a sensitive, bright child who is eager to learn and who works well within her structured classroom, the ASQ-SE score completed by the parent is elevated suggesting significant behavioral concerns. Jana does not agree with many of the ratings of the parent. From her perspective, his behaviors are related to the parent’s poor parenting and lack of structure at home rather than a problem in Jason. Furthermore, she is worried that suggesting an evaluation will lead the parent to label Jason as a “problem child” rather than working on her parenting skills. She recommends that the family worker check in with the mom to see if she wants to attend a parenting group. Without guidance from an early childhood mental health professional, Jana overlooks how her exceptional skills in providing structure and anticipatory discipline allow Jason to perform well within the classroom. And while parenting skills training may be needed, without further evaluation Jason’s inherent difficulty with self-regulation—particularly in unstructured environments—may go unaddressed, possibly leading to more significant challenges for him and his parents later on.

The standardized ASQ-SE protocol does allow for considerations of elevated scores as part of the referral decision-making process. Listed on the measure are the following considerations, which should be addressed in partnership with the parent:

- Setting and time in which behaviors occur;
- Developmental delays;
- Physical health or biological factors;
- Culturally typical expressions of behaviors; and
- Stressful life events.

Once scored, who contacts the parent regarding an elevated score varies considerably among programs. In the above scenario, the teacher, having established a relationship with both the child and parent, may be the best person to help the parent determine the next steps. However, the teacher may benefit significantly from consultation with an early childhood mental health professional who can help her become more aware of her own bias and aid
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her in developing the skills in responding to the significant concerns expressed on the ASQ-SE by the parents. The consultant may supply a script for the staff to use, be available to answer questions before and after the follow-up visit, and provide resource information for assessment. In another program, the mental health consultant may be asked to make the contact, which may be on the phone or in person with a parent the consultant has not yet met. If the consultant is the person who will be available to provide the assessment and treatment, this approach may be optimal. However, if the consultant will not be involved in follow-up, his or her skills would be better utilized by providing support to the staff member with the best relationship with the child and family. Again, it is important to stress that an elevated screening score is not a diagnostic procedure or an indicator for the need or direction of treatment. An elevated score is a collection of symptoms, which need further evaluation by a trained mental health professional.

For sites in which the implementation and completion of the screening process is not running smoothly, an analysis of potential roadblocks may be beneficial. It is quite common for early childhood educators, parents and even mental health professionals to have worries about the screening and diagnoses of young children, concerns about lack of treatment resources, and misperceptions regarding the use of medication and other treatments. Within the educational system, often parents and teachers alike are worried about mental health screening or assessment as “labeling” a child. In order to successfully employ system-wide screening, administrators, staff, and parents may need to become more familiar with the concepts of social and emotional health in young children and services of early childhood mental health as well as have the opportunity to explore underlying worries and preconceptions. Once allowed to explore their own misgivings and provided with language that focuses on the child’s ability to form relationships, regulate emotions, and learn and explore environments, staff can more effectively partner with parents. The goal of screening and assessment is to determine the best course of action to help the child and family get back on developmental track.

Best Practice Recommendation

**Goal:** Provide valid and reliable early childhood mental health screening and referral for EHS and HS children.

**Rational:** While MSHA has engaged all Minnesota organizations to adopt the ASQ-SE to screen for social and emotional difficulties, inconsistencies in administration and referral limit effectiveness of screening process. Furthermore, decisions regarding referral must follow standardized procedures with appropriate involvement of the parent in the decision making process.
**Action Steps:**

1. Ensure accurate administration and scoring of ASQ-SE by addressing specific concerns of individual sites (e.g. parents resistant to participation).
2. Create opportunities for staff to explore biases and concerns regarding mental health screening and “labeling” of children.
3. Develop protocols and mental health consultation opportunities for staff regarding how to partner with parents when they have indicated on the screening measure that their children are experiencing social and behavioral problems (i.e. elevated ASQ-SE score).
4. Explore efficacy of current practices in which screening leads to services (e.g. offering parenting support) vs. assessment.
5. Engage qualified staff who may be used in other programs (e.g. licensed clinical social workers) in assessment and referral process.
6. Create relationships with mental health providers trained in assessment and treatment of very young children and their families and determine involvement in the referral process.

