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Saturday Plenary: Promoting Children's Mental Health in Early Childhood Settings

Lyn Gordon: I would like to introduce Maureen Breckenridge, the Executive Director of the Oregon Family Support Network, who will bring you greetings from families in Oregon.

Maureen Breckenridge: I'm really happy that so many people are here. Early childhood is so very important, as we all know. Especially as our kids get older we see the things that we wish we had done. As a grandmother, I know I see things that I know as a grandmother I can do with my grandchild in the early years that I didn't know as a parent.

First of all, I want to acknowledge the Oregon families who are here, who did some presentations yesterday. There is Jeanne Shultz here from Eugene and Don Bougher from Washington County who was a moderator for many of the panels, and Deb Depew and Carol from Zero to Three, and Jeanine is here also, and she is from a community resource center. There are some other parents who aren't still here—Mike Rice and Theresa Rea and five children. All these people have come and done a great job—and Bill Richards. It was really exciting to see what Oregon families can bring together to the whole community. I want to thank them for doing that. These people have to leave their jobs, leave their kids, they are sleeping all together. They are bunking out, to do this. I appreciate that. It is a great message for all of us.

I have been invited to other conferences to do a welcome, and I don't know that they want to invite me back, but they did invite me back here. I have a welcome hat so you really know that I want to welcome you, formally, so you will know that this is my official

welcome hat. I am a lady in this hat. I am going to be very nice and welcome you to Oregon and tell you everything is beautiful here and that we are very, very happy to have you here.

This is the hat, by the way, that I can wear to the legislature for you, to represent your needs to our legislators, so they know the seriousness of our job and what we do and what we bring to the community. Last year when I wore my welcoming hat it was not present, because I was only on the job a few weeks, and I don't know if you could handle me that way. So I let you know some of my stiff background. I am a lawyer, and I have kids and all that stuff.

This year I want to tell you, the keynote speaker said that one of the problems is when you only have a hammer, you see everything as nail. Well, I have a hammer and my nails are the family voice. So anytime I get an opportunity to speak on behalf of the family voice I do it.

I have to change hats. Do you know what kind of hat this is or where you wear this hat? Oregonians, east of the mountains, where do you wear this hat? Hunting, right, so people don't shoot you in the woods. Well, I am an advocate. I have to wear this hat. I am a family member. I have to wear this hat. This is my advocacy hat and we actually, in my groups, had little family-driven badges, so just in case you don't know what we are all about, we are here to do this.

I want to tell you that in my opening address last year, this was the family voice I heard:

We don't want our kids in residential treatment anymore. We don't want to have to drive three times a week several hundred miles and leave our other kid at home, who also has their own difficulties. We don't want to do that. We don't want our kids in jail anymore as a form of treatment.

Guess what? This year I am here to tell you that things have changed. We were part of a lawsuit this year and the State of Oregon is now going to have a budget note and it is going to change the way things are done in Oregon in residential treatment. I am going to say that publicly, because everybody has been hushing this

up, and they are acting like it is a little thing. Well, the families who put their lives on the line, to tell their stories about their kids need this to be public. So I am going to make it public, just as we did with the Bazelon Report, and say this is why we wear these hats. Sometimes you might be happy to see me and sometimes not, but in general, the families are pretty happy that we are getting this work done. I want to thank everybody for doing that.

Nancy Jambor, who is sitting over here, made the mistake of inviting me to do a welcome, too. It was Early Childhood, and I was there with a parent, from Eugene, who has a couple of kids. At the end of listening to a couple of days of what people thought about our families, and what you needed to do to work with our families and little kids, we couldn't just give a welcome. So I gave Dave Letterman's Top Ten Things that parents from Oregon want you to hear. That was remembered by some people and quickly forgotten by others.

But I did bring a picture of this little guy. Since I am not giving a presentation, I thought I would just bring his picture. Can you see what that is? It's legs. These are the legs and these are the little shoes. That is my grandson, so that means I am going to put on my grandma hat, and I'm a grandma and I was sitting, on Mother's Day, with the other grandma and my grandchild and my daughter.

The other grandmother said, "Oh, Kristin,"—my daughter—"what happened with the lady? Did he ever pass those tests?"

And I thought, "hum, I wonder what that is about."

She said, "Oh, yeah, it worked out fine."

Later I said, "What lady were you talking about?"

She said, "Mom, remember before Thomas was born, someone came to the house and they checked to see if there was lead in the paint, because it is an old house, and that I had the supplies and everything I needed for the baby. And then when you came over here when he was born, the nurse came over and she spent the week with us and showed us how to put him in the little tummy tubby where he sort of floats to get his

little nervous system relaxed and everything. And they taught us how to work with him there, because he was pretty wired up like that. So they spent the week with us doing that.”

I said, “Yeah, yeah.”

She said, “Well, I brought him in there for shots and that’s where you go to do that. One of the other ladies does a little test to see where he is and if he is learning what he is going to learn.

“It was one of those bad days, Mom, when he was throwing his arms up in the air and he was going stiff, and he was biting and he was kicking, and they said he didn’t pass this test. So they sent me to a pediatrician and the pediatrician said, ‘Ah, what is going on in life?’

“I told about moving to another house and some other stressful things.

“The pediatrician said he was over stimulated and a child with that kind of a nervous system, ‘you don’t test them when they are over-stimulated like that. So let’s just do this again, and I’ll do it here’ —he is way over where the test is...”

I said, “Why were they talking about the lady being in your house, Kristin?”

She said, “When we moved to this new house, the lady came over to see how Thomas as adjusting and she was helping me.”

I said, “Oh, is that why you are asking him, ‘Do you want to wear the red socks or the black socks, Thomas? Do you want to eat potatoes or rice?’”

She said, “Yeah, they taught me that he is upset because of the move and the things in his life and we speak two languages and everything. They were teaching me how to give him some choices so that he can manage his own life.”

I said, “Isn’t that terrific?”

Then she called him, “Thomas, come here, I need to talk to you. Look in my eyes, Thomas, look in my eyes.”

He is only two, and I brought him to school and she was talking to the teacher and how they got together

with those ladies, too, and how they are discussing what kind of a school Thomas will go to in the town, and how probably he should have some more structure. That is going to be helpful for him. He has a real big IQ and so we want to make sure that he gets more individualized attention. You can imagine how good I felt leaving my grandchild, knowing that there were other ladies—grandmas, whatever—who are helping my daughter to raise this child.

The interesting thing is that everybody in this community gets that. Her girlfriend is a multi-millionaire and she had to learn how to work with her little kid, but she didn’t know anything different was going on because she was an only child and she didn’t know to give the child some independence. Her other girlfriend who had a premature baby, she had a live-in person there who was helping her with her two little children who were young. All the mothers were sitting around talking about these ladies.

Right now you are probably wondering where she lives, right? She lives in The Netherlands, and this is what is possible. The word mental health has never come up. There is no split in who is doing what. There are people who are developing citizens and I am so very happy that that is where my grandchild is. My sister works in Ireland in this work, and they, too treat their children as their families and their children. The boundaries aren’t there that we have.

I hope that when you talk about the hammer and the nails and everything, and you really want to pound the same nails, that you can see that maybe there are new adaptive micro-systems that were put in through computers or whatever else, and you don’t have to go around hammering nails.

Bill Richards, at the Oregon Family Support Network youth presentation said, “OK, everybody, put your arms up like this.” (Holds arms wide.) I am going to ask you to do the same things. Ready? Put your arms out like this. What is this? What is that? It is all the possibilities. That’s what we have. So welcome to Oregon.

Steffen Saifer: I am a faculty member at Portland State University and with the Regional Research Institute as well as the Director of the Child and Family Program at the Northwest Regional Educational Lab. We are off to a roaring start here, except we are cutting off our caffeine at this point.

Welcome to the first plenary session for this conference on early childhood mental health, or as we are calling it, Promoting Children's Mental Health in Early Childhood Settings. I am honored and delighted to be the moderator of this panel on this issue. It is very exciting. It is a field I've been working in for many years, and it is also introduces the first of many conundrums we are going to be dealing with on this panel, which is what does it mean, "early childhood and early childhood settings"—how do you define early childhood? Well, generally for our purposes we are defining it from birth to school-age, birth through five, but depending on who you talk to and which constituents, it could be birth through grade three. For early childhood education folks, that is early childhood. Definitions, coming to terms, is going to be a big challenge with us this morning.

