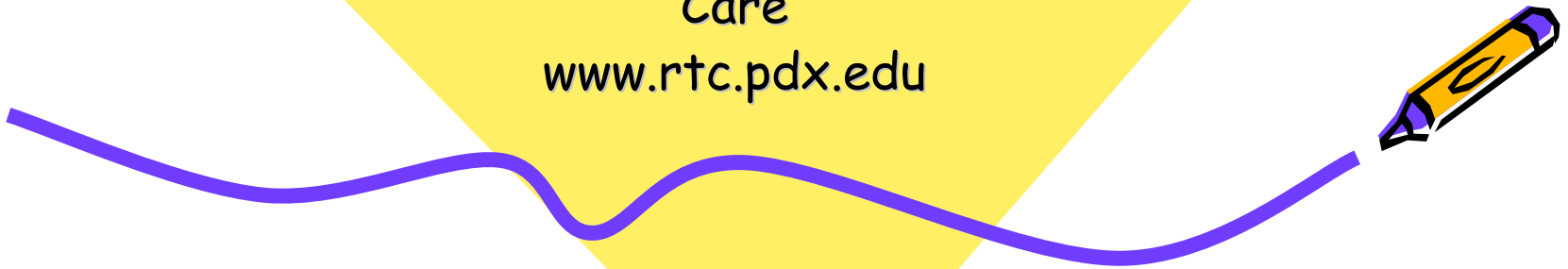




Promoting Children's Mental Health in the Child Care Context:

Current Research on Models of Inclusion in Child
Care

www.rtc.pdx.edu





Research & Training Center on Family Support and Children's Mental Health

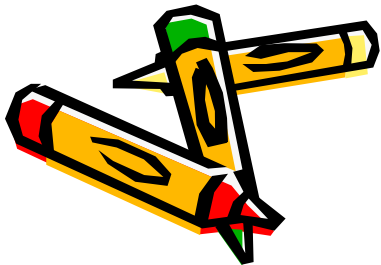
Portland State University, Portland, Oregon

Models of Inclusion in Child Care Project

Supported by:

National Institute on Disability and
Rehabilitation Research (grant # H133B990025),
United States Department of Education, and

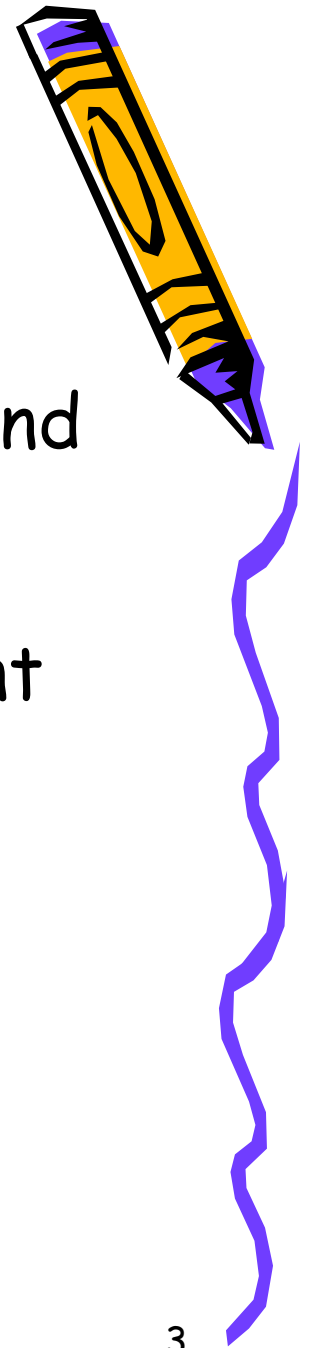
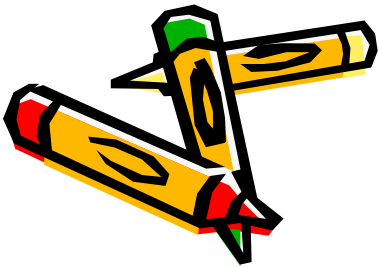
the Center for Mental Health Services,
Substance Abuse and Mental Health Services
Administration.



Georgetown University Training
Institutes July 2002

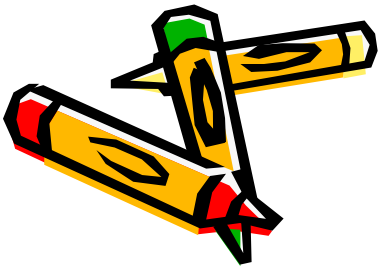
Project Staff

- Eileen Brennan, Principal Investigator and Presenter
- Jennifer Bradley, Project Manager
- Shane Ama, Student Research Assistant
- Sara Berman, Graduate Research Assistant and Parent
- Natalie Cawood, Graduate Research Assistant
- Lynwood Gordon, Consultant and Parent



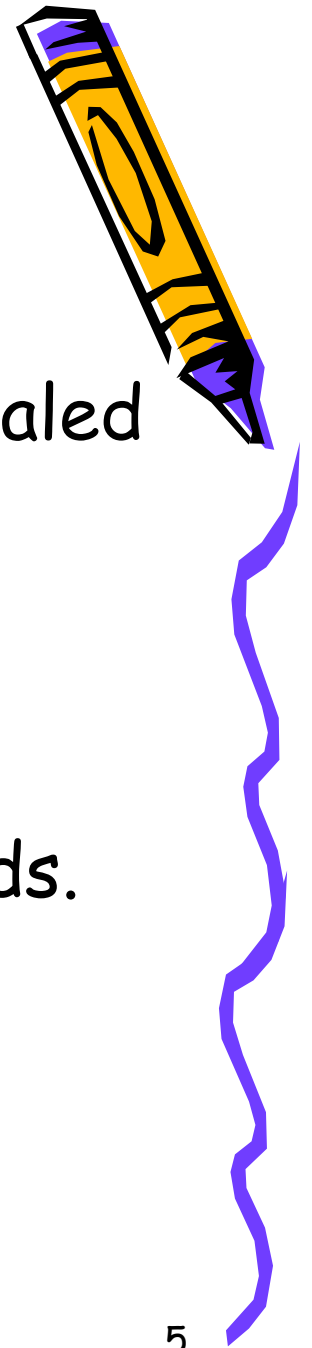
Problem Statement

- Although 5-10% of employed parents care for a child with emotional or behavioral challenges, family support resources are notably lacking.
- Particularly, child care is difficult to find and maintain for these families (Rosenzweig, Brennan, & Ogilvie, in press).



Families Need Child Care for Children with Emotional or Behavioral Challenges

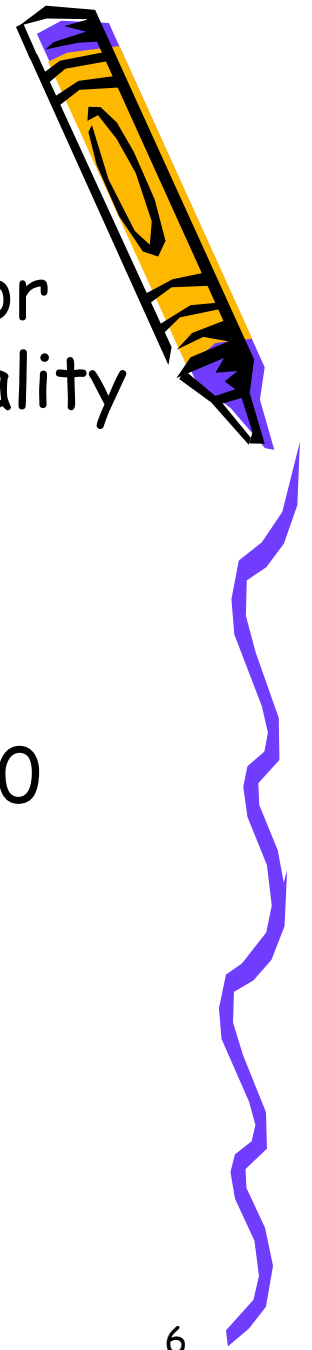
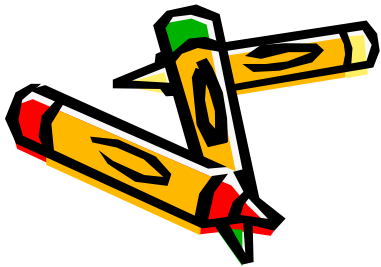
- Focus group study with 41 parents revealed child care as a major issue:
 - hard to find, since few qualified providers.
 - expensive.
 - lacked flexibility to meet family needs.
 - if given at home, required major adjustment of family members' lives.
- (Rosenzweig, Brennan, & Ogilvie, in press)



Child Care Issues

- Parents having children with emotional or behavioral disorders reported lower quality of care than other parents.
- Child care arrangements were changed significantly more frequently.
- Children with behavior problems were 20 times more likely to be dismissed from care than other children.