**Topic 2: Working With Staff To Understand, Recognize And Respond To Children’s Social And Emotional Needs**

While screening provided an opportunity to appraise parental concerns regarding the social and emotional development of children, it was also helpful to understand from the perspective of staff and administrators which behaviors they encountered and found challenging in the children they serve. Using a modified version of the “Challenging Behavior Questionnaire” (JFK Partners, 2005), teachers, home visitors, and administrators were asked questions about the types of behaviors that children demonstrate in their programs that were considered “challenging,” which behaviors they felt confident in addressing, as well as the impact of the perceived challenging behaviors in children on their personal sense of mental wellness. While the questions were asked about “challenging behaviors,” they reflected the teachers and administrators perception of what they found challenging rather than the identifying verified social and emotional issues experienced by the children in their settings.

Asked to identify the specific types of challenging behaviors they experience within children in their classrooms, of the 19 listed behaviors, the behavior identified most frequently was “irritable, mad or frustrated easily,” with the second most, “disrespectful, defiant,” third “inability to share,” and fourth “hurts self or others” (Graph A). These four behaviors were also prioritized by administrators and three of the four behaviors topped the challenges reported by EHS staff. When asked which behaviors had the greatest negative impact on staff and the program in general, the externalizing behaviors which can make staff and children feel unsafe and out-of-control topped the list: hurting themselves or others; disrespectful or defiant; and using inappropriate language - yelling or screaming. These are also the behaviors for which
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administrators and staff are most likely to seek the help of the mental health consultant. Similar findings were reported by Dr. Sarah Hoover in the Colorado study. She recommended that because these externalizing behaviors may make staff and children feel threatened and unsafe, policy and practices supporting teachers and creating environments that feel safe should be a high priority (Hoover, 2006).

Graph A. Most Frequently Reported Challenging Behaviors

The most frequently reported behaviors found to be challenging often cluster together and are expressed at the same time by the same child. Therefore it is important to consider how many children, teachers, and administrators perceive as expressing challenging behaviors. Remarkably, only 7% of the reporters marked that these behaviors occurred in less than 10% of the children served. The vast majority of adults on average see 2 or more children in a class of 17 expressing these behaviors. Alarmingly, 37% of Head Start staff estimate these behaviors in 30% or more (at least 5 out of 17) of the students served.

When asked which challenging behaviors teachers and administrators felt most successful in addressing, the most commonly reported was inability to share. While developmentally, sharing is a skill on which most young children need practice, and for which staff is trained to help develop, only slightly more than 50% of staff reported success. Moreover, staff reported less competence with the management of this developmentally appropriate issue than administrators. This may be an indicator of the impact of considering these challenging behaviors on staff sense of competence. (Chart B)
Administrators were asked in this survey whether children with challenging behavior have a negative impact on the well-being of staff and the extent to which staff are impacted. Fifty percent of directors reported that children’s challenging behaviors have a negative impact on staff’s well-being, and of these, 28% indicated that every staff member in their program is impacted in a negative way by children with challenging behavior.
ILLUSTRATION:

Tania and Lynnette were particularly concerned with the hitting, inappropriate language, throwing things and running out of the classroom in which several children in their class were engaged in. Questioning their abilities to manage these behaviors, they asked for help from the mental health consultant. In response the consultant spent one hour each day for one week in the classroom. The consultant’s goal was to better understand the experiences of the teachers and children in the classroom. In addition, the time allowed the consultant to model some techniques and language that could be used by the teachers with children who were having difficulty managing behaviors. The following week, the consultant met with the teachers and program director, asking first what they had observed and learned during the week. During the week, the consultant noted a considerable tension between Tania and Lynnette and markedly different teaching styles. Using these observations, the consultant wondered about the teacher’s experiences during the day and their sense of partnership, and then used the conversation to reflect on how their tension might translate to the children’s experiences. Given a technique that would encourage communication between the teachers directed at giving children the sense of security and stability, the teachers were asked to reflect upon the discussion and bring back the following week a plan for creating a more cohesive and less conflictual working relationship. While the consultant was certain that all of the challenging behaviors expressed by the children were due to the teachers’ conflict, the management of these behaviors was significantly compromised by the lack of communication and shared vision. The consultant continued to meet monthly with the team to monitor the success and challenges experienced by the teachers and children. Over time, the challenging behaviors diminished and the teachers’ sense of confidence and competence recovered.