I purposefully called this Helping Children with Challenging Behaviors. That is very purposeful and very thoughtful and it has gone through many iterations over the years that I have been working in this field. Helping Children with Challenging Behaviors is another way of looking at this issue which I think is easier and healthier. Have you seen a three-year-old with mental health issues? Well, maybe. But have you seen a three-year-old with challenging behaviors? Oh, yeah. Calling it challenging is good, I think, because it doesn't put an evaluation, it doesn't put a judgment on it. I could be a perfectly functional, in fact a healthful behavior to the child in that context, but be challenging to you as the parent or the teacher. The challenging part, I think, takes the judgment out of it. Helping, of course, puts it on a positive note, because what is our goal here. Our goal here is to help these children with these challenging behaviors to get their needs met in a better way, to get them happier, put them on a positive note.

The next conundrum is that all these players that come together in the field of early childhood mental health, they come from different backgrounds in terms of their education, their cultural social history of these fields, come out of different places. We have parents, of course. The first two are the people that spend the most time with young children, the parents being primary. The way I am going to frame it is by looking at the different perspectives of how people view the term "early intervention." Parents here, how many of you knew what that meant the first time you heard early intervention? Very few. Probably what happened as a parent, your jargon flag went up. Oops, "early intervention," here is some jargon. You know it is jargon because you can't figure out what it means through any kind of logical reasoning. Or it could mean so many different things that you aren't sure what it means. It is one of those jargon terms.

The second most amount of time young children spend with child caregivers, is with early childhood teachers. For this group of people, early intervention generally is age-related and it is generally like three to five, pretty much. For some people it is younger. The next group, early intervention for special educators has a very specific age-related meaning. It is birth through three, because three to five is called something else. You can imagine all these people in the same room using the term and not knowing what they mean.

Mental health specialists is the next group. For them early intervention could mean, for many of them, the time when you do the intervention. So you get into the problem early, as opposed to waiting for it to become a crisis. So it is not age-related, but it is temporal, or time related.

Then there are pediatricians who are very involved in this, of course. For them early intervention means that you have a 7:45 appointment in the morning. That's not fair to pediatricians, but it was sort of a good joke for this time of day.

In our work with early childhood folks, child caregivers, Head Start teachers, primarily, we came across another interesting other conundrum, another problem, which is we noticed that they were not

effectively helping children with challenging behaviors. What we saw is that they were kind of ambivalent—not all of them, of course—they tend to be inconsistent, unsure. They felt a little guilty when they were too directive and as one of the consequences they used ignoring a lot. Another way of ignoring was pretending not to see that this kid was strangling the kid next to him. Here was the problem, and then we try to figure out where this was coming from.

What we discovered in talking to other early childhood educators and the teachers themselves and supervisors is that the problem was that they had this dichotomy, and I think it is a false dichotomy that was set up for them, which is you can either be child-centered or you can be teacher-directed. You can't do both. They are mutually exclusive. Child-centered is good, so you have to do that. And teacher-directed is bad, so you don't do that. But then you have this child who needs a lot of teacher direction. You are not supposed to do that. So they were in this dilemma, this conundrum themselves, not knowing what to do.

One way we helped them get out of this dilemma was to create another view of it, a less dichotomous view, where you look at child-centered and adult-involvement—not teacher-direction, but adult-involvement—kind of the intensity of help. The intensity of help is based on the need of the child. The more need, the more intense help.

As a curriculum, a way for you to see how these kind of four quadrants work out, is from the curriculum perspective. So low child-centered, in the bottom left corner there, an example of that is worksheets. Low child-centered, low adult-involvement. That is sort of the worst of both worlds, if you will. So child is working on his or her own, on a worksheet. It is not child-centered because they didn't choose it. It is Monday morning, so this is the curriculum at 9:00. The child has no choice and the teacher is not very involved. Then if we move up on the left side, low child-centered, high adult involvement would be something like drills or flash cards. There is a lot of interaction and adults can do this very well. They can even make it kind of fun. They could be responsive

to the kids' individual needs, where they are at in terms of these math issues or something. But low child choice. The child isn't choosing to do this. The child would probably rather be doing something else.

At the bottom right is high child-centered, low adult involvement. The classic example is recess: 300 kids out on the playground with one teacher. The kids, that is the most important time of the day for them. All these incredible social relations are going on. The boys are chasing the girls, the girls are chasing the boys. And often in terms of developing skills, social skills in this case, it is a negative thing, because there is no adult involvement, so the kids who are good at manipulation or bullying get to win. That is the problem there. So the ideal is this high adult involvement, high child centeredness. A good example of that, when it is done well, are projects based on children's interests, where it is very interactive and the adults monitor it. It happens over a long period of time. It is very hands-on, and it has high educational value.

How does this same thing look in terms of behavior, the kid with a challenging behavior? Low child-centered, low adult involvement—time out, we will stick you over there, and hopefully something magical will happen during the time you are in time out and you will come back and you will be a perfectly wonderful child. On the upper quadrant is a reward system. High adult involvement, very structured by adults, low child centered, no choice here. Everything is done to you. The bottom right quadrant is the high child-centered, low adult involvement is you ignore it or you pretend not to see it. And the ideal high adult involvement, high child-centered where you teach the appropriate behavior to the children to help them get their needs met and their problems solved in a way that is not hurtful, is socially acceptable, and is effective. So why is it high child-centered? Because you are looking at what the child is trying to accomplish, what the child's problems that they are trying to solve are, and you are helping them do that in a more effective way that is positive for themselves and for others.

I put down some guiding principles that I would say all the players in the field could abide by and if they did, we could avoid some of the miscommunication and conundrums that all the players have.

The first one is whatever it is, we *individualize*. What may work with one child may not work with another. We may need to be very directive with one and even the same child in different circumstances.

The second point is *assume ignorance not malice*. Now three and four-year-old are perfectly capable of malice, as we know. But approaching it from that perspective isn't helpful to them or to us. So assume ignorance. Assume it is an issue that they just don't know, and help them learn, teach them the appropriate behavior. Fix the program or yourself, your own response to the behavior, not the child.

The next point is *give as much help as is necessary*, but no more. It doesn't matter what player you are, use the principles that work, from whatever field you are coming from. Have a full toolbox of positive strategies. There is that hammer and nail metaphor. You can't just have a hammer in your toolbox, you need lots of tools because there is going to be a different array of problems. Even the same child, you will need a variety of tools to help that child in different circumstances. Keep moving toward less intrusion and more controlled child choice. This is another way to help people out of the child-directed, teacher-directed problem, which is, yes, you may be very directive now. You may be physically directing a child with challenging behaviors, but you are not going to stay there. You are going to help build capacities so you can move out of that and help that child become more independent and do those behaviors on his or her own.

Expect inclusion, that is the first resort. I guess if there is a last resort, there can be a first resort, right? So expect inclusion as the norm, and only under very dire circumstances would you not do that. What we find a lot is that in terms of challenging behaviors, this is the one area of "need" or disability where people feel it is just perfectly acceptable to segregate kids out by their need, when in fact they need good role models

of kids with good behavior. Check your assumptions. Ask questions, don't assume you have all the information regardless of which one of those roles or positions you are in. Find and use allies for help and support. No single person on that list can do this alone. We all need each other. Some of those people will be helpful and some of those people will not be. You have to figure out who your allies are, and stick with them. You tell your allies what you know, what you need, and you teach them how to speak your language. "This is what I understand. This is how I can understand it. Speak my language." If you are a professional working with a parent, "this is what this jargon term means."

Next we have our panel. The first to speak is Beth Green. Beth Green is a Senior Research Associate with Northwest Professional Consortium. She has been involved for many years with the National Evaluation of Early Head Start and is co-principal investigator for Guidance for Program Design: Addressing the Mental Health Needs of Young Children and their Families in Early Childhood Education. Beth is with the Research and Training Center on Family Support and Children's Mental Health at Portland State University.

Abbey Alkon will speak next. Abbey is at the University of California, San Francisco, where she is an associate professor in the School of Nursing. She is the principal investigator of the Health Child Care California Project, the Child Care Health Linkages Project and Health Line. She serves as the director of the California Child Care Health Program.

Both Beth and Abbey will be focusing—not exclusively, but a lot—on mental health consultation to early childhood programs.

Then Eileen Brennan, who is here at Portland State as a professor of social work. She is the principal investigator for Models of Inclusion in Child Care and the co-principal investigator for Support for Working Caregivers Project. They are also both projects based at the Research and Training Center.

Glen Dunlap is here from Florida, Professor of Child and Family Studies, Director of the Division of Applied Research and Educational Support of the University of South Florida, Louis de la Parte Florida Mental Health Institute. He is the director of the Research and Training Center on Positive Behavior Support, and that is going to be the topic that he is going to address, which is an approach called Positive Behavior Support, and also the Center for Evidence-based Practice: Young Children with Challenging Behavior—there is that great term again—at the University of South Florida.