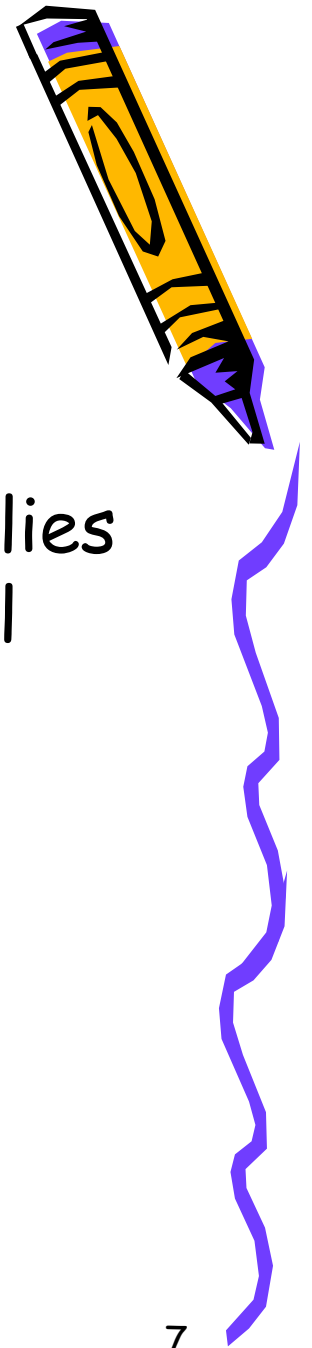
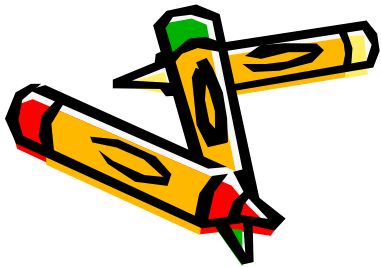
(Emlen, 1997)



Aim of Models of Inclusion in Child Care Project

To investigate programs and strategies that result in improved access for families of children with emotional or behavioral disorders to child care that is:

- Inclusive,
- family-centered,
- culturally appropriate, and
- high quality.



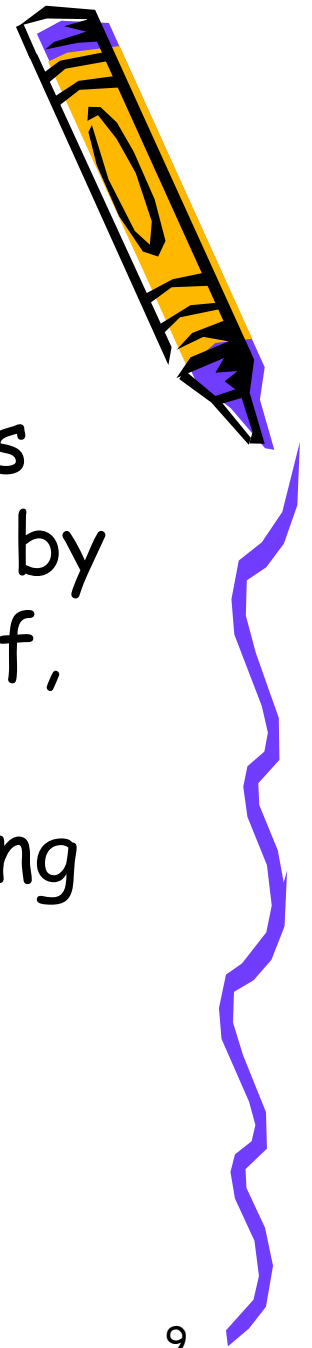
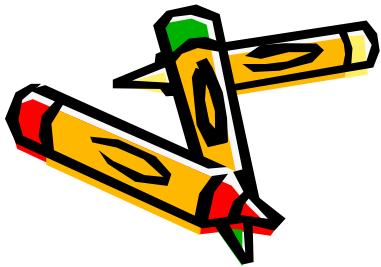
Inclusion

the delivery of comprehensive services to children with emotional and behavioral challenges in settings that have children without these challenges, and the participation of all children in the same activities, with variations in the activities for those children whose needs dictate the adaptation. (See Kontos, Moore, & Georgetti, 1998).



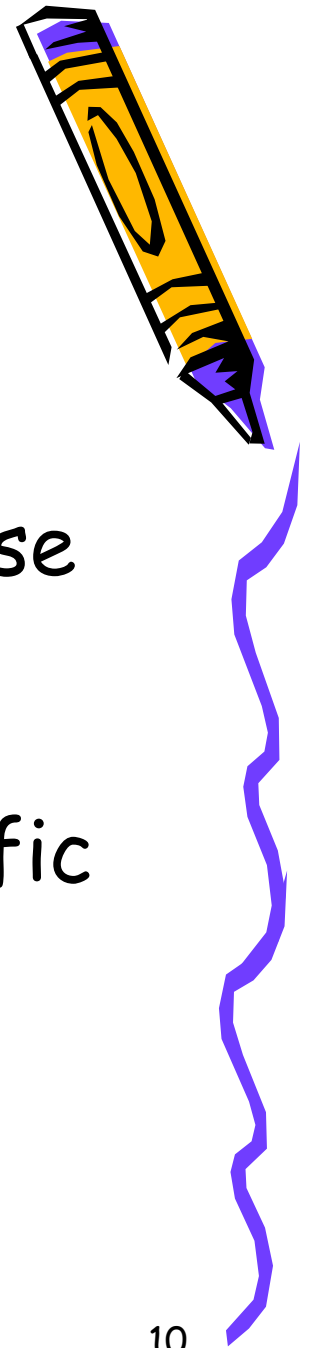
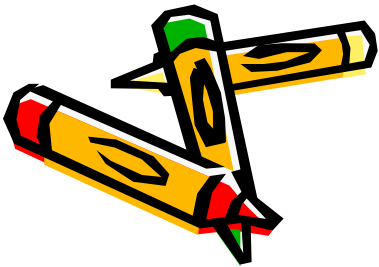
Family Participation

Views, expertise, values, and needs of family members are prioritized by child care administrators and staff, who seek to work with them as partners in promoting the well-being of their children.