In addition to concerns about behaviors that were challenging for staff to manage in the classrooms or home visits, there were concerns expressed about the level and intensity of social and emotional experiences of families. Language and cultural differences between staff and families added a complexity to service provision. Often differing by region of the state, many programs reported significant and overwhelming challenges experienced by the family including parental incarceration and illicit drug use, particularly methamphetamines. Furthermore, many organizations identified high levels of significant parental mental illness. Working with parents who are challenged by significant mental illness or chemical abuse requires skill and expertise not typically gained in training for teachers, home visitors and administrators. Parental mental illness challenges parents’ ability to engage in appropriate
Social and parenting activities thereby impacting staff and programs across program areas. Even when a program’s primary focus was on the educational success of the children, staff needed to receive specific training and consultation regarding approaches and referrals for parents experiencing significant emotional difficulties. For programs directed at improving the social and emotional health of parents and families, parental mental health screening, assessment and services mandate the involvement of professionally trained mental health consultants and providers. For example, if addressing parental or family mental health was a key program component, screening for maternal depression should be included as an overall commitment to ensure healthy emotional development.

**Best Practice Recommendation**

**Goal:** Fully Implement High Quality Classroom Experiences.

**Rationale:** Substantial research indicates quality childcare and educational programs are effective when group sizes and child-adult ratios are smaller and when caregivers hold less-authoritarian beliefs about child rearing (NICHD). In addition, stimulating environments that provide comfortable settings for both children and adults enhance the overall well-being and positive regard between teachers and children.

**Suggested Action Steps:**

1. Determine the availability of staff to children throughout entire program day. For example, if one of three adults in the classroom spends most of the program day engaged in chores and classroom maintenance, the realized child:adult ratio may be closer to 10:1.

2. Evaluate the physical environment in terms of supporting child and adult comfort, development, stimulation, and relationships. Limited space may negatively impact teacher’s perceptions, creativity, and relationships with children. Settings may also unintentionally create behavioral challenges for children by requiring children to behave in large group settings in ways which are not developmentally appropriate.


**Best Practice Recommendation**

**Goal:** Create working environments in which staff have the opportunity to reflect and develop skills necessary to manage challenging situations and relationships.
Rational: Because working with young children, particularly those in poverty, demands great skills and emotional presence, staff must themselves be supported to develop the necessary skills and reflect on the ways in which the challenges experienced by children affect their interactions. Feeling overburdened by the challenges can lead to burn-out, staff conflict, and tense interactions between adults and children. In addition, the passion that brings adults into the field, combined with the intimate work conditions of early childhood often amplifies personal issues and experiences. Staff need an opportunity to talk about personal reactions and challenges and learn techniques to enhance their interactions with children, parents, and other staff members. For EHS and other home-based service providers, additional consultation should be provided in recognition of the intimacy and complexity of home-based work.

Action Steps:
1. Dedicate leadership and financial means to providing reflective consultation and supervision throughout the organization, including top administration.
2. Home-based and parent support staff should receive regular and frequent (e.g. weekly) reflective consultation, preferably by mental health consultant. These sessions can be held as a group consultation supplemented with individual sessions.
3. Provide specific training opportunities regarding reflective practice to each level of staff within organization (e.g. administrators, lead teachers.)
4. Address at sites, the particular issues and concerns staff have about the children served and other related issues (e.g. class size, environment).
5. Determine if there are children whose behaviors and needs suggest referral for additional mental health services by engaging mental health consultants in thorough assessment of classroom experiences (i.e. multiple observations, classroom modeling, teacher engagement).