So first up is Beth Green.

Beth Green: This is great to see so many people here on a beautiful Saturday morning. I know if you are from Portland or Oregon, giving up minutes in the sunshine is very difficult. If you are from out of town, I want to let you know that if you are feeling bad because you are missing the famous Portland Saturday Market, that it is actually open on Sundays, too. So you can sneak down there if you are here tomorrow.

I am going to be talking to you today about effective models for early childhood mental health consultation. Since we have a minute, I am going to acknowledge the hard work of our project team. We have been working now for almost four years together on this project looking at early childhood consultation in Head Start Programs. Maria Everhart who is down in the front is our project manager and has been working really hard. And Lyn Gordon, who you have already seen many times, we are lucky to have him with us on our project. Maria Garcia-Gettman, who is not here today because she is home with her new baby, has been our graduate research assistant for all these many years. So that is the team that has been behind some of the work that I am going to be talking about today.

The first question is just the general one of, “why do early childhood programs need to provide mental health service?” First, and many researchers have noted, there seems to be an increasing prevalence of behavioral and emotional problems within children under five. That is what I am talking about in terms of my definitions of early childhood. Second is that

behavior and emotional problems in preschool children are especially challenging for families and teachers. I like the words, “challenging behaviors” or “challenges in young children.” I have a two-year-old so I know something about challenging behaviors in early childhood.

One of the things that we found in our research is that one of the major problems for teachers is that challenging behaviors really shift the focus in a classroom away from—even in the most well-intentioned teachers—being able to provide good positive support for the group as a whole toward behavioral control of the child (or children) who has a problem. In particular we see aggressive behavior as being a big problem. We are talking about pinching, biting, hitting, strangling, whatever, that this leads teachers to seem to put aside any of their more supportive, family-friendly, child-focused kinds of strategies, and really think about exclusion. They think about, “This kid is disrupting the classroom. He or she needs to be somewhere else.”

I want to share with you a little anecdote. This research is within the Head Start setting where, of course, we have children who are at high risk for challenging behaviors because of their socio-economic risk factors and other things. But my child is in a day care center—a pretty good, mostly middle class, kind of day care center. I was picking her up one day and I saw the teacher jump up, scream at the top of her lungs, “No, biting, Tom!”—let’s say “Tom”, it wasn’t Tom—grab the child, run to the other side of the room, throw the child into his seat and then come back and say to me, “We have to do this. We were told by his pediatrician that this is how we are supposed to deal with his biting behavior.” She was embarrassed, I could tell. You could also tell the room, all the other kids stopped. My little girl ran over to me and looked at me and said, “Tom is sad.” It just broke my heart, needless to say. I didn’t think this was the most appropriate way of dealing with aggressive behavior in a classroom full of two and three year olds. I went and talked to the administrator and said, “You know, I have the name of someone you might be able to call who might be able to give you a little more guidance.”

“Not to bash pediatricians,” as we already have a little bit this morning, “but perhaps this pediatrician is not giving you the right kind of advice on how to deal with this aggressive behavior.” The good news for me is that they were not throwing him out. But the bad news was it totally disrupted the classroom, and all of the effort of this teacher was directed on keeping this child from biting. I tend to be nonchalant about the biting issue, because my little girl went through a biting problem herself. My point is even this middle class, very positive, very NAEYC-accredited kind of day care, still, when faced with a kid sort of beyond what they were used to dealing with in terms of aggressive behavior, really didn’t know how to deal with it, really didn’t know how to face the problem.

About ten years ago an article in *American Psychologist* came out by Petrokowski and Jane Knitzer and some other folks, really calling for a new way of addressing the growing issue of challenging behavior in very young children, especially in the Head Start context. What they tried to argue was that the traditional way of involving mental health professionals in early childhood settings, that is, bringing in a mental health consultant to deal with a problematic children, often taking that child out of the classroom and doing some play therapy or some other sort of individualized treatment, was not going to be an effective strategy for promoting children’s mental health in Head Start more generally.

In Head Start, of course, you are dealing with more children who have challenging behaviors and conceptually needing to support a more positive view of how to deal with children’s mental health problems, behavioral challenges. So they called for what they called a paradigm shift away from this traditional problem-focused view of early childhood mental health toward a more holistic way of approaching children’s mental health. Basically what they argued was that in order to really be effective you needed to do prevention. You needed to support the entire classroom. You needed to have integrated mental health consultants so that the Head Start teachers and staff didn’t feel like mental health was a separate issue that you had to bring in a professional to deal with,

but that part of their job and part of working with the mental health consultants would really help the teachers be able to promote positive social and emotional well being on a day-to-day basis.

The revised Head Start performance standards called for programs to adopt this more comprehensive approach, and called for programs to provide sufficient mental health consultation to meet the children’s needs. That is how it was worded. Other than that, the performance standards did not give a tremendous amount of guidance around what sufficient mental health consultation would mean.

One of the things, in trying to adopt this paradigm shift, a number of researchers—Roxanne Kaufman in particular—have begun to make a distinction between what they call child-centered consultation, which is the more traditional model that I described, where it is problem-focused, child-focused, working with a particular child on his or her particular problems out of context primarily, versus program-centered consultation. Program-centered consultation is where a mental health professional works with the staff, works with the program managers and administrators to do a variety of things—everything from providing training, formal training, to providing informal support, case consultation, working with the director to develop a mission statement, to develop a more holistic, program-wide approach to how to think about mental health issues and how to support children’s positive mental health. That is a distinction that I am going to come back to.

Head Start programs are not given any guidance about which kind of consultation they should have. Ten years ago there were very, very, very few programs that were doing this kind of program-level consultation. Piotrkowski and her colleagues found that only about 18 percent of Head Start program directors knew about and were implementing some kind of program-level consultation. There is really an exclusive reliance on the external consultant model. In our research we have conducted a survey of 79 Head Start programs, including 800 staff directors and consultants. The good news is that we found that on average about 60

percent of the program directors were doing at least some kind of what we would consider to be program-level consultation strategies. This is important if you think about the shift toward a more holistic, integrated mental health approach. You want the staff to be empowered. You want them to see consultation as part of what they are doing and not as a stand-alone, separate component. However, we also found that only about 7 percent of the programs involved the mental health professional in program-level kinds of activities frequently. Still the predominant model we are seeing is focused on individual child, problem-focused consultation.

Just to give you a few more examples. One way to integrate mental health into a program's functioning is to have a mental health professional who is on staff, as opposed to an external, contracted consultant. We basically found that the number of programs with a salaried mental health professional had not increased in the past ten years. We found very low levels of program spending on mental health, averaging about 2 percent and that did not vary particularly widely. We found that overall programs reported about 1 to 1 ½ hours of consultation per year per child. We averaged out the number of hours of consultation that they had and the number of kids they were serving and that was about what it worked out to. So a relatively low level on a per child basis.

Our question became, if they are not hiring salaried mental health professionals, and if they are not spending a large proportion of their budgets, and given that programs—Head Start programs and any program—have a limited budget and financial resources, how can you make best use of those limited mental health care dollars on things that made a difference in how programs structured their mental health consultation relationships, did it make a difference?

As I said, we have been involved for about four years in a research project, and if you are interested, we are going to have a session at 11:30 that goes into much greater detail on our project. But basically what we found is through some qualitative studies that we did,

there seemed to be an issue of how the relationship with the mental health consultant was established. That is, even given limited amounts of consulting or limited dollars for consultation, those programs in which the mental health consultant was seen by staff as sort of part of the team, as someone they could go to if they had an issue, as someone that they worked with and knew by name, that person was approachable and available to them, that those programs seem to be doing a better job in implementing positive strategies for dealing with challenging behaviors. So in our survey, we looked at the difference between programs where the consultant was rated as highly integrated into day-to-day activities, basically programs in which the consultant was really seen as part of the team, versus programs where the consultant was less integrated.

The first thing we looked at is, are these programs structured differently? Are they spending more money to have an integrated model? Are they having more consulting time? Basically what we found was no.

There were no differences between programs where the consultant was highly integrated versus programs where there was less integration in terms of the hours of consultation per child, the amount of their budget that they spend on mental health services, their use of in-kind services for mental health, the number of children needing mental health services, or a wide variety of other demographic characteristics related to the programs.

We did, however, find that integrated programs—and this was interesting—reported that their consultants did more overall, more frequently provided services, even though the hours were not different. So that was interesting. Then they did both program types of consultation, working with staff and management as well as individual child-focused types of consultation. We did find that these programs tended to bring in other funded streams for mental health, significantly more than low integration programs, and they were more likely to have their consultants on staff. They also, interestingly enough, were significantly more likely to have a written mission statement specific to

children's mental health. These were programs that maybe were thinking about mental health more, had a more cohesive vision for what they wanted, and had good relationships with consultants who provided a lot of frequent activities.