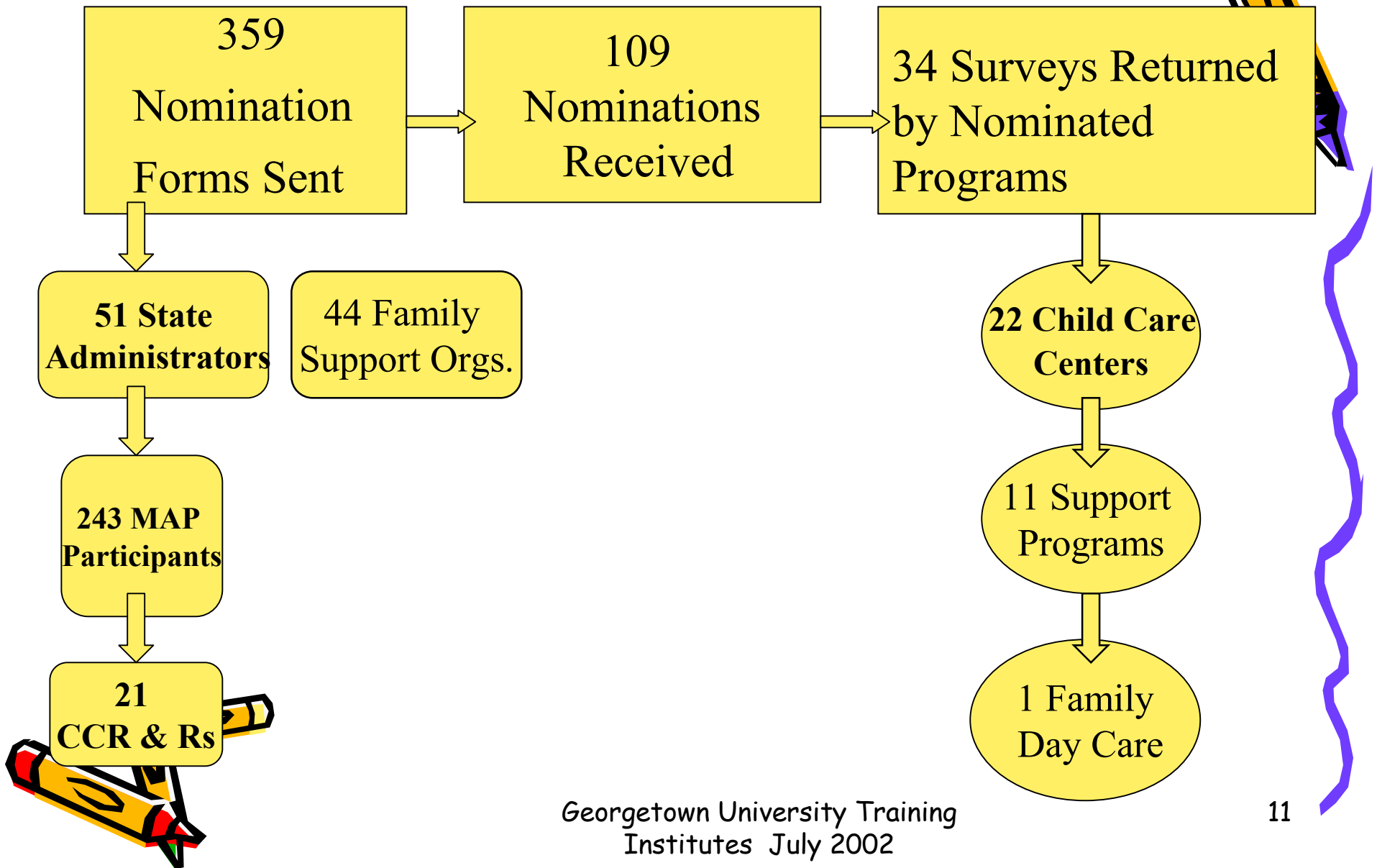


Cultural Competence

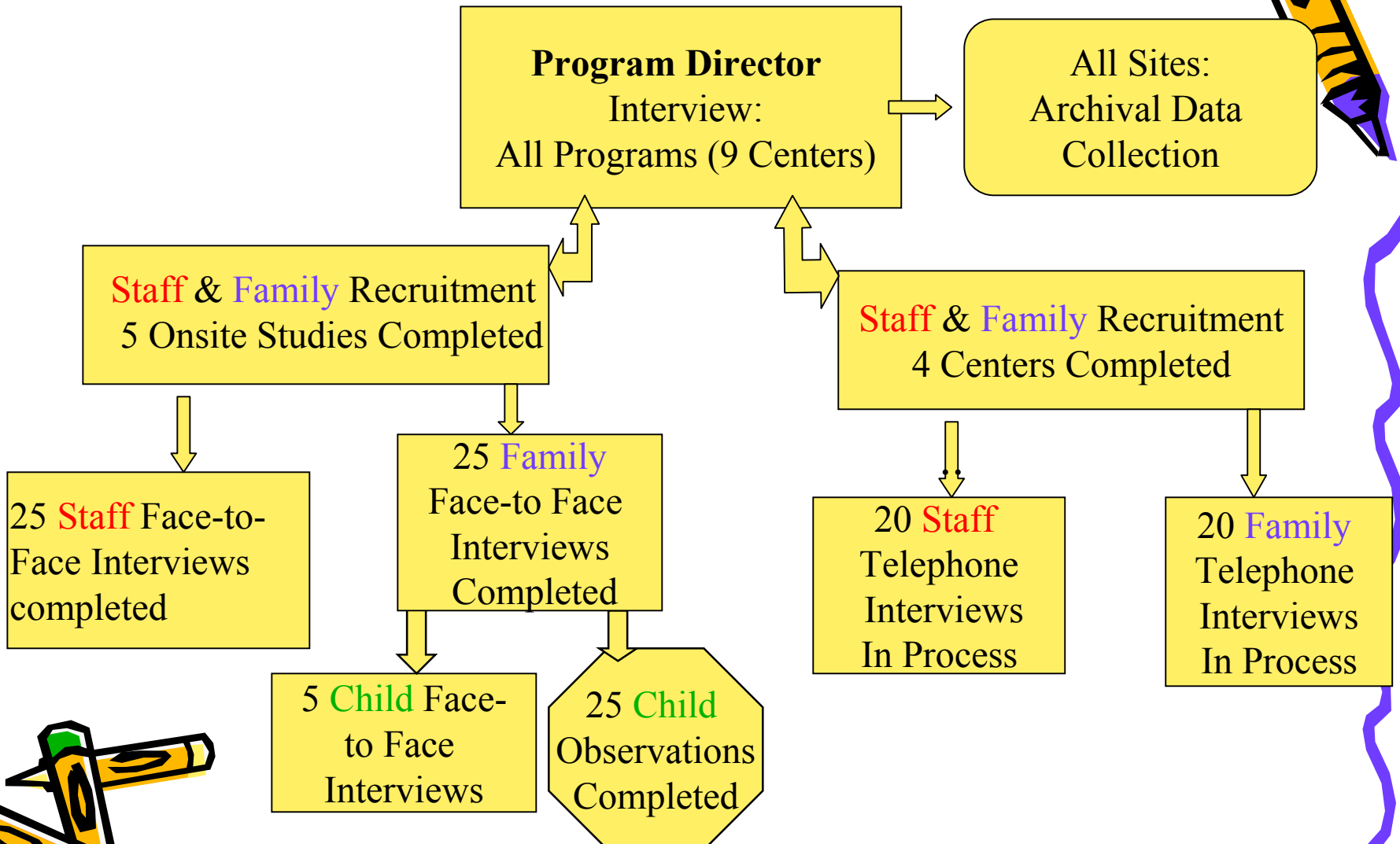
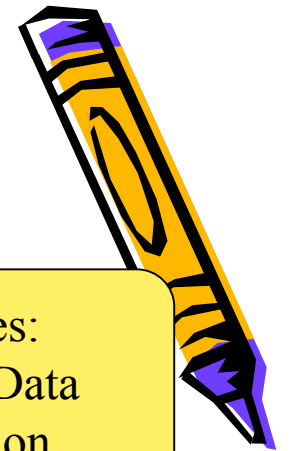
Adherence to a system of values, beliefs, and practices within diverse groups and individuals who share cultural knowledge to increase the overall quality of care in any specific setting of child care.



Model Program Identification Process



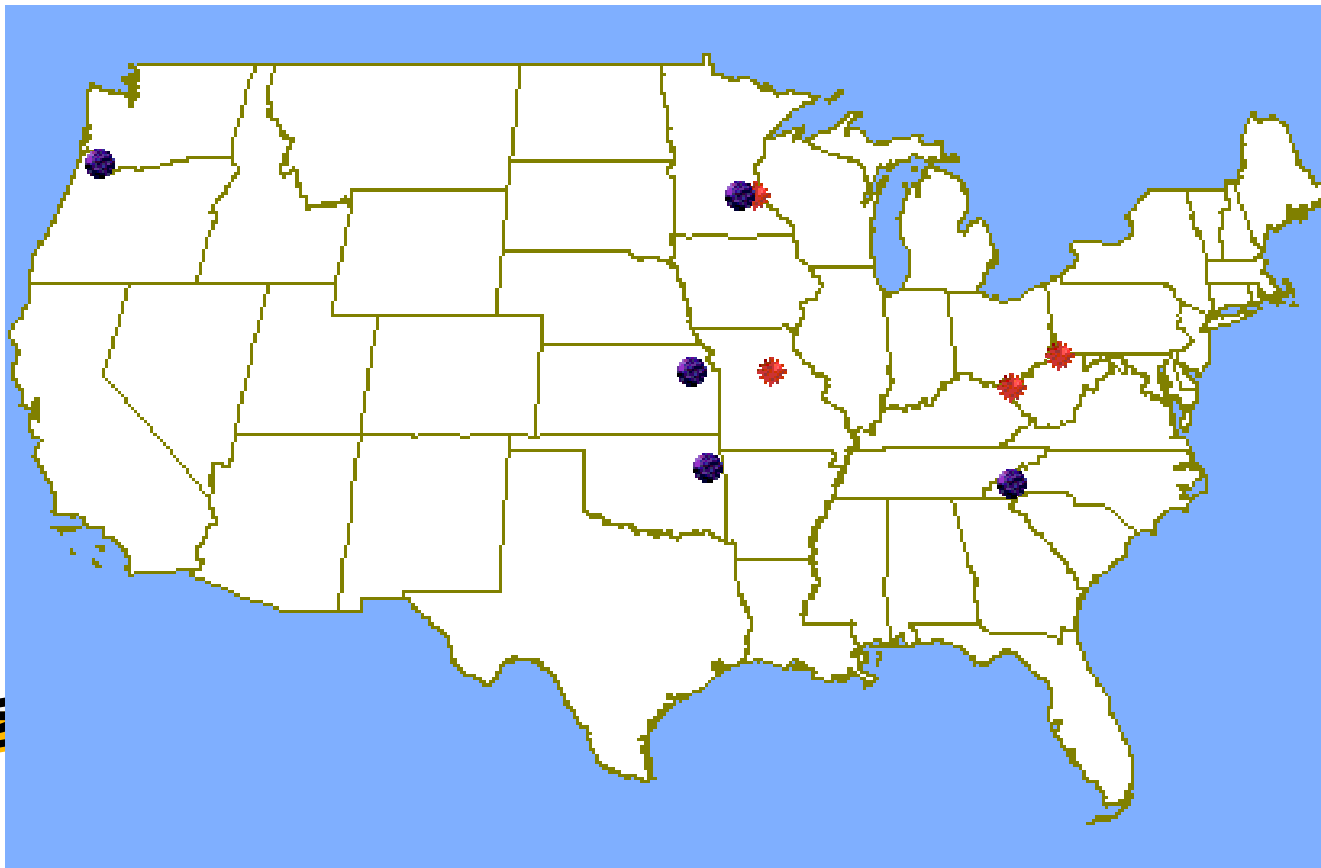
Case Study Methodology-Inclusive Child Care



Where the Centers Are

Telephone = RED

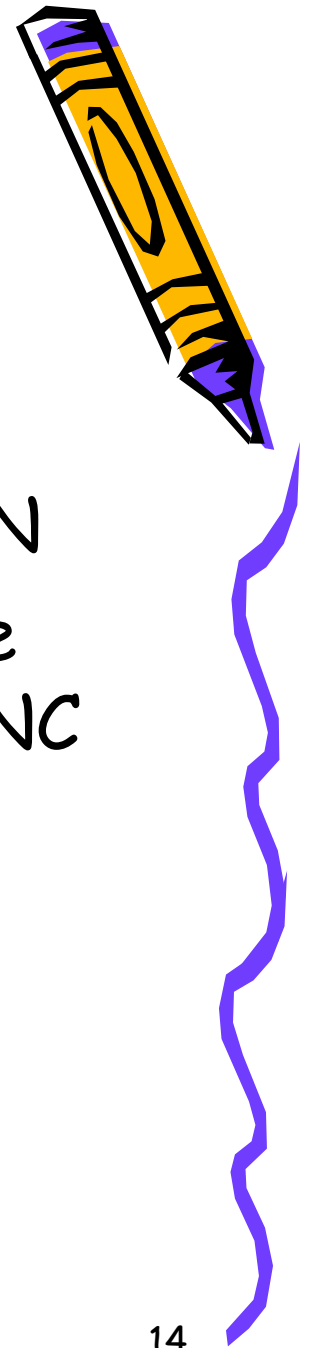
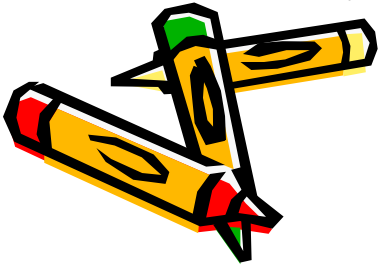
Face to Face = PURPLE