Topic 3: Mental Health Consultants

While the federal regulations call for the scheduled involvement of a mental health consultant, Head Start program administrators have operated without the benefit of detailed guidelines regarding best-practice service and financial models for early childhood mental health services. A 2004 survey of Minnesota Head Start grantees indicated that while Head Start funding provides resources for mental health consultation, 86% of programs consider understanding and addressing the mental health needs of enrolled children and families to be among their organization’s greatest challenges. Two major roadblocks emerged: lack of early childhood mental health professionals, and insufficient funding to provide services. As reported by Dr.
Glenace Edwall at the Minnesota Head Start Association 2006 Summer Institute, 40% of programs were unable to find qualified consultants, particularly in large rural areas of the state. Forty-four percent of the organizations surveyed wanted to purchase more time with the mental health consultant but many stated that the cost of the consultant was prohibitive. The funding for mental health consultation and services came from the general fund, competing directly with other programs areas. Without dedicated or earmarked monies for mental health, services in some organizations were reduced to meeting the minimum federal standards. Cost was less of an issue for organizations with Early Head Start and mental health consultants were engaged in some programs as a part-time or full-time position.

Beyond federal requirements, directors and program administrators have been without guidance as to how to develop job descriptions for the mental health consultants that meet the specific needs of their organizations and populations served. In response, most reported developing a contract with the mental health consultant through a collaborative process. Unlike a typical business model in which the organization dictated services and qualifications, these contracts seemed indicative of the lack of administrative clarity regarding the organizational mental health mission and the services needed to achieve the goals and objectives. In the MHSA 2006 Assessment of Mental Health Survey, administrators were asked to list the top three activities of mental health consultants. The results were surprising because there was very little consistency between organizations and the activities listed were often vague (e.g. “provides consultation,” “services to staff and parents.”) Even the most common response, “observations of children,” was supplied by less than one-third of the organizations. Consistent with this variability, review of mental health contracts suggested the job descriptions of mental health consultants included laundry lists of activities (Table 1). The long list of services seemed to create huge expectations for the mental health consultant, often for a limited number of service hours. In addition, these contracts in general provided little direction for the mental health consultant. Many mental health consultants reported not knowing how much of their time was to be dedicated to which services. Furthermore, consultants reported frequently being limited in providing services they deemed necessary to fulfill their duties because of budgetary restraints. A few consultants reported prematurely ending services because contracted hours were exceeded.
Table 1. List of contracted duties listed in mental health contracts.
- Fall and Spring Observations – written reports
- Target Observations – written reports
- Parent Educational Sessions
- Training Sessions for staff
- General availability for parents, staff – office hours
- Referral conversations with parents
- Staff Case consultation
- Treatment Groups for identified children
- ID community resources
- Full time MH provider for children, parents and staff

Analysis of Specific Activities Provided by Mental Health Consultant

As mentioned earlier, the primary activities of mental health consultants reflected the traditional Head Start emphasis of mental wellness by providing support to all Head Start children and families. Observations of children were most frequently mentioned as the way to meet this mandate. One organization reported being asked directly by the federal regulator about if they had scheduled fall and spring observations to meet the mental health mandate. As a result many organizations contracts with mental health consultants focused on these classroom observations or targeted single session (observing children identified by staff or parents as having challenging behaviors) and write-ups on every child observed.

While well-intended and adequate for the federal requirements, one-time observations were not consistent with early childhood mental health best-practice, since the complexity of issues experienced by children, families, and staff may not be experienced in a single observation. One mental health consultant who engaged in targeted observations conceded often on the day of observation, the target child typically did not show the behaviors of concern. Following protocol, the consultant would base the write-up and recommendations on the teachers’ perspective of the problems and ASQ-SE ratings. In other settings, the consultant would make recommendations regarding classroom environment (e.g. amount of stimulation) or classroom management techniques. Again, while these types of observations may be helpful, the usefulness of the activity decreases if the mental health consultant has limited contact with the teachers or infrequent opportunities to follow up with additional support to the teaching staff.

Consistent with best-practice early childhood mental health, organizations found the mental health consultants to be most helpful when they developed working relationships first with staff. Without the familiarity and acceptance brought about by regular contact, several mental
health consultants stated they faced staff resistance to receiving feedback or recommendations. Again, these were barriers most frequently experienced when the mental health consultant did not have established relationships with staff. Only in a limited number of organizations where the mental health consultant is on site for a significant number of hours per week were good staff relationships and integration of the mental health consultant reported.