The next question, then, was does integration make a difference? Does it make a difference in how staff behavior and does it make a difference in terms of the kinds of outcomes that the programs are getting? Basically what we found is that staff from integrated programs had much higher levels of prevention-focused approaches, strengths-based services, parent involvement in services, and culturally competent services. These are based on staff reports of their behaviors. That is important to keep in mind. But they were, anyway, reporting that their program was much more likely to do these things. There were no differences, interestingly enough, in the desire for therapeutic classrooms—they all wanted them—and the perception that some children would be better served outside of Head Start. This goes to this issue of inclusion and the problem where we are still seeing—even with programs who are doing more prevention, more strengths based, more family-focused kinds of services—that they are still struggling with how to deal with these children with challenging behaviors. They are still reverting to, “Well, maybe the kid will be better off somewhere else because then I could focus on the other kids in my class more.” So that's a challenge.

In terms of the overall program functioning, they also basically rated their programs as much smoother in terms of transition and much more positive classroom environment, less need for improvement in their services, shorter times between referrals and assessments. And importantly, they also reported that their mental health services were much more helpful in terms of supporting a variety of positive child outcomes, such as increasing positive behavior, and reducing externalizing behavior and internalizing behavior.

What we are finding is that even for controlling for the amount of consultation that programs have,

programs that are able to structure their consulting relationships in ways that really integrate the mental health professional into the overall program, and how that program works and what staff are doing, seem to be more effective.

What does this say in terms of what programs can do? First, programs should require a broad range of activities. This model of bringing in a consultant to provide limited child-focused kinds of services is simply not going to be able to have much of an impact. Have consultants who are available and responsive. Even if their contracted amount of time is relatively small, have someone who is willing to work with staff on a closer one-to-one basis at least so they all know the consultant's name and who he or she is, and that they can call them if they have a problem.

Strong leadership support for mental health. We found that programs who were higher in integration also tended to have leaders who advocated for more resources in the mental health area and who promoted a more cohesive vision of mental health across staff levels.

Written mission statements. That again goes to leadership and the importance of having programs, early childhood programs, that see mental health in this more holistic ways, that don't see mental health as specific to children with problems, but see it as something that is a part of everything they do.

A final note, who you hire as your consultant, at least in terms of the data that we had, didn't seem to make a difference. It didn't matter if they were school psychologists, or working for a non-profit, or what level of education they had, or how long they had worked with the program. It was integration of the consultant and working with them to be integrated across levels of program functioning that really made a difference.

Steffen Saifer: I think there is some really important research that Beth is working on that is going to be a really great practical help, not only to Head Start programs, but all programs who work with young children. It is great that her work is setting some future

directions. How can you effectively use the money you do have, that you are putting into mental health services, better? That is the kind of information that programs need and this project is providing it. It is great to see high practical application to research.

Our next presenter is Abbey Alkon.

Abbey Alkon: Good morning. Today I am going to talk about two different evaluation projects. One of them is in San Francisco. We did a mental health consultation evaluation project in the late 1990's. I am also going to talk about a statewide program that we have in California—the Child Care Health Linkages Project.

The background to our work is that we know that the prevalence of behavior problems has increased in young children. Some nationwide surveys have shown that it has been as high as 20 percent. We also know that 63 percent of 0 to 5 year old children attend child care today. We know that prevention efforts are important and that child care staff can really help us identify children with behavior problems. We also know that early identification of problems can hopefully lead to a decrease in the incidence of these problems for adolescents.

The San Francisco mental health consultation project was called Early Childhood Mental Health Initiative. It was a program that involved four different agencies that provided mental health consultation to over 40 childcare programs. These programs served low income, ethnically diverse children ages 0 to 5 years old. It was funded and supported by the Miriam and Peter Hass Fund in San Francisco. The goals of this initiative were to enhance children's emotional lives and social abilities, and to strengthen child care staff's ability to work with children who have difficult behaviors.

The initiative included four different programs, and all of them had core mental health services that were similar across the agencies. They all provided supportive counseling which encouraged a relationship between the mental health providers and child care staff. There were some differences across these four

programs in terms of the intensity, the duration and the number of sites that they served.

The research questions that I will be addressing in this evaluation study were, “what were the most common mental health consultation activities?” “Does mental health consultation improve teachers' level of competence?” “Is the duration of mental health consultation services associated with teacher turnover, center quality, or teacher's self-efficacy?” In a more qualitative way, we wanted to know how the child care staff think the mental consultant's services changed the care at their centers.

Our study design was over one year. It included 25 centers and 14 of those centers had never had mental health consultation before. At Time 1 and Time 2 we had interviews of the directors and administrators. We did center observations, which included a quality measure, the Early Childhood Environment Rating Scale. We have surveys that the directors and teachers completed on demographic information, activities of the consultants. One was called a Goal Achievement Scale, which told us how much change happened during the mental health consultant's time in the center. The other was a teacher opinion survey which looked at teacher self-efficacy, or their sense of competence in this area. We also conducted focus groups with the teachers and the consultants. At Time 2 we added some case studies.

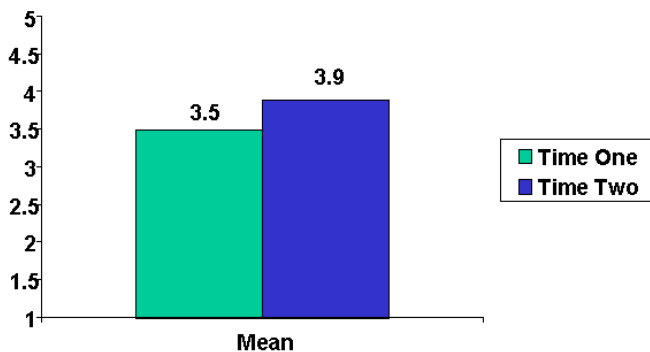
I'm going to talk about some of the results now. In terms of our teacher demographics, most of the teachers were female. The average number of years they worked in child care was about 10. The mean number of years that they worked at the particular center where we were studying this evaluation was about 6. Another question that we asked on this survey was we just wanted to know about the number of children that the teachers were worried about in their class to get a sense of their concerns about kid's social and emotional problems. The average in the classroom was about 5. Our results also showed that the most common consultation activities, as reported by teachers and directors, were in this order: first, it was observing children; next, consulting with the director;

followed by consulting with individual teachers. Then came meeting with individual families, participating in staff meetings, and consulting with groups or teams of staff.

In terms of the teacher's level of competence, it was reported that they had an improved understanding of children's difficult behaviors based on the intervention. They also had an improved understanding of children's social and emotional development. And they were able to work more effectively with parents. Some areas that they felt they still needed to improve after the one-year evaluation were they still needed to know about referrals to mental health agencies, and they wanted more knowledge and comfort in referring children and families. They also wanted to see some more improvements in their work environment, particularly the degree of supervision and support from their directors.

Another result was the teachers' self-efficacy improved. And here [Figure 1, below] you can see at Time 1 the score was lower than at Time 2. This showed that the teachers felt more competent in managing challenging behaviors.

Figure 1.
Results: Teacher's Self Efficacy Improved



Next, I will just highlight three of the items in this scale that changed over time. The way it was written on the form was, "There are some children in my classroom that I simply cannot have any influence on." The change was in the positive direction by Time 2, and it was significant for the 35 teachers that filled out this form. The next one is, "As a preschool teacher, I can't really do much because the way a child develops

depends mostly on what goes on at home." That also significantly changed in the positive direction. The last one I felt was actually even more important. It says, "I feel a sense of hopelessness about the future of the children that I work with." Luckily, with this intervention, there was a positive increase in people feeling better about this from Time 1 to Time 2.

Now I'll talk about the duration of services. What we looked at was the length of mental health consultation. It was associated with lower teacher turnover rates, positive changes in center quality and an increase in the teacher's self-efficacy. The way we looked at duration of mental health consultation was really that the significance happened when mental health consultation was involved in that center for over one year. So the centers that had consultation less than a year did not have these significant changes.

In the more qualitative ways with focus groups and interviews, we asked how the teachers felt they changed based on mental health consultation. They felt they had a greater curiosity and empathy about behavior, even when the behavior was difficult to manage. They developed new skills, in particular in observing, assessing, and planning, and they were taking more responsibility for changes in the classroom. So our conclusions are that the effective consultation was really positive for the child care staff. Mental health consultation improved several different aspects of the center life. Teacher turnover rates, center quality, and the teacher's increased self-efficacy skills.