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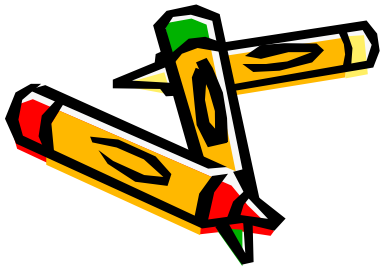
Centers Selected for Onsite Study

- Little Angels Child Care Center, Milwaukie, OR
- Broken Arrow Clubhouse, Broken Arrow, OK
- St. Benedict's Special Children's Center, Kansas City, KS
- Fraser School, Bloomington, MN
- Family Resource Center, Lenoir NC



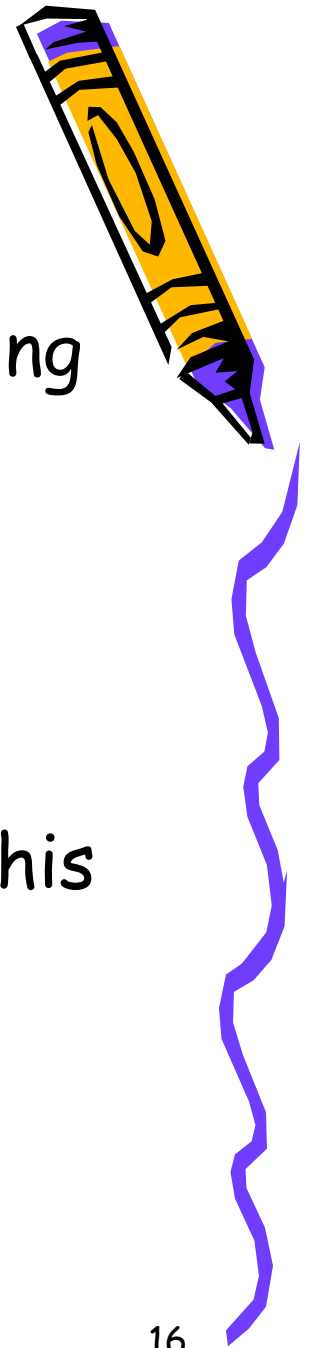
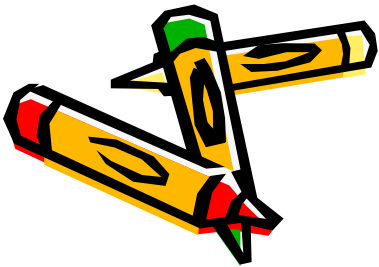
Centers Selected for Telephone Interview Study

- Kinder Haus Day Care Center/Kinder Tots, Morgantown, WV
- McCambridge Center Day Care, Columbia, MO
- River Valley Child Development Services, Huntington, WV
- Wayzata Home Base, Wayzata, MN



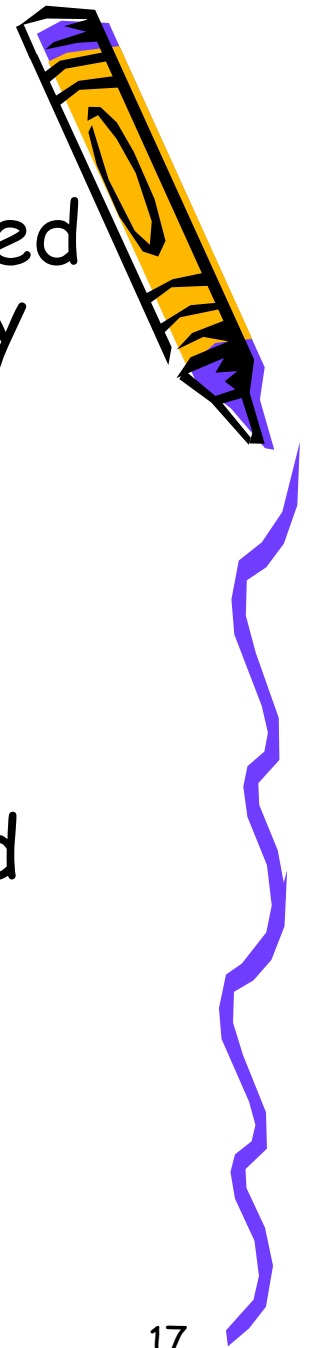
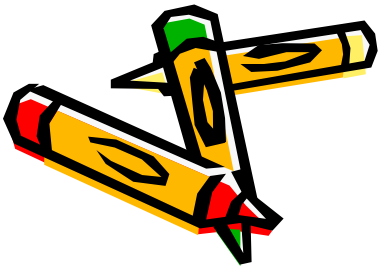
Study Methods

- Adult participants were interviewed using schedules developed for:
 - Directors (90-180 minutes)
 - Staff (approx. 60 minutes)
 - Family members (approx. 60 minutes)
- Children were observed by two researchers for a period of one hour; this time included transitions at the center (e.g. clean up, coming in for lunch).



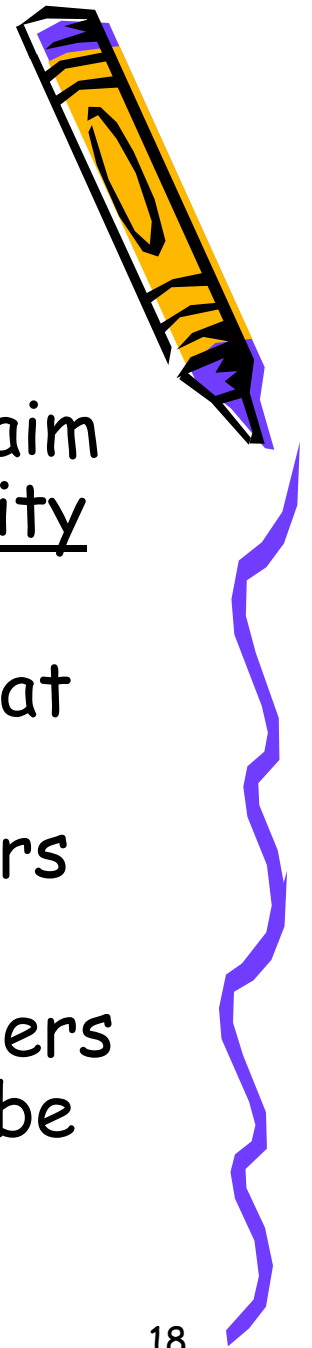
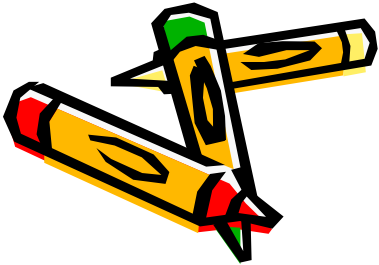
Data Analysis

- Interview transcripts were analyzed using a qualitative grounded theory approach.
- Directors, staff, and family members' transcripts were coded separately, and major themes and subthemes have been revealed.
- Child observations were also coded for patterns of interactions of observed children with staff and other children.



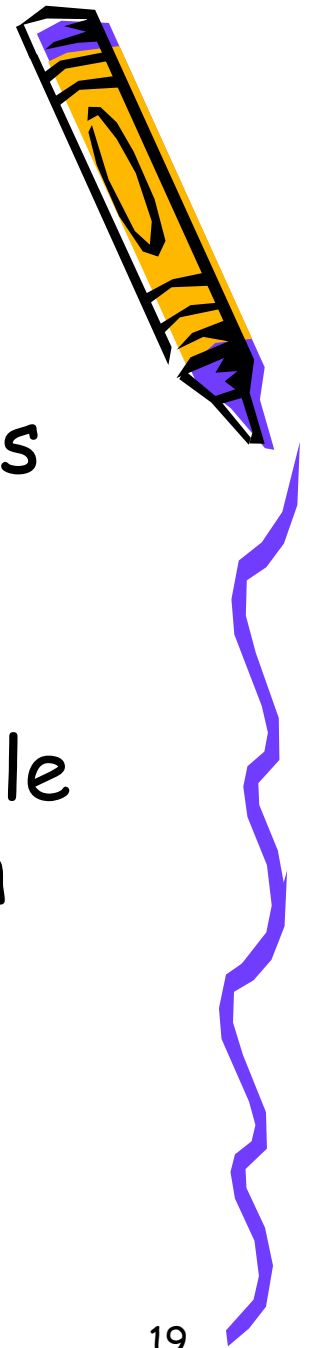
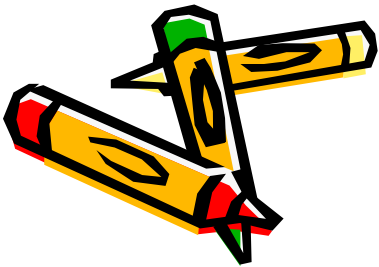
What We Learned from Child Care Directors

- The directors revealed that a primary aim of the centers was to provide high quality child care for all children.
- Directors imparted a belief to staff that children with emotional or behavioral challenges could be served in the centers (See Schock, 2002).
- A stable core of dedicated staff members was essential to the center's ability to be inclusive.