These challenges were present for many mental health consultants when they were asked to work with parents or provide parent training. While some mental health consultants were invited to all-center family activities to increase their visibility, across most programs, when mental health consultants provided parent support or training sessions, parental attendance was reportedly low. When a child was identified with a possible mental health concern in which the program wanted to engage the mental health consultant, parents were notified of the mental health consultant’s observation of their child but direct contact with the parent prior to the observation was rare. In addition, usually because of time and travel constraints, post-feedback by the mental health consultants were most often directed through the observation write-ups and recommendations or telephone calls. Often it seemed that mental health consultants were engaged in parental contact when the staff was unsure of how to address the issues with the parents and, in response the mental health consultants, were asked to make the contact. As reported earlier, if the consultants provided services or would have ongoing, consistent interactions with the families, this approach was consistent with best-practice. However, if the consultants were present only to assist in connecting with third-party providers or to deliver information with which staff was uncomfortable; these would be less-than-optimal use of the mental health consultant. Under these conditions, a more productive course of action may be to support the staff to effectively engage families facing difficulties.

A few sites have engaged in mental health treatment services on-site for children with identified and diagnosed mental health disorders. Two primary means for financing services emerged: providing on-site, full-time mental health services paid for by an organization; or providing services on-site through service contracts with mental health organizations in which the agencies bill third-party payers for treatment services for children with diagnosed mental illnesses. For mental health agencies partnering with HS organizations, funding through third-party reimbursement was often inadequate and unstable. For example, financial model required 5 children in a treatment group. Out of 10 children referred to the program, 8 parents consented to the diagnostic assessment, 6 children qualified however only 4 parents complete the necessary consent for services or billing paperwork. Other complicated factors included limited parental involvement due to the physical distance between the treatment services and families’ homes or lack of parental availability or resistance to be involved in services. Under either funding scenario, mental health consultants should have been well-trained in the most current diagnostic procedures and categorization of children under
the age of five, specifically, Diagnostic Classification 0-3 Revised (DC0-3R, Zero To Three, 2005). In addition, treatment services provided with EHS and HS children and their parents should have strong research-based efficacy. The list for these intervention treatment services Health Division.

Best Practice Recommendation

Goal: Engage mental health consultants to aid in building the capacity of staff, families, programs and systems to prevent, identify, treat and reduce the impact of mental health problems among children and their families.

Rational: Early Head Start and Head Start programs are often situated best to identify very young children and families struggling with social and emotional difficulties. Mental health consultation and services can enhance the ability of staff to provide quality educational experiences, guide screening and referral processes for social and emotional difficulties, and support therapeutic interventions of those children with diagnosed mental health disorders. The range of these services will be dictated by the mission and financial structures put in place to support the mission of the organization and the current needs and qualifications of the staff. Consider contracting with more than one mental health consultant, using consultant’s areas of strengths (e.g. reflective consultation, systems change, child evaluation).

JFK Partners Mental Health Consultation in Early Care and Education - A Resource and Sustainability ToolKit for Providers provides the structure for the following objectives and consideration.

I. To build the capacity of staff, families, and programs to:
   • prevent and reduce the impact of mental health problems among children served in EHS/HS settings;
   • prevent and reduce the impact of problems in the parent-child and family relationships;
   • screen, identify and refer children who are in need of mental health assessments; and
   • aid parents in accessing appropriate assessment and treatment services for their children.
Suggested Action Steps: Engage mental health consultant(s) to develop the capacity of staff and programs by:

A. Providing consultation and training designed to improve program quality and interactions between children and staff; understand the impact of mental health issues; and discuss role in screening and referral;

B. Creating interventions to address staff stress levels and workplace conflicts;

C. Providing reflective supervision and consultation to allow administrators and staff to reflect on feelings, experiences and relationships in order to better support social and emotional needs of children, families and colleagues;

D. Creating classroom preventive/intervention activities that benefit all children and families;

E. Engaging in consultation, training and oversight of screening and referral process; and

F. Providing linkages to community-based mental health services.

II. To increase the capacity of organization to:

- provide treatment services for children with diagnosed mental health issues and their families.
- provide services to enhance parent-child relationships and enhance parenting skills for those parents with a child suffering from social and emotional problems.