We conclude from these findings that mental health consultation is needed, but we know that it is not always available in most child care facilities, at least in the Bay Area and San Francisco. Mental health consultation improves the quality of child care centers. Children's emotional and behavioral development is enhanced in high quality centers. So we hope that we can have more mental health consultation so we can improve the quality in general of our child care centers.

Now I'd like to talk about a statewide program that I am presently involved with on health consultation, which includes both the physical and mental health. I

am the director of the California Child Care Health Program, which is located in Oakland, and serves statewide programs in the state of California. I work with an interdisciplinary team of nurses, physicians, child care providers, researchers and administrators. The website [<http://www.ucsfchildcarehealth.org/>] is there if you want more information. There is a lot of information there that you can download for free on health and safety for providers and parents.

I am going to focus the rest of my talk on the Child Care Health Linkages Project, which is a statewide project. In particular I am going to target the information we've learned about children's health and behavior.

The background to this study is that children in out-of-home child care have more illnesses than children cared for at home. We also know that many child care facilities do not comply with the National Health and Safety Performance Standards. These are standards that have recently been revised in 2002, and are recommendations from the American Public Health Association and the American Academy of Pediatrics, to try and improve the health and safety in all child care centers in the country. We also know that child care health consultation is a new role for health professionals. There are few child care programs associated with child care health consultants in California. Evaluations of health consultation programs are needed.

The purposes of the Child Care Health Linkages Project is to improve the health and safety of young children attending child care facilities in 20 counties in California by providing county-level health consultation services. This project is funded by First Five California, which is a proposition that is taxed on our cigarettes to help fund services for 0 to 5 year olds. The key components of this project are education, service, and research. The education component is that we have a California Training Institute where we provide standardized training for child care health consultants, child care health advocates. Some of the content covered includes scope of practice, regulations, research, cultural competence, and many other topics.

I just want to explain a little bit about what is a child care health consultant. It is a health professional, many times a nurse, sometimes a physician or health educator, who provides guidance and technical assistance to child care providers in health and safety issues in child care. Their activities include on-site assessments, advice and other things.

The next slide talks about the service. We fund 20 county health consultation programs, and provide technical assistance to the staff, which is phone consultation, strategic planning, and resources and project management. The child care health consultant focus is broad. The consultants will make sure the children have medical homes, health insurance, immunizations, oral health, and you can see, last, but not least, we have social and behavioral health problems. So it is one of many priorities that is important to the child care health consultants program.

Our research goals for this project are to evaluate the California Training Institute, describe the health consultants' roles and responsibilities, describe the county-level health consultation programs, evaluate changes in the children's health status, and to monitor the child care facility's compliance with the key National Health and Safety Performance Standards.

In terms of what I want to talk about today on behavioral health goals, what we wanted to do is identify behavioral health themes within the Linkages study, using qualitative and quantitative methods, and describe the behavioral health concerns and priorities of child care and health professionals. Briefly, just to say, in our study design we included health consultants, child care directors and administrators. In terms of the behavioral health concerns that the child care consultants said were most common that they were dealing with at the child care center were concerns about aggression, biting, bullying and hitting, social relationships, disobedient and defiant behavior, internalizing behaviors with shy and withdrawn children, and children with clinically diagnosed problems.

The results of our qualitative focus groups and interviews show that there were three themes that

arose from the consultants and the directors in terms of behavioral health. The first theme is physical health and behavior. Hearing and vision problems can be misinterpreted as behavior programs. Second, the child care provider needs guidance. Providers are not certain what to do when a child has a challenging behavior. Immediate assistance is needed. We need more training to manage children with behavior problems. The third theme is individual children's needs, where the child care health consultant sometimes conducts individual behavioral assessments and provides referrals to mental health services for children with behavior problems. They said we need trained health professionals in child care to provide mental health services and facilitate communication with parents about behavior problems. From one of our surveys to the administrators, we asked the question, "What are the health problems you are most concerned about for children in child care?" and 78 percent chose behavioral /emotional problems for infants and toddlers, 94 percent chose behavioral/ emotional problems for 3 to 5 year-olds.

Just to share some quotes from the child care providers and health consultants on the first theme, which is physical health or behavior, one child care provider said, "The majority of the children who have speech problems also have behavior problems." The health consultant said, "His behavior is not because he is a bad kid. It is because he can't hear you." Child care provider needs was another theme. One child care provider said, "I'm not a trained person to handle children who have severe behavior issues." The health consultant said, "Providers are screaming for help in managing behavior, because it is the burr under the saddle. It is the thing that causes them a lot of grief."

Our conclusions are: The child care providers, health consultants and child care administrators are concerned about children with behavior problems in child care. Child care providers want help working with children with behavioral problems. There is a lack of available, accessible mental health resources for children 0 to 5 years old in California. The implications of this work is that mental health professionals are needed to support and guide child

care providers working with children with behavior problems, to consult with child care health consultants and child care providers, to provide direct services for some children ages 0 to 5, to empower child care staff to identify children at risk for behavioral and emotional problems, and to provide training for child care and health professionals on behavioral health issues. Thank you.



Steffen Saifer: Thank you, Abbey, that was great. Was that last slide like the storm clouds lifting? I was trying to give the optimistic view of that slide [*above*] rather than the pessimistic view. What I love about the work that Abbey is doing is that it is integrating mental health issues with other health issues on a statewide level. If we want providers at the local level to do inclusion, we need to model and demonstrate inclusion ourselves at all levels. Here is Eileen Brennan.

Eileen Brennan: While they are getting that up, you can find the purple sheets. The purple sheets are for Models of Inclusion in Child Care Project. I just want to call your attention to a couple of the features of this. I've got an outline of the presentation, but there is also on the next few pages two tables that are taken from a monograph that we will be publishing on this study in the middle of the summer. It will be available in PDF format over the Internet and we hope, also, in hard copy format. [*Editors' note: the monograph is available for downloading at <http://www.rtc.pdx.edu/pgProjInclusionMono.php>*] This project is sponsored by the National Institute on Disability and Rehabilitation Research and is part of the Research and Training Center on Family Support and Children's Mental Health.

I'd like to thank our project personnel, one of whom is running the slides, Dr. Jennifer Bradley. Natalie Cawood, Shane Ama, Peris Kibera, Arthur Emlen, and also Andrea Doerfler who has recently joined our

project who is a Ph.D. student with our Ph.D. program in the School of Social Work.

The reason that we decided to do this project was that we found through working with caregivers who had children with emotional or behavioral challenges, that one of the biggest challenges was finding child care. It was very difficult. Arthur Emlen of our Institute had done a survey of over 800 parents, and a high percent of these parents had children with emotional or behavioral challenges. Those that did find that child care arrangements were less stable, of lower quality, and the children with emotional or behavioral challenges were 20 times more likely to be asked to leave, to be expelled, in common parlance, kicked out of the child care centers. That was a relatively distressing finding for us all. So we aimed to find child care centers that successfully included children with emotional or behavioral challenges alongside children who were typically developing, that were inclusive, family-centered, culturally appropriate and high quality in their services.

We used the inclusion definition offered by special educators Kontos, Moore and Georgetti and adapted it. What we wanted to see were centers where children with emotional or behavioral challenges received a whole range of services along side their typically developing peers, and that they got to participate in all the activities that their peers did, but maybe those activities were slightly modified. We also looked for family support. What was it that these centers did that helped the families? We used the constellation of formal and informal services and tangible goods that are determined by families, the Federation of Families definition, to talk about family support in this study.

So what did we do? First of all we asked family support organizations, state-level child care administrators, and heads of child care resource and referral networks throughout the United States if they knew of programs that did this successfully. We had 109 nominations, which was wonderful. We used an advisory committee of family members, child care experts, researchers and children’s mental health practitioners to choose nine of these programs. We

used a qualitative method approach where we went out and observed and we did interviews with parents and with other family members, as well as the directors and the center staff. You can see that they are scattered throughout the United States. You will see [below] that the five centers that we visited were actually from coast

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

to coast. On the next slide [below] you can see that for additional centers that we contacted people through

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

the telephone and did telephone interviews. The next slide [below] shows the entire set of participants—9

Participants and Procedure

Study Participants	Number	Data Collection
Directors	9	Interviews, Archival Data
Staff	40	Interviews
Family Members	40	Interviews
Children	25	Observations

directors, 40 staff, 40 family members, and 25 children who were observed interacting with staff and peers.