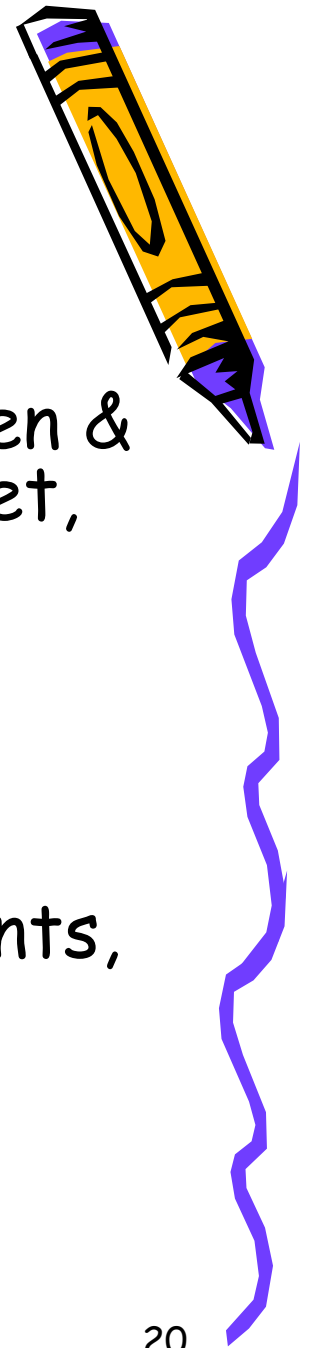
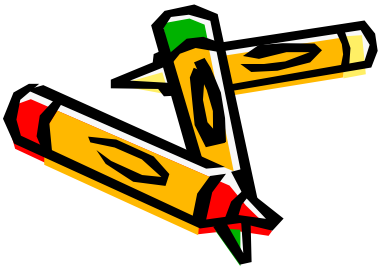
What We Learned from Child Care Directors

- Staff training about the challenges children face was critical to the success of the programs.
- Funding has been difficult to cobble together; directors have to design creative funding packages to pay staff as well as they can.



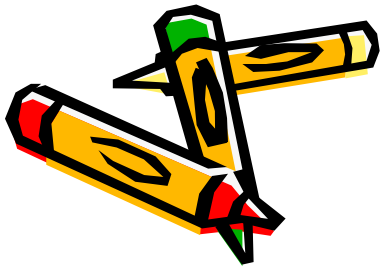
What We Learned from Child Care Directors

- Onsite mental health consultation (Cohen & Kaufmann, 2000; Donahue, Falk, & Provet, 2000) has been a crucial resource for:
 - maintaining children with challenges in the care centers, and
 - addressing staff concerns regarding their practice with these children.
- Families are seen as essential participants, and as vital sources of information concerning their children.



What a Director Said About Families at Her Center

"The role of families? Well, they're why we're here. I like to tell the teachers that they write our checks. So if they don't like our program, they'll go somewhere else. They are also very appreciative of what we do, especially [for] our children that have out of control behaviors...So the role of parents, well they're just part of us. We just all work together."

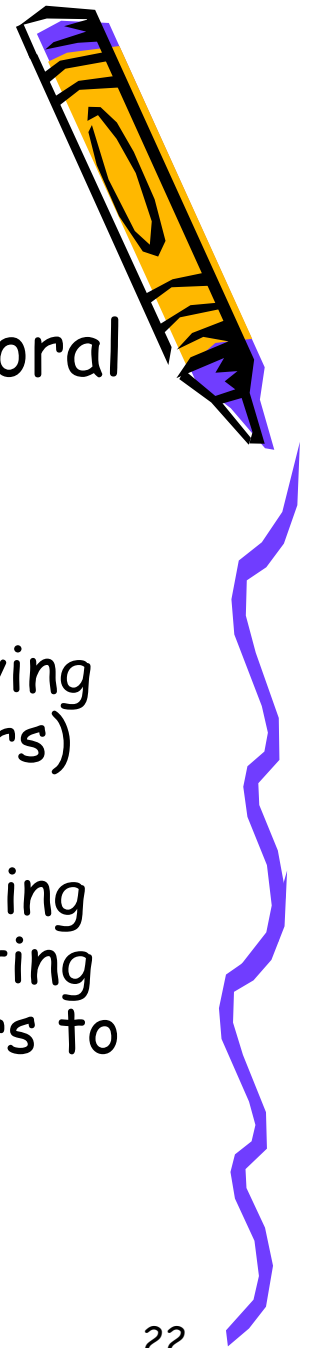
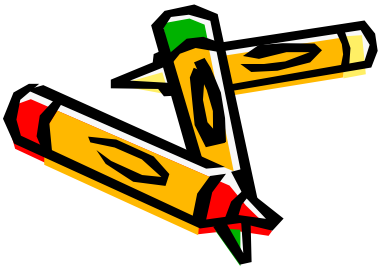


What We Learned from Staff

(Brennan, Caplan, & Ama, 2002)

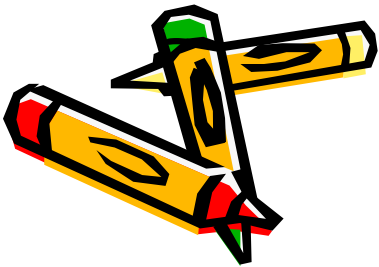
For children having emotional or behavioral challenges, staff used a variety of inclusion practices which either:

- Promoted emotional growth and positive behavior (e.g. building relationships, modifying environments, modeling of positive behaviors) or
- Transformed negative emotions or challenging behaviors (e.g. using visual prompts, promoting activities to control feelings, teaching peers to assist child with challenges)



Staff Example: Peers Learn to Respond to Negative Behavior

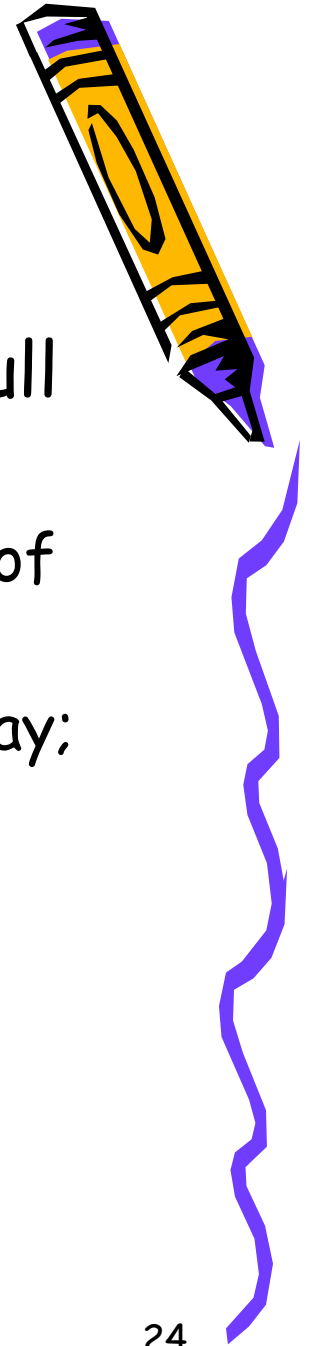
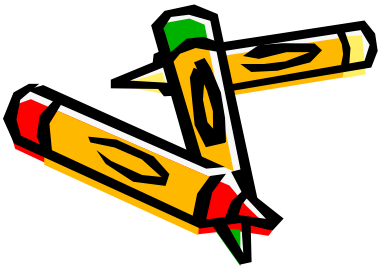
- "He loved to just run up to the kids and just knock them down on the floor and just jump right on top of them...He stopped pushing the older children as soon as they started saying 'No, don't push me. I don't like it. It hurts'...[then] He targeted younger children because they could not speak up for themselves...[One younger child] just laid down spread eagle on the ground, and the child who was getting ready to do the pushing just stopped. It was like "what are you doing? Now I can't push!"...[the younger boy] figured out a way to handle it on his own...then he stopped. "



What We Learned from Staff

Staff faced considerable barriers to full inclusion, for example:

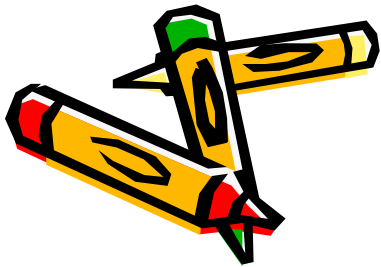
- Lack of time for planning and coordination of services;
- Multiple transitions within the child care day;
- Low pay for staff, reflected in turnover;
- Insufficient training opportunities; and,
- Lack of resources for intercultural communication.



Staff Example: Barriers to Full Inclusion

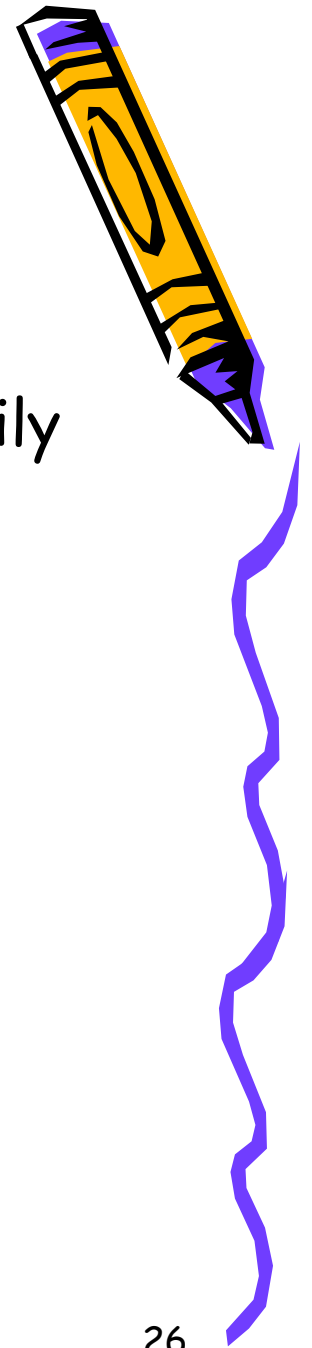
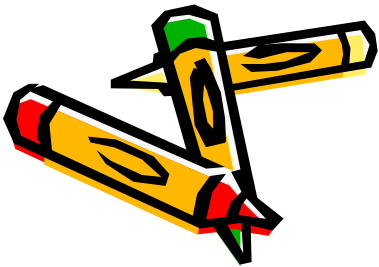
CULTURAL CHALLENGES

"just the language barrier as well as the cultural beliefs about children with special needs were such that [it was difficult to have the family members] recognize the value of him being involved in the day care, and appreciate the fact that he was down on the floor with the other babies rather than in his own crib."