Suggested Action Steps: Engage mental health consultant(s) to improve outcomes for identified children and families by:

A. Providing direct services with identified children and their families and teachers.

B. Engaging in clinical assessment or partner closely with community-based mental health services who provide assessment and diagnostic services.

C. Developing individualized therapeutic plans to address the factors in the EHS or HS setting that can contribute to the success of children struggling with behavioral and emotional problems.

D. Consulting with family to support the emotional and behavioral success of identified children.

III. To increase the capacity of staff, programs and organizations to:

- prevent and reduce the impact of parental mental health problems among the parents of children served in EHS/HS settings; and
- screen, identify and refer parents who are in need of mental health assessments.
Suggested Action Steps: Engage mental health consultant(s) to:
   A. Provide intervention services provided to identified children and staff, which may include classroom, group and/or individual/family therapeutic treatment services.
   B. Create intervention services provided to the parents of identified children and/or to the parent(s)/child dyads or triads.

IV. To increase the capacity of organization to:
   • provide treatment services for parents with diagnosed mental health issues as they impact parenting and parent-child relationships.

Suggested Action Steps: Engage mental health consultant(s) in:
   A. Screening, assessment and diagnostic services for parents of children in program who are suffering from mental health problems.
   B. Collaboration with adult mental health providers for parents with mental health conditions.
   C. Intervention services provided to the parents with mental health problems and their children.

Considerations When Contracting With Mental Health Consultant


   The self-evaluation checklist provides mental health consultants and administrators to identify the core strengths and type of consultation that matches best with program, child and family based consultation and clinical interventions. The checklist allows administrators to determine if contracting with more than one consultant for various aspects of the program would make the best use of the skill-sets brought forth by mental health consultants.

2. Require mental health consultants to be trained on the most recent diagnostic procedures including DC0-3R and if providing services, on research-based treatment models with proven efficacy.

3. Follow the recommendations regarding qualifications of mental health consultant created by Dr. Glenace Edwall:
   A. Full-time position, possibly split between agencies, would be superior to contracting of professional time. Contracting is “quite expensive and limits access.”
B. Enrollment of mental health professionals involved in the Children's Mental Health System (Children’s Therapeutic Services and Supports or CTSS) and health plans to expand service capacity
C. Consultant can be responsible for presenting updated information on early childhood mental health and well-being; should know the local system of care

Conclusion

This report sought to create a systematic conversation in Minnesota Head Start community regarding the knowledge and expertise, screening and referral process, preventive and intervention services within the classroom, and to provide best-practice recommendations that could be directly integrated into Minnesota Head Start programs. Supporting the social and emotional development of young children and their families exists on a continuum. Services provided by organizations can range from providing appropriate screening and referral to interventions for children with diagnosed mental health disorders. In so doing, EHS and HS services enhance a child’s and family’s strengths while appropriately and responsively addressing those circumstances that can threaten it.


http://www.jfkpartners.org/WhatsNewItem.ASP?NUMBER=68
Appendix A
Complete List of Report Recommendations

Best Practice Recommendation

Goal: Create a feasible, outcome-based mental health mission statement.

Rational: Because a mission statement typically includes the reason that a service or program exists – who it serves, what it contributes, what it delivers – it provides structure for determining the methods and values for the organization, helping to inform programs, policy, and financial decisions. For example, if the organization’s mission is to ensure the mental wellness of all children and families served through providing comprehensive mental health prevention and intervention services to children and their families, the necessary resources, expertise, and financial structure necessary to fulfill mission can be clearly defined and supported at all levels of the organization.

Suggested Action Steps:
1. Dedicate leadership to early childhood mental health from the top of the organization.
2. Create opportunities to explore reaction to the terms and concepts of early childhood “mental health” for all members of the organization.
3. Establish the particular needs of the children and families served.
4. Determine the range of services to be provided within the organization and those services to be provided through referral to outside agencies.
6. Redirect licensed clinical social workers who may be providing universal services (2 x per year) to targeted services.
7. Determine measurable outcomes.
8. Calculate cost and funding structure necessary to meet mission.
9. Promote and communicate social/emotional health mission throughout organizations and the children and families served.