What did we find? Well, we found a number of things. Today I am just going to be hitting the highlights of two of these. Jennifer Bradley and her group will be talking about family support and how the families were worked with in a session after this one. If we can talk about inclusion philosophy, this was shared by the directors and the staff. They believed in these principles. All of the directors and 29 of the staff—even though they weren't asked, "What is your philosophy?"—talked about the ways they approach children. I'm not going to read all the quotes from them, but you can take them away from you on this sheet where the PowerPoint is. But just to let you know that they established an inclusion mindset. To be able to work in these centers, you had to believe in this. If you didn't believe in this, your job was terminated. So they bought into this. They communicated this to every staff member, including those people who drove the kids around and those people that made the lunches.

The first and most important principle was to value and accept all children, regardless of their abilities or challenges. They simply accepted those children that walked in the front door with their families. They provided a natural environment for care, which meant that if they were going to give services to the children that were mental health services, it was done on the playground, or in the classroom for the most part. A few of the centers still had people that gave pull-out services—individual one-on-one services—but they tried to have people come in and give it on the floor with the kids. They adapted the program to meet the individual needs of the child. They all said—all the directors—"We do not change the child to meet the program. We change the program to meet the child." The fourth was also that they developed and delivered family-centered services. They made it clear, "You can't really serve the needs of the whole child unless you really try to meet the needs of the family as well." So they were clear about this. The fifth thing that they all bought into was that they wanted the families and children to have success. One of the directors said,

"You tell the parents three positive things that happened before you say anything negative about the child." They wanted people to know their children were succeeding at least in part.

How did they put inclusion into practice? They devised what I called promotion strategies and transformation strategies. Some things were clearly to develop good social and emotional skills. Some things were clearly to handle negative emotions and negative behaviors. That chart that you have in the handout [Editor's note: please see complementary handout], that will be in our monograph, looks at what the adults did, what the peers did, and then lastly how they changed the environment. I am just going to be talking today about what the adults did. I will give you the nine strategies of each of those very briefly.

The first one is to **build a relationship with the individual child**—especially children with emotional and behavioral challenges—very, very well. Develop that bond, because the child will test the bond.

The second thing is to **team with family members**. Determine what does a family want for the child, what are their goals for the child. Learn about the child's home culture and make the child care center conform to the home culture rather than expecting the child to fit into the child care's cultural center.

The third strategy is to **work from knowledge about individual children**. The parents are the experts. They see the child the most. The family members do. So they learn from the family members and they also got consultation with individual children.

The fourth strategy was to **build a developmentally appropriate curriculum**. I would just like to briefly talk about what one very experienced special educator who worked in a wonderful child care center did. She talked about doing circle time. They did exercises like deciding what they would put in soup. She said, "Here are some dry noodles for everybody, all the way around the circle, and then gives the antsy ones something that they can legitimately fiddle with while we are making the list of what needs to go into the soup." The kids with behavioral challenges are focused

because it is hands-on. So they adapted that notion of talking and contributing so that it would be useful for the kids with emotional or behavioral challenges.

The next one is **balancing consistency with flexibility**. So designing a consistent, predictable environment while maintaining flexibility.

[The sixth strategy is] **assisting children to stay safe and calm**. This was critical. The children had to feel safe. This came up over and over again. Many times the aggressive behavior was them feeling unsafe. So they taught self-soothing behaviors, and they let the child remove themselves to a quiet space.

They also used **multiple sensory channels**. Drawing pictures out to show what the behavior was that was the good behavior, the accepted behavior, within that setting, using physical guidance, touching the child to keep the child focused.

A strategy was **supporting the children through times of transition**, sometimes removing them before and inserting them back in the classroom after transitions. Giving them transitional objects to take home with them so that the time of leaving wasn't traumatic.

The ninth strategy—**promoting social and emotional development as necessary for learning**.

The next set of strategies were aimed at dealing with difficult behavior.

They engaged in **pre-emptive planning**. They looked ahead. They knew when stormy clouds were arising and they changed the environment around the child to short circuit negative behaviors.

The second strategy was to **use consultation to develop formal and informal supports**. We have heard a lot about that this morning.

The third strategy was to **assist the child to use verbal self-expression**. All behavior communicates, and in fact, many of the children just needed language help. They also taught the children to use signs rather than scratching and biting to get what they needed if they had low verbal skills.

To **substitute more appropriate behavior**, many people used art as a vehicle of expression. They used drawings to illustrate desired behavior.

They **fostered problem solving** in children and sometimes that had tremendously positive affects on children, as you can see from this example.

They **employed redirection**, so when a child was distressed, they redirected to new physical activity or mental activity.

They **focused attention appropriately**. That is, they focused not on the negative behaviors, but on positive behaviors. So if a child slugged another child, they focused on the victim. "Oh, you are very distressed, but you are handling it so well," ignoring the child that did the negative behaviors.

The eighth thing was they had to **plan for the safety of the children**. This does not work if the parents of all children don't feel their child is safe. So there were safety plans, acknowledging the individual needs of children.

The ninth strategy was to **work as a team to address negative behaviors**. One of the staff members said you have to bring in fresh patience. Fresh patience was really critical. They also met as a team and they confessed to each other that they were losing it, that they were not able to handle certain children. They bring in another staff member when they need it and they plan together and they work with the parents.

Finally, then, these next slides show just a boy with uncontrolled behavior was stopped in his tracks, literally, by teaching the peers how to handle that behavior. I hope that you will get a chance to read this in the slides.

The next one was a girl who was not able to go to kindergarten because she couldn't look adults in the face and she would not talk to anyone except her parents. She was brought to the child care center and a wonderful teacher who we observed working with art, got the girl to start talking about her art and worked so that she felt safe, she started revealing her inner feelings, and she was able at the end to talk to anyone. But it was a really remarkable experience for this

woman, who felt privileged to engage in it, and in fact, this woman was trained as an art teacher and did not have any mental health training, but she was able to do this with this child.

So what are the implications of this study? That you can care for children with pretty serious emotional or behavioral challenges alongside typically developing children. This is safe and it is good for the typically developing children who know how to work in a real world environment when they leave the child care center.

The second thing is it is crucial to adopt a staff philosophy that we will care for all children and we will embrace inclusion.

Thirdly, that inclusive care required creative and innovative practice based on knowledge of individual children and their family, and on consultation with mental health service providers and solid staff development. The training has to be there.

Then lastly, family support needs to be a part of the services offered in an inclusive center, in some ways almost the heart of the services, because the children cannot succeed if the families are not getting their needs met.

I thank you very much and am looking forward to hearing Glen Dunlap's presentation.

Steffen Saifer: Thank you, Eileen. We got some great, practical specific information about what front-line early childhood teachers do to help children with challenging behaviors. Wonderful examples. We will let Glen get ready to go.

Glen Dunlap: Actually I will be really quick. I have a meeting at 10:15. I am going to take a look. Maybe the person I'm meeting with is here. Eloise Boterf, are you here? I'm going to have to go really quick then. Actually I hope she will understand. It is probably not the first time that a general session has gone over a bit. I do appreciate your patience. You have been here for some time. You are actually attending and all that kind of stuff. I really like that a lot. I hate to be up here presenting to empty tables. So could

somebody get these tables out of here—this one, that one, that one. And bailiff, could you bar the door.

This is a real pleasure for me to be back in Oregon. I lived in Oregon for a year some time ago, and I remember most of the time—I love the sun, you see—I lived in Eugene and drive up the McKenzie Highway and go over the crest of the mountains and sit in Sisters or Bend and see places where it is always sunny. And here it is sunny now, which is great. Maybe I will move back. This is nice.

Your handout pertinent to this session, which I will make brief, is the yellow one. That has the slides. Actually it has some of the slides and it has some repeated including the data slide on the back pages enlarged thanks to the clever person who was responsible for this.

Lyn, thank you.

On the white handout [*at the end of this article*], which has the resources, I would like to point out the ones that I want to refer you to if you are interested in this kind of thing. Under the websites on the first page, the first two websites are pertinent. Those are websites that I either manage or my folks do. They have information relevant to the content that I am presenting. Further down, the OSEP [Office of Special Education Programs Technical Assistance] Center on Positive Behavior Interventions and Supports, that also includes material that I will be sharing. Then a little further down, the Research and Training Center on Positive Behavior Support, that is a key one.

If you flip over, the articles—this is not a coincidence—that have Dunlap in them, those are related to the content that I am going to share with you. So if you look for Dunlap and also Fox—my close colleague Lise Fox has done a lot of the work. Then further down there is a book by Lucyshyn and colleagues, which is titled *Families and Positive Behavior Supports*, so that title might be a clue that it is relevant to what we are talking about and to this conference.

The case study that I was going to share with you, which I will not share with you, but I will share some

pictures, and maybe some real big messages, is presented in this book. There is a chapter written by the mother and by Lise Fox and by myself which describes the case study. That is important stuff.