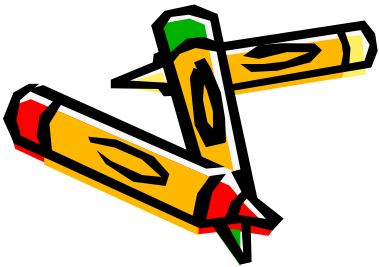
What We Learned from Staff

- Staff viewed family members as:
 - Experts on their children's challenges, family life, and culture;
 - Part of a team with staff to provide appropriate care;
 - Consultants on program decisions; and
 - Key to obtaining services for their own children.
- Staff used a variety of community resources to provide family support.



Staff Example: Role of Family Members

- FAMILY MEMBERS PART OF TEAM
 - "A three-way team [is needed] to be able to provide the proper care that the child is going to need...It takes a child and the family members and ourselves or the counseling staff."

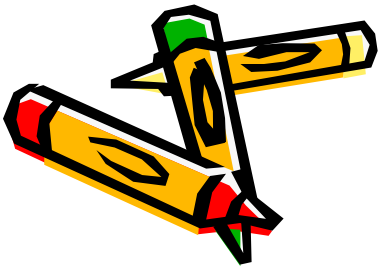


What We Learned from Family Members

(Ama, Berman, Brennan, & Bradley, 2002)

In prior experiences with other care providers, family members found communication and practices impeded inclusion. They reported:

- Being treated as "the enemy" or as knowing nothing;
- Staff had no time or desire to talk;
- Language or cultural barriers; and
- Staff expected them to take responsibility for the child's behavior at the center.

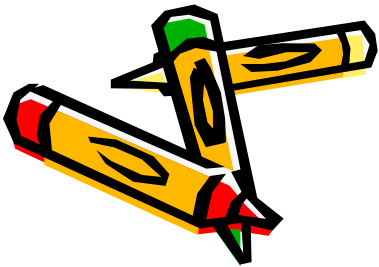


What We Learned from Family Members

(Ama, Berman, Brennan, & Bradley, 2002)

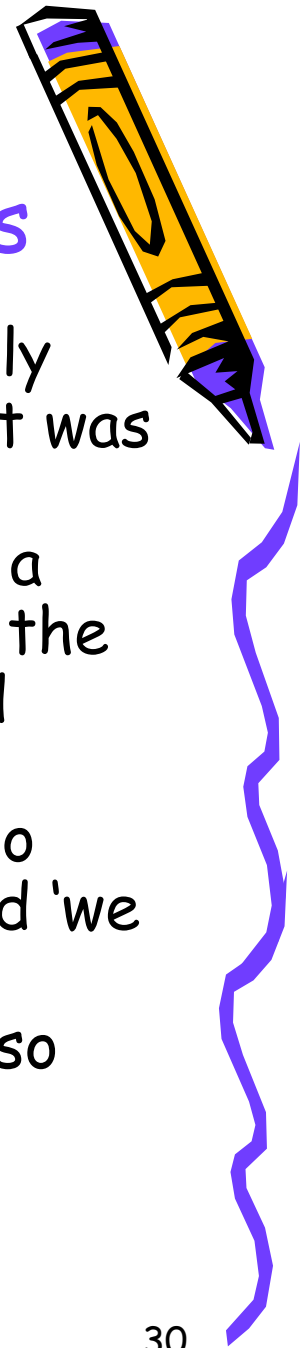
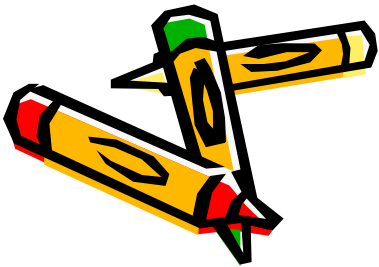
In the inclusive centers, family found:

- Staff took an active interest in their children;
- Staff had the time and desire to talk to them;
- Staff listened to them and learned from them; and
- They were involved in their children's lives at the centers.



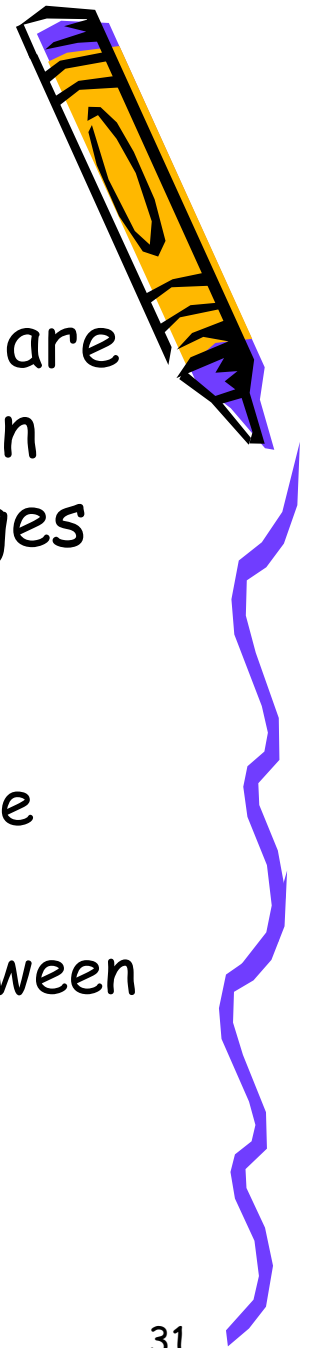
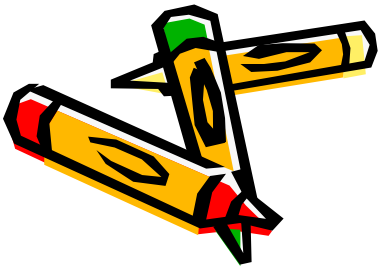
An Example of Positive Communication Reported by Families

"They communicate to me constantly...especially when he was here full time, when I'd come in it was almost like we'd have a little parent-teacher conference everyday. Some daycares it's like a madhouse, and they don't have time to talk to the parent because they're so busy flitting around trying to get everybody in control. Here they have time because of how the program runs...so everyday it was: This is what we did today; and 'we tried this and it worked'. Or I'd tell them something that I tried at home, and they are so open to ideas...there's no bad idea."



What We Learned from Family Members

- Family member perceptions of inclusion are generally positive whether their children are typically developing or have challenges (Stoneman, 2001).
- However, both sets of parents had:
 - Hopes that children will learn to be sensitive and accept differences, and
 - Fears regarding the possible tradeoffs between quality and inclusion.



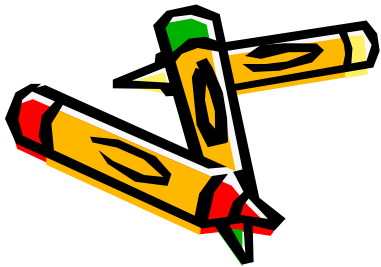
Centers Needed to Ease Fears for Both Sets of Parents

Families with Children who are Typically Developing

- Safety worries
- Poor behavior modeling from peers
- Child will not receive adequate attention or have needs met
- Handled by staff communication, trust

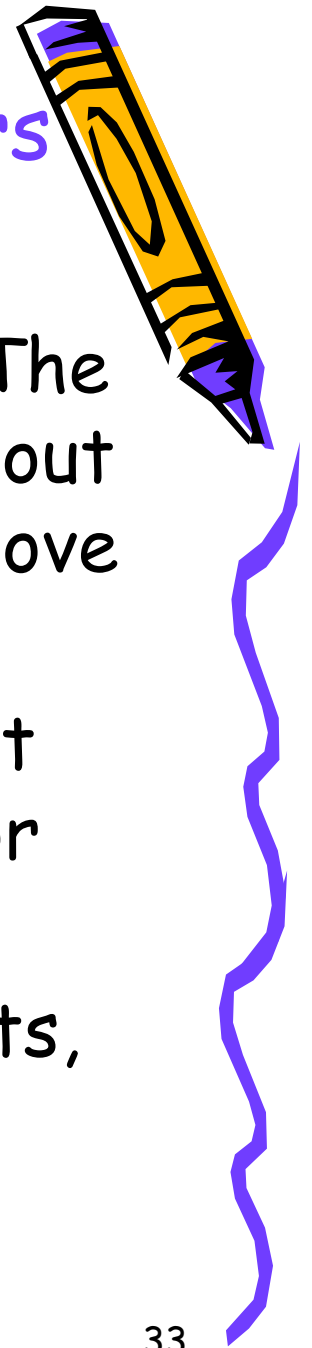
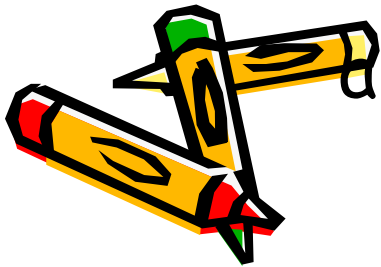
Families with Children who have Special Needs

- Safety worries
- Child will be teased by peers (See Bailey & Winton, 1987).
- Child will be singled out by staff or expelled
- Handled by staff communication, trust.



What We Learned From Family Members

- Family members reported choosing the centers for their family atmosphere: "The staff are genuine and genuinely care about the children. They love the kids, they love what they do, you can tell."
- Trust, learning, and professionalism (not simply training) - a major difference for our participants.
- Everyone is an equal partner. Specialists, teachers, families - all communicate and work together.