Best Practice Recommendation

Goal: Provide valid and reliable early childhood mental health screening and referral for EHS and HS children.
Rational: While MSHA has engaged all Minnesota organizations to adopt the ASQ-SE to screen for social and emotional difficulties, inconsistencies in administration and referral limit effectiveness of screening process. Furthermore, decisions regarding referral must follow standardized procedures with appropriate involvement of the parent in the decision making process.

Action Steps:
1. Ensure accurate administration and scoring of ASQ-SE by address specific concerns of individual sites (e.g. parents resistant to participation).
2. Create opportunities for staff to explore biases and concerns regarding mental health screening and “labeling” of children.
3. Develop protocols and mental health consultation opportunities for staff regarding how to partner with parents when they have indicated on the screening measure their children are experiencing social and behavioral problems (i.e. elevated ASQ-SE score).
4. Explore efficacy of current practices in which screening leads to services (e.g. offering parenting support) vs. assessment.
5. Engage qualified staff who may be used in other programs (e.g. licensed clinical social workers) in assessment and referral process.
6. Create relationships with mental health providers trained in assessment and treatment of very young children and their families and determine involvement in the referral process.

Best Practice Recommendation

Goal: Fully Implement High Quality Classroom Experiences.

Rational: Substantial research indicates quality child care and educational programs are effective when group sizes and child-adult ratios are smaller and when caregivers hold less-authoritarian beliefs about child rearing (NICHD). In addition, stimulating environments that provide comfortable settings for both children and adults enhance the overall well-being and positive regard between teachers and children.

Suggested Action Steps:
1. Determine the availability of staff to children throughout entire program day. For example, if one of three adults in the classroom spends most of the program day engaged in chores and classroom maintenance, the realized child: adult ratio may be closer to 10:1.
2. Evaluate the physical environment in terms of supporting child and adult comfort, development, stimulation, and relationships. Limited space may negatively impact teacher’s perceptions, creativity, and relationships with children. Settings may also unintentionally create behavioral challenges for children by requiring children to behave in large group settings in ways which are not developmentally appropriate.


**Best Practice Recommendation**

**Goal:** Create working environments in which staff have the opportunity to reflect and develop skills necessary to manage challenging situations and relationships.

**Rational:** Because working with young children, particularly those in poverty, demand great skills and emotional presence, staff must themselves be supported to develop the necessary skills and reflect on the ways in which the challenges experienced by children affect their interactions. Feeling overburdened by the challenges can lead to burn-out, staff conflict, and tense interactions between adults and children. In addition, the passion that brings adults into the field, combined with the intimate work conditions of early childhood often amplifies personal issues and experiences. Staff need an opportunity to talk about personal reactions, challenges and learn techniques to enhance their interactions with children, parents, and other staff members. For EHS and other home-based service providers, additional consultation should be provided in recognition of the intimacy and complexity of home-based work.

**Action Steps:**

1. Dedicate leadership and financial means to providing reflective consultation and supervision throughout the organization, including top administration.
2. Home-based and parent support staff should receive regular and frequent (e.g. weekly) reflective consultation, preferably by mental health consultant. These sessions can be held as a group consultation supplemented with individual sessions.
3. Provide specific training opportunities regarding reflective practice to each level of staff within organization (e.g. administrators, lead teachers.)
4. Address at sites, the particular issues and concerns staff have about the children served and other related issues (e.g. class size, environment).
5. Determine if there are children whose behaviors and needs suggest referral for additional mental health services by engaging mental health consultants in thorough assessment of classroom experiences (i.e. multiple observations, classroom modeling, teacher engagement).
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Integrating Mental Health Services With Early Education
Dr. Terrie Rose, PhD, LP

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Terrie Rose, PhD is a licensed psychologist, national speaker, clinical consultant, and accomplished leader with diverse experience in program innovation, research, training, and philanthropy. She is the founder and president of Baby’s Space: A Place to Grow, an innovative non-profit organization seeking to bringing exceptional education and parenting services to young children and families residing in poverty in an effort to ensure that all children have a solid foundation for success in school and life.

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