Here's my plan. I want to talk generally about what positive behavior support is and then talk about what positive behavior support with young children is. Here I was going to do a case study, but I'll just whip through that pretty quickly and then sum up. If you are still here and we have time for questions, that would be wonderful. I'm really just going to hit big points, no details here, because I have just been blowing too much time talking about tables and barring the door and things like that. So here is the definition of positive behavior support.

Positive behavior support is a values-based, empirically valid—meaning it is research-based—approach that is derived from social, behavioral and biomedical science—meaning it is not aligned strictly with one specific conceptual orientation but rather draws upon a multiplicity of frameworks that are values-based, and that include hard data that we can replicate. Finally it is for resolving problem behaviors and helping people lead enhanced lifestyles. Yes, it is focused on challenging behaviors and challenges in behavioral adaptation in general, but the goal is to help people lead better, enhanced, and more satisfying lives.

Some procedural features of positive behavioral support: Usually when I present on positive behavior support to folks who don't know it very well, the first question is, "What does it look like." Can you show me a videotape of this technique? It is not a technique, it is a process. That is a very, very important distinction. It is a process that is based on an individualized understanding of the individual and the context in which she lives and interacts and behaves. The understanding is obtained through a process of functional assessment and person-centered planning. Positive behavior support uses multiple components from a behavior support plan that is derived on an individual basis from the assessment process. Those multiple components are many, many different things. The behavior support plans includes like where you

provide interventions and support, when you do it, how you do it. It usually means to build competence through instruction so that people don't need the challenging behaviors and then redesigning the environment so as to help prevent the occurrence of challenging behaviors to make it more nice for the person who is challenges with these problem behaviors. Finally, as I said before, the goal is to build skills, relationships, resilience, quality of life, and secondarily to reduce the occurrence of challenging behaviors.

Historical foundations: Positive behavioral support sort of emerged in the mid-1980's to late 1980's, principally as a function of painful aversive stimuli being applied to individuals with severe disabilities. This evoked lots of understandable concern from advocates and family members and some professionals. So this was a major inspiration. But at the same time, the movements of deinstitutionalization and least restrictive environment were becoming prominent and these kinds of intrusive, painful, stigmatizing interventions were just not allowed in general education class, or in McDonald's, or in libraries, or anywhere else that we all live. Then there was also research contributing to a functional understanding of problem behavior.

Conceptual foundations: A lot of the foundational intervention strategies are based on applied behavior analysis and instrumental learning there, but also humanistic psychology and philosophy, person-centered values, and an ecological perspective. And then a pragmatism and an appreciation for multiple disciplines and multiple methods of investigation and intervention. Positive behavior support has been sort of exploding in many ways. There have been literally hundreds of published research studies in the last 15 years, primarily using case study methods, single subject experimental designs, and qualitative methods of inquiry. But we have also seen the principles and procedures are established in federal and state laws, including IDEA—although we are waiting to see what happens with that—federal and state funding initiatives to develop community capacity in positive behavior support and as I said, many research articles

in journals including the *Journal of Positive Behavior Interventions*. If you would like information on this I would be delighted to share it with you.

Here we are in terms of positive behavior support. First of all since the mid-1980's, positive behavior support has expanded greatly from populations that were principally folks with developmental disabilities to include children who are identified as having emotional and behavioral disorders and severe or serious emotional disturbances, general education students, and young children and early intervention. A lot has been going on there. Initiatives in most state now exist to build capacity in functional assessment and positive behavior support. It is beyond the individual level. I'm not going to talk about that, but if you go to these websites you can learn about that. Many efforts to integrate positive behavior support into additional systems, including mental health systems, child protection systems, and so on. These are some websites. We are involved with these. All of these have downloadable information. They are on your handout, so let's go on to the next one.

I want to spend just moment with this and turn now to positive behavior support with young kids. We are really focusing in the needs of those few kids, maybe five per classroom, maybe three per classroom, maybe two, who present with the kinds of challenging behaviors like tantrums and biting and resistance and elopement and all kinds of stuff that drive teachers, caregivers, therapists, family members nuts, and they don't seem to be resolved with the universal and secondary kinds of prevention efforts. But we also like to emphasize this model, or this triangle, [see *facing page*].

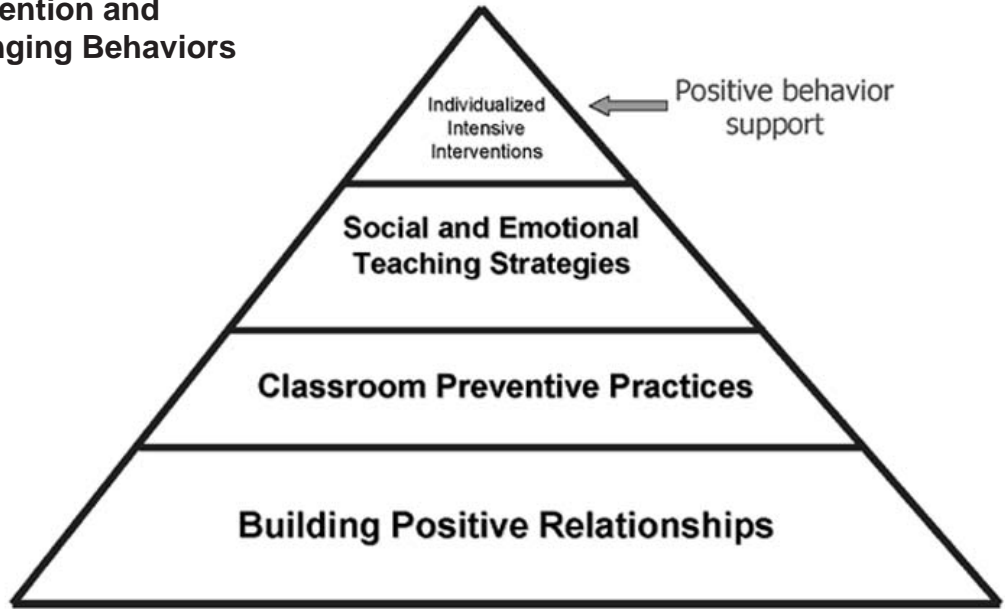
At the bottom you see building positive relationships. That is universal prevention. Many, many children don't display challenging behavior as long as they have positive relationships with adults, with parents and with peers. This is universal and we need to start there. We don't like to talk about individualized interventions without ensuring that we have a basis of positive relationships in place. Next, classroom preventive practices—Eileen talked a lot about this—having

classrooms in the right way. Next, social and emotional teaching strategies. These are targeted group interventions. There are many good ones out there. Caroline Webster Stratton's fine work and Incredible Years curriculum, Hill Walker's on First Steps to Success and so on. These are like targeted group kinds of things. But then you get to those few kids who are really pushing the buttons and for whom these other programs don't work. These are kids who need more individualized and more intensive kinds of interventions. These are the kids for whom we are focused in regards to positive behavior support. I am going to not spend time here, but the positive behavior support components, these are in the articles—comprehensive assessments, team building, person-centered planning. If you are not familiar with person-centered planning—I suspect that most of you are—it is an incredibly powerful strategy for building teams and supporting families and supporting kids and building a unified vision and a unified approach. Our families buy into it. This [*facing page*] is a picture of an invitation that some parents put together for persons that are planning a meeting around their son Mikey. If you get a big magnifying glass you might be able to read it in your handout.

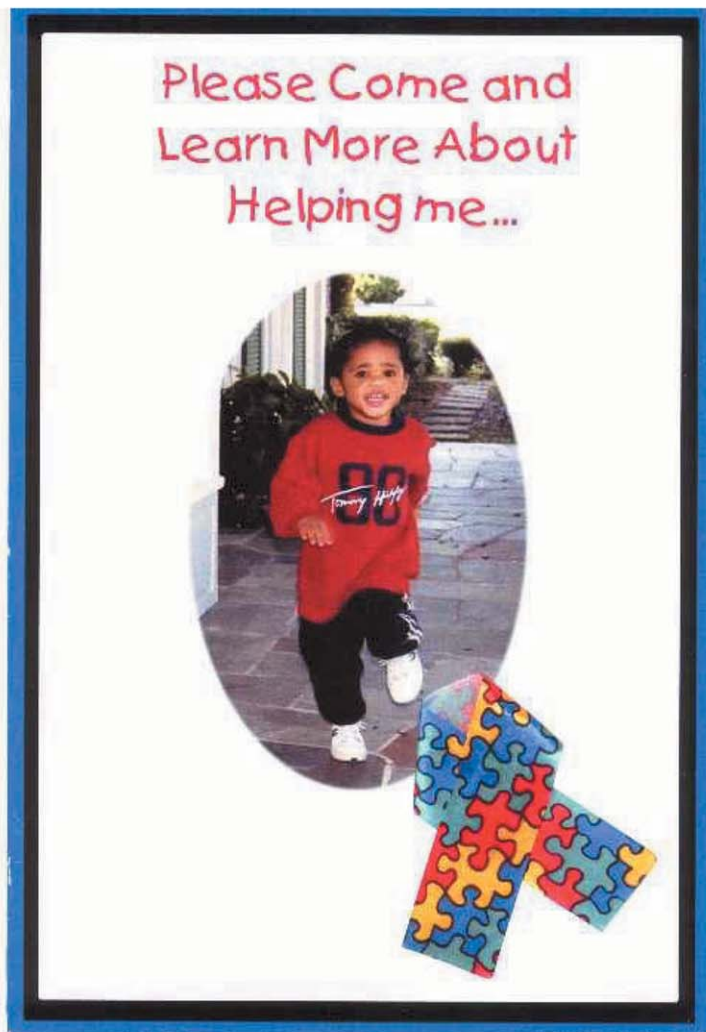
Functional assessment: That goes to a big comprehensive behavior support plan, including communication-based interventions and family support and many other components. It is also followed by issues with respect to longitudinal support. This is the case I am not going to share. Again, if you are interested I can send you materials and you can look on websites. We have some stuff on Joe and he is in this book. Nila is Joe's mother and you will see a picture of her soon. I show this and my evaluations usually go up a bit.