Child Care Choice: Similar Concerns, Separate Priorities

Families with Children who are Typically Developing

- A lucky occurrence
- Program had a reputation for high quality.
- Wanted child to learn to accept differences.
- Felt encouraged by staff attitudes.

Families with Children who have Special Needs

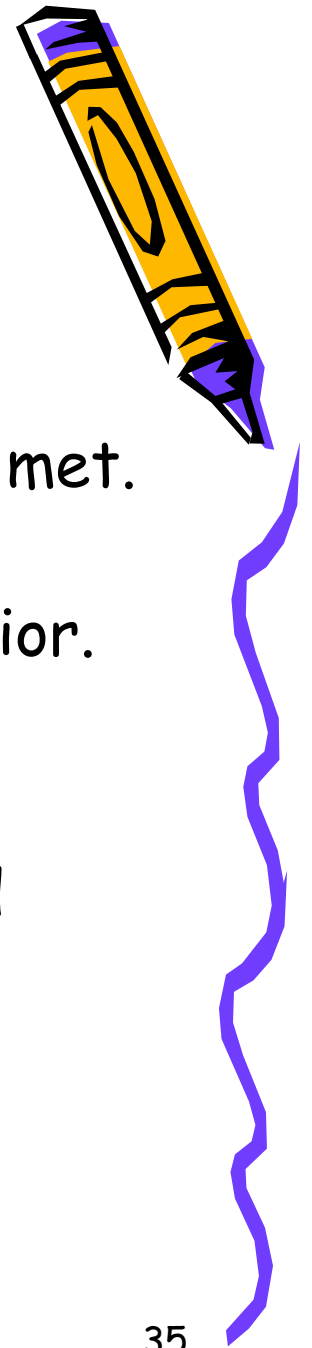
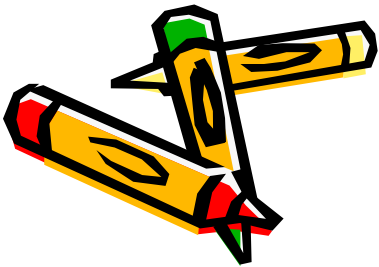
- Arrangement accepted them, had expertise.
- Child needed boundaries, routines.
- Wanted child to learn 'sociability.'
- Felt encouraged by staff attitudes.



What We Learned from Family Members

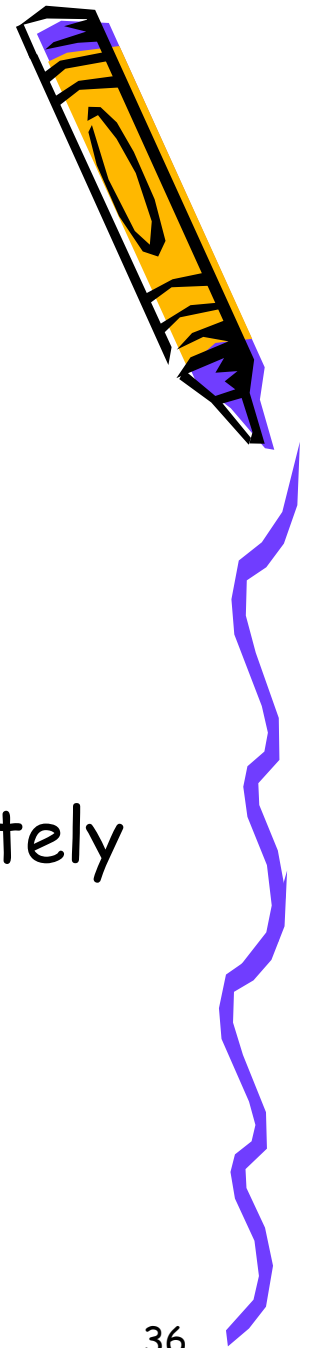
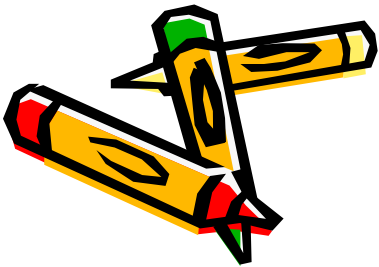
Families See Positive Outcomes From Inclusive Care:

- Children "learn to love learning." Goals are met.
- Children with emotional and /or behavioral challenges learn to control their own behavior.
- Enrolled children teach parents and other family members acceptance.
- Child feels more comfortable in school, and around other children and adults.
- Family's "serenity level goes up."



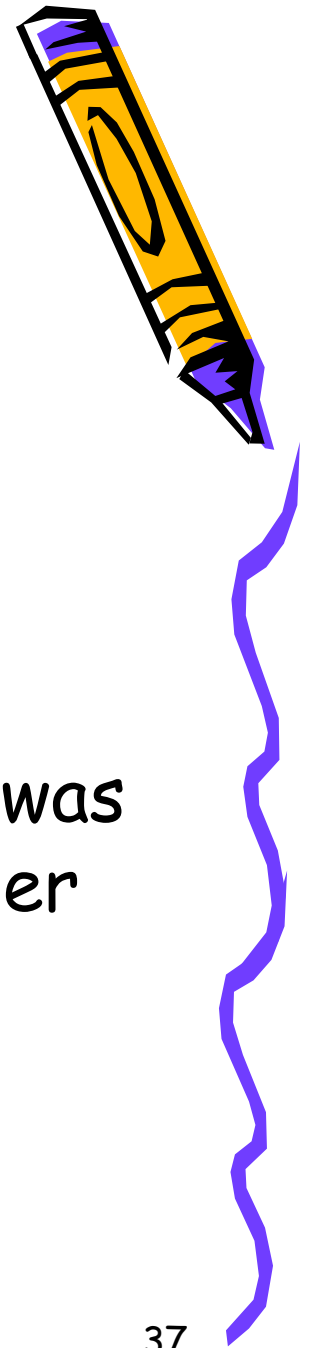
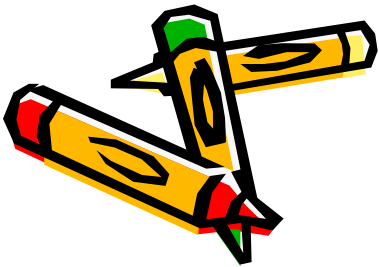
What We Learned from Observing Children

- Staff supported the inclusion of children with challenges by:
 - Structuring the environment to encourage cooperation
 - Anticipating needs and challenges
 - Teaching peers to respond appropriately to special needs
 - Mental health service provision integrated into classroom activities



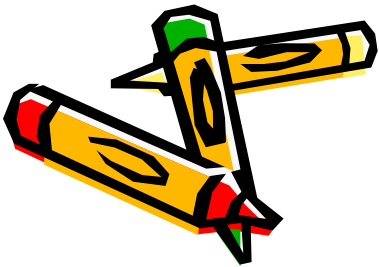
An Example of Structuring the Environment

- Classrooms included pets -sometimes several- in the environment. In one classroom, a child with attachment concerns was given responsibility for jointly caring for the class doves. She was observed patiently reminding her younger "assistant" to wash his hands after feeding the birds.



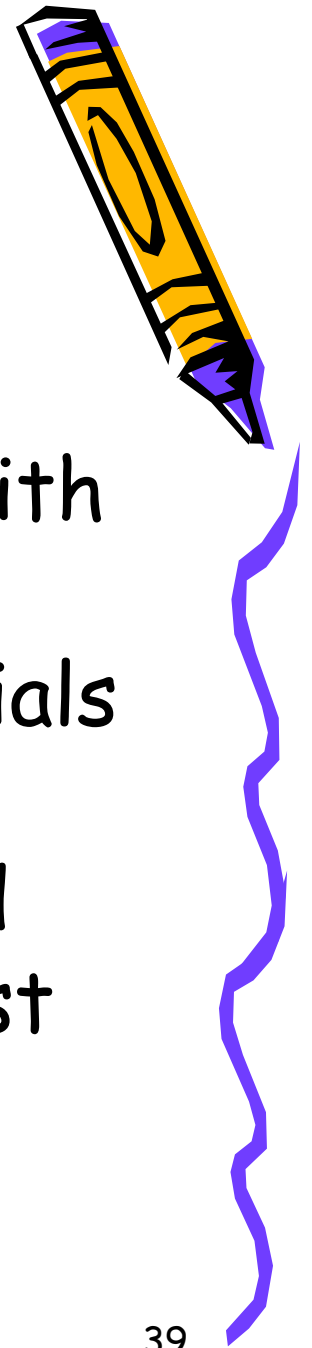
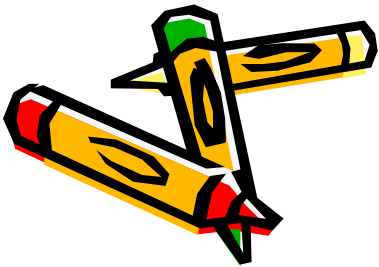
What We Learned by Observing Children

- Child to child interactions gave evidence of inclusion
 - Building on opportunities structured by teachers...
 - Children accepted differences in their peers with challenges...
 - ...and included them in activities and friendships.



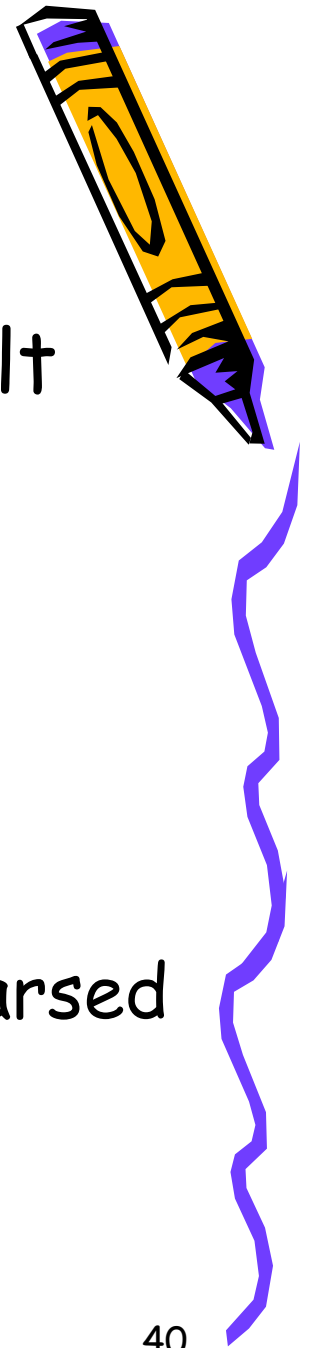
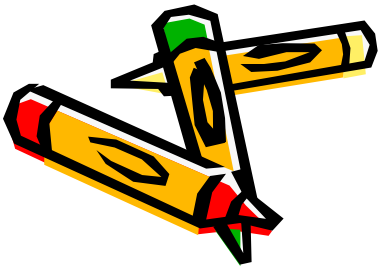
An Example of Inclusion in Activities and Friendships

- In one half-day program, a child with autism-spectrum behaviors was observed sharing space and materials with peers during art time. As he finished his painting, another child hugged him, stating "You're my best buddy!"



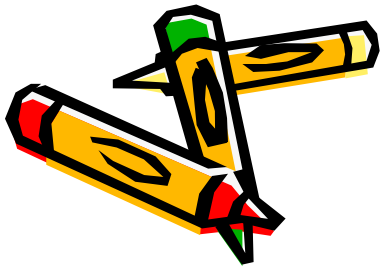
What We Learned by Observing Children

- Staff helped children with difficult times of transition:
 - Using predictable schedules...
 - With multiple, developmentally appropriate cues...
 - And physical calming techniques...
 - Multiple staff members in well-rehearsed roles facilitated transition times.



An Example of Use of Physical Calming

Appropriate, timely use of touch to communicate and comfort children was frequently observed. At naptime in one center, a child with developmental delays and behavioral concerns was gently helped to fall asleep by a teacher's back rub. In another setting, a school-aged child leaving for school was reassured by the director's arm around her shoulder.



Preliminary Conclusions

- Inclusive practices promote social and emotional development, particularly self-regulation (Shonkoff & Phillips, 2000).
- Family support, the provision of assistance and resources that families can use to meet their goals, is part of the services offered in inclusive centers (Friesen, 1996; Rosenzweig, Friesen, & Brennan, 1999).
- Inclusion is an indicator of center quality (Irwin, Lero, & Brophy, 2000).
- Staff of these model centers are well situated within their social ecology (Bronfenbrenner, 1995)



Promoting Children's Mental Health in the Child Care Context

Supplementary Workshop Materials

Workshop #11

Georgetown Training Institutes

Saturday, July 13, 2002

Washington, DC

Workshop Presenters:

Karen Tvedt
Director of Policy
Child Care Bureau

Eileen Brennan
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Research and Training Center on Family Support and Children's Mental Health
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Mental Health Services Administration

Attachment A

Results of Preliminary Qualitative Analysis of Staff Data

Based on: Brennan, E. M., Caplan, E. H., & Ama, S. (2002, April). *Including children with challenging behavior in child care settings*. Paper presented at the annual meeting of the Western Psychological Association, Irvine, CA.

- I. Inclusion Practices: Promotion of Emotional Growth and Positive Behavior
 - A. Staff reported inclusion practices
 1. Building of relationships between individual staff and children.
 2. Encouraging of verbal and artistic expression of emotions.
 3. Modifying environments.
 4. Modeling of positive behaviors by staff and peers
 5. Creating a safe and structured environment for each child.
 6. Engaging the child in the problem-solving process.
 7. Promotion of consistency between home and school.
 8. Class activities in structured order; children feel in control.
 9. Choices built into program; safe boundaries maintained.
 10. Animal care to promote empathy, attachment, and emotional growth.
 - B. Examples of Inclusion Practices Promoting Positive Emotional Growth
 1. SYMBOLIC EXPRESSION OF EMOTION

“[through drawing] in a matter of minutes the child is turned completely around. He’s no longer mad, he’s calmed down, he’s talking, he’s laughing, he’s showing you his artwork.”
 2. EMOTIONAL GROWTH THROUGH ANIMAL CARE

“[a girl] with attachment disorder...got attached to our rabbit...When the realization hit her that Fluffy was dead, and for the first time in her life, she actually cried...from then on she started growing.”
 3. ENVIRONMENTAL MODIFICATION

“because she would rather stand in front of the mirror [by herself] and play housekeeping all day long. We are gradually moving the mirror closer to where the other kids are.”

4. SAFE AND STRUCTURED ENVIRONMENT

“sitting behind a child while somebody is presenting at circle time...providing massage or bear hug, to help this kid be calm and focus and stay with whatever is going on in front of him.”

II. Inclusion Practices: Transforming Negative Emotions or Challenging Behavior

A. Staff reported inclusion practices

1. Using visual prompts for what child needs to do.
2. Promoting activities to help child get feelings under own control.
3. Teaching peers to assist with child's challenges.
4. Ignoring outbursts.
5. Redirecting attention away from negative reactions.
6. Using physical guidance to help child establish control.
7. Removing child from difficult situations, such as transitions.

B. Examples of Inclusion Practices Transforming Negative Emotions/Challenging Behavior

1. IGNORING OUTBURSTS

“I have a child that, if she doesn't get her way, pinches, slaps, or scratches. When she did this on the playground, I went to her victim and didn't even have eye contact with the aggressor. Just first aid, sympathy for the victim...she was beside herself because we did not recognize [her].”

2. REMOVING CHILD FROM DIFFICULT SITUATIONS

“We had a child who the minute we said ‘in five minutes we're going to clean up’ would go into a major tantrum...So we found something for this kid [and an aide] to do about seven minutes before it was time to clean up...the world didn't fall apart for him, and he was eventually able to stay.”

3. TEACHING PEERS TO ASSIST WITH CHALLENGES

“He loved to just run up to the kids and just knock them down on the floor and just jump right on top of them...He stopped pushing the older children as soon as they started saying ‘No, don’t push me. I don’t like it. It hurts’...[then] He targeted younger children because they could not speak up for themselves...[One younger child] just laid down spread eagle on the ground, and the child who was getting ready to do the pushing just stopped. It was like “what are you doing? Now I can’t push!’...[the younger boy] figured out a way to handle it on his own...So after the children finally stood up for themselves and said, ‘Please don’t push us anymore,’ then he stopped.”

III. Barriers to Full Inclusion

A. Staff reported barriers

1. Insufficient time for planning to meet the needs of the individual children, and for coordination of care.
2. Highly challenging situations, such as multiple transitions, part of child care *per se*.
3. Lack of resources for intercultural communication.
4. Not enough staff in each classroom to handle the most challenging children.
5. Low pay for staff; reflected in turnover.
6. Insufficient training opportunities for staff.
7. Lack of mental health consultation time.
8. Not enough centers willing to take on challenging children.

B. Examples of Barriers to Full Inclusion

1. CULTURAL CHALLENGES

“just the language barrier as well as the cultural beliefs about children with special needs were such that [it was difficult to have them]recognize the value of him being involved in the day care, and appreciate the fact that he was down on the floor with the other babies rather than in his own crib.”

2. STAFF CHALLENGES

“ I think the biggest barrier is child care consistency among staff. You will have a staff person you’ll talk to and they will all be on board with the ideas we talked about. And then they will quit and we are at ground one again.”

3. NEED FOR ADDITIONAL CENTERS TO MEET THE CHALLENGES

“I wish there were more and more centers that could meet the needs of the children...parents are driving...thirty, forty, miles...every day to bring their children because they know we can work with their children and get through it.”

IV. Role of Family Members According to Staff

A. Staff stated that the role of family members at their centers was:

1. Providing information about their children’s challenges, family life and culture.
2. Working as team members with staff to provide proper care.
3. Collaborating on setting goals for the child
4. Following through on obtaining services for their own children.
5. Volunteering to provide resources and services for the center.
6. Consulting about program decisions.

B. Examples of Staff Statements on the Role of Family Members

1. FAMILY MEMBERS PART OF TEAM

“A three-way team [is needed] to be able to provide the proper care that the child is going to need...It takes a child and the family members and ourselves or the counseling staff.”

2. SHARING INFORMATION ON CHILD

“The mom helped a lot with bringing in resources from the different people who have given her written information [about her child’s autism] and just sharing things.”

3. FOLLOWING THROUGH ON SERVICES

“The family...told us they would seek counseling, had set up appointments...that were always cancelled...If we have nobody as a support team to back us up...then we’re fighting a battle that we’re never going to get through.”

4. CONSULTATION ON CENTER DECISIONS

“Every six months parents are invited to come and air their opinions on the program, adjust anything they may or may not want in the program.”

V. Resources Used by Staff to Assist Families

- A. School district specialists.
- B. Public health and mental health staff.
- C. Local consultants.
- D. Community trainings.
- E. Published materials, internet.
- F. Charitable organizations
- G. Volunteers and interns.
- H. Inclusion and early intervention program.
- I. Financial assistance agencies.
- J. Child care organizations.
- K. Community youth development and recreation organizations.
- L. Child welfare agencies.
- M. Community police.
- N. Family support organizations.

Attachment B

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