Actually if I had the foresight and the funds, I would have brought Nila and Benito with me, because whenever I present with her—and I do often, every chance I get—my evaluations go through the roof. You can see this case study. Isn't it fascinating? It is really good. I love all the detail that I'm sharing with you. The support plan was actually many pages. It is reproduced in this book that I mentioned to you. If

Figure 2. Model of Prevention and Intervention for Challenging Behaviors



Mikey's Invitation



On May 2, 2001, my mommy and daddy are inviting you to dinner and a meeting. Dinner starts at 6:15pm and the meeting will start at 7:00pm. The meeting is about me. The fancy title of the meeting is Person Centered Planning.

Mommy and daddy want to develop a plan that will help me and them. You're a special part of my life so you're included in the plan. So please come. You will get some yummy food and you will learn lots about me and how you can help.

Some really neat people from C.A.R.D. (Center for Autism and Related Disabilities) are going to be helping us all out. They work at the University of South Florida.

Mommy and daddy want you to try to be on time 'cause there is lots to talk about. Oh, please call mommy or daddy if you need directions or have any questions. Our number is [redacted]

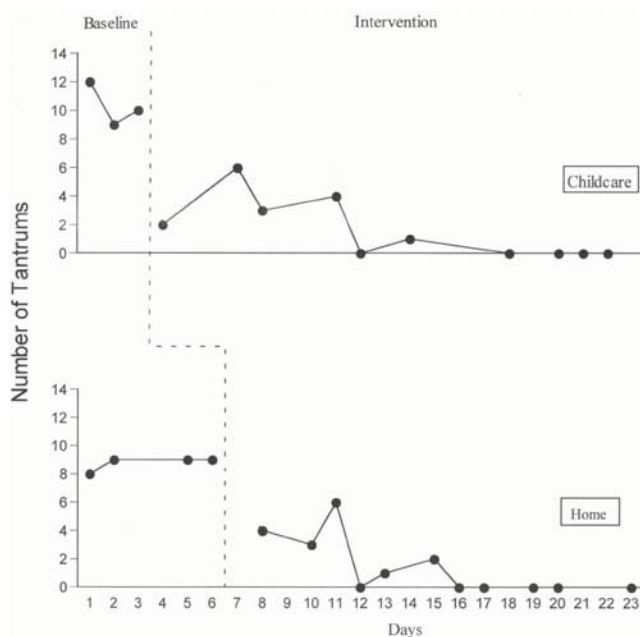
I'll see you at the meeting,

Mikey

you are really interested in this, I can send you information about it.

This is a research session so there is data. This [Figure 3, below] shows his tantrums in child care. He was about to be booted out of child care and then at home, on the abscissa (the horizontal axis) are days, and the vertical axis (the ordinate) presents number of tantrums per day. So you can see that good things are happening with Joe.

Figure 3. Case Study: Tantrums in Child Care and at Home



This is happening back in 1996, I think. Family support—they had real extended family issues which was a huge, huge priority for this big Italian family. Self-advocacy was a big thing, and Nila had become about the most effective self-advocate that I’ve worked with, and I’ve worked with many. Respite and in-home assistance, these were key features of the family support plan. This is a picture, and here is another picture. This is Joe later when he went to his family to Cozamel for a vacation, which had been a dream of theirs on the person-centered plan when we first started working—to be able to go as a family on vacation was a big deal. They went and they were all smiles. Joe is now 10 years old and he is included in his general education classroom. He has autism, but

he communicates and he gets along with his peers and most importantly with his family.

Let me quickly sum up in 10 seconds or 20 seconds. Right now we have about 50 or 60 studies that have been published using positive behavior support with young kids. By young kids I am talking about 3, 4, and 5-year-olds. We don’t have too much with toddlers. It is mainly with preschoolers, not surprisingly. But that is being changed. There is more work being conducted now with toddlers. We are also involved with a lot of development efforts to integrate positive behavior support approaches within full community systems, including early childhood mental health systems, as well as to look at positive behavior support as a mechanism for helping entire programs, like early childhood centers and things like this. We are working on that right now. In Tampa, in Hillsborough County, we have a really exciting partnership developing and some federal research moneys to help evaluate it and do research on it. I hope that at a subsequent conference I will have some more data to share with you. Thank you very, very much.

Steffen Saifer: Well, my evaluations of you are very high, even without your partners. I’m sorry we ran a little bit late. Most of us are doing presentations afterwards, so you will have an opportunity, we are going to be around. Please ask us questions. One last hand for the whole panel. Thank you very much for hanging in there.

Editors’ note: Slides from these presentations can be viewed on the Portland Research & Training Center website at <http://www rtc.pdx.edu/pgConfProc.shtml>

RESOURCES
PROMOTING CHILDREN'S MENTAL
HEALTH IN EARLY CHILDHOOD SETTINGS
BUILDING ON FAMILY STRENGTHS
CONFERENCE, PORTLAND, JUNE 2003

Selected Resources from the Panel: Steffen Saifer, NWREL; Beth Green, NPC Research; Abbey Alkon, UCSF; Eileen Brennan, PSU; Glen Dunlap, USF

Center on Evidence-based Practice: Young Children with Challenging Behavior.
<http://www.challengingbehavior.org/>

Center on the Social and Emotional Foundations for Early Learning.
<http://csefel.uiuc.edu/>

The Child Care Bureau. Comprehensive information regarding child care policy and research in the United States is available at this web address, including recent initiatives in the mental health area. Includes links to specialized websites on afterschool care, child care information, and child care program and research initiatives.
<http://www.acf.hhs.gov/programs/ccb/>

A Good Beginning: Sending America's Children to School with the Social and Emotional Competence They Need to Succeed. The Child Mental Health Foundations and Agencies Network (FAN).
<http://www.nimh.nih.gov/childhp/monograph.pdf>

Healthy Child Care America. Web materials for family members, child care providers, and providers of professional services are available on this site which is sponsored by the American Academy of Pediatrics. The Healthy Child Care 2000 national campaign included action steps to improve children's mental health.
<http://www.healthychildcare.org/>

Mental Health: A Report of the Surgeon General. Chapter 3: Children and Mental Health.
<http://www.surgeongeneral.gov/library/mentalhealth/toc.html#chapter3>

The National Center for Children in Poverty. This website includes many important publications regarding the Center's research, aimed at improving the situation of children and families who live in poverty. Important studies involving children's mental health are available.
<http://www.nccp.org/>

Off to a Good Start: Research on the Risk Factors for Early School Problems and Selected Federal Policies Affecting Children's Social and Emotional Development and Their Readiness for School.
<http://www.nimh.nih.gov/childhp/goodstart.cfm>

OSEP TA Center on Positive Behavior Interventions and Supports.
<http://www.pbis.org/>

Project SUCCEED in Head Start.
<http://www.rri.pdx.edu/pgProjectSUCCEED.shtm>

Research and Training Center on Family Support and Children's Mental Health. Our website features research projects focusing on early childhood mental health and family support, and provides links to summaries of key research studies and mental health websites.
<http://www.rtc.pdx.edu/>

Research and Training Center on Positive Behavior Support.
<http://www.rrtcpbs.org/>

Zero to Three. This organization which promotes optimal development in the early years maintains a website for families and care providers that has important information concerning infant mental health.
<http://www.zerotothree.org/>

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