

Mental Health Consultation In Head Start: Selected National Findings

Mental Health Services Survey Report

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I. GOALS, DEFINITIONS, & OVERVIEW OF RESEARCH

The purpose of this five-year project, as stated in the grant proposal to the National Institute of Disabilities and Rehabilitation Research, is:

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

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

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

To meet these goals, the project has engaged in a number of activities, including:

1. A comprehensive review of the literature on effective and/or promising practices in early childhood mental health services.
2. Development of a conceptual model of factors that may influence the effectiveness of mental health services provided in early childhood settings.
3. Qualitative research focused on exploring the conceptual model, and on understanding the factors associated with implementing mental health approaches that are consistent with best and/or promising practices.
4. A national survey of Head Start programs, to learn about effective mental health approaches in early childhood settings.

The results presented here represent a subset of results from the national survey that was conducted in 2002-2003.

The final phase of the project is to develop research-based training and technical assistance materials for Head Start program directors, managers, and mental health consultants. We anticipate that these materials will be available in early 2004. For more information about the project, please visit our website at: <http://www.rtc.pdx.edu/pgProjGuidance.php>

Definitions of mental health consultation. Throughout this report, the abbreviation “MHC” is used to refer to “Mental Health Consultants”. *Consultants were defined as the person or persons responsible for mental health services within a Head Start program, and thus were not always contractually hired “consultants” in the traditional sense.*

We also describe two types of consultation: “child-focused” and “program-focused”:

Child-focused consultation refers to traditional, individualized consultation in response to a specific child need, and includes services such as screening, assessment, referral, or direct therapeutic service.

Program-focused consultation refers to work that a consultant does to improve the mental health services of the program as a whole, such as staff training, working with management teams to develop vision statements and approaches, and support for staff wellness.

Definitions of *promising practices*. Many of the research questions investigated awareness and implementation of *promising practices*, for early childhood mental health services. We defined promising practices based on our review of the literature, and in particular on definitions provided by Simpson, Jivanjee, Koroloff, Doerfler, and Garcia (2001) and Cohen & Kaufmann (2000). For the purposes of this study, early childhood mental health services were defined as:

1. Inclusive of all children
2. Prevention oriented
3. Community-based
4. Strengths-oriented
5. Involving parents in decision-making
6. Understanding the child’s behavior in the family context
7. Attending to staff wellness
8. Culturally competent

Measuring effectiveness. Additionally, we were interested in understanding the effectiveness of existing mental health services. Because of resource limitations, we did not have direct measures of effectiveness in terms of changes in individual children or families. Instead, we relied on staff and parent perceptions of program effectiveness by asking about outcomes in children, the families, or program operations.

Organization of this report. The following research questions guided the national survey, and provide the outline for presentation of findings in this report:

- A. How are mental health (MH) services structured in Head Start?**
 - 1. What are the characteristics of mental health consultants (MHCs)?
 - 2. What are the roles of the mental health consultants?

- B. What are beliefs among Head Start staff and parents about how best to deliver MH services?** In particular, to what extent do staff approach mental health issues and mental health services in ways that are consistent with promising practices in mental health services for young children?

- C. Do Head Start staff and parents believe that their MH services are effective, and if so, what kinds of outcomes are achieved?**

- D. Are there differences in various groups of staff, programs, or parents that influence implementation of promising practices or perceptions of program effectiveness? In particular:**
 - 1. Does how a program structures its mental health services influence promising practices or effectiveness?
 - 2. Do different kinds of MHC characteristics and activities relate to promising practices or effectiveness?
 - 3. Are there differences in program location, demographics, staff make-up, or other factors that influence promising practices or effectiveness?

II. SUMMARY OF SURVEY PARTICIPATION

Report findings draw from 802 staff surveys and 154 parent surveys representing 79 participating Head Starts. Public Program Information Report (PIR) data were used to select a stratified random sample of Head Start programs. Programs were selected to be representative in terms of number and ethnicity of children served, amount of mental health consulting, and geography. Initially 196 Head Start directors were invited to have their program participate. 79 programs agreed to participate, and provided the research team with staff lists. From these staff lists, a random sample of teachers, assistant teachers, and family advocate/family service workers were selected. Surveys were also sent to each program director, mental health services coordinator, and one mental health consultant from each program. Researchers mailed 1265 surveys to individual staff, tailoring the surveys slightly for three types of recipients: administrators/managers, direct service staff, and mental health consultants. 802 or 63% of the surveys were returned.

Programs were also asked to recruit 3 parents who had been involved with their mental health services. Because of confidentiality issues, programs were asked to provide the surveys to the parents directly. 155 parent surveys were received from 62 programs. Results of the parent survey are presented separately, see Section IV, on page 19.

For a detailed discussion of the sampling method and survey process, please see Appendix A. For one example of the survey itself, please see Appendix C.

III. HEAD START STAFF SURVEY RESULTS

A summary of results from the national survey and from your program is presented below. The findings are organized according to the research questions described in Section I.

- Results from staff surveys are presented first.
- Parent data are shown in Section IV, on page 19. Note that because of the small number of parents from each program, program-specific results are not included for the parent surveys.
- 12 staff persons returned surveys from your program; however, the actual sample size for specific questions may differ because of missing data. For example, if this report says 50% of your staff felt the mental health services ‘helped a lot’ with a classroom, it may not be exactly half of 12, but half of a slightly smaller number of staff *who answered that particular question*. In general, no more than three or four staff at any given program skipped any particular question, so percentages still provide a straightforward indicator of survey results.

A. How are mental health services structured in Head Start programs?

A 1. What are the characteristics of mental health consultants?

About one in five (22%) of mental health consultants are employed directly by Head Start. About one-third (33%) are “outside consultants” otherwise in private practice, on contract with Head Start. 72% of consultants surveyed were women, and 28% were men. Every mental health consultant who answered our survey had a college degree, and 37% had a Ph.D. or equivalent. The professional training of typical mental health consultants was usually either psychology or social work.

Public Information Report data for the 79 participating Head Start organizations shows that:

- 60% of programs utilize at least one psychologist,
- 60% use at least one social worker, and
- 28% use some other type of licensed therapist.
- Only 15% utilize at least one psychiatrist, and
- 5% use at least one nurse.

Table 1 provides further overall characteristics of the national sample. One more notable finding is that the ethnic diversity of mental health consultants is not as reflective of national Head Start families as it is for administrators, who in turn do not mirror the Head Start families as well as direct service staff. (*See Appendix B for more detail.*)

Table 1. Characteristics of Mental Health Consultants.

Employment:	% OF 69
By Head Start Organization	22%
By Non-Profit	23%
By Government	7%
In Private Practice	33%
School-Based or Other	15%
Time With Organization:	% OF 68
Up to 1 year	7%
1 to 3 years	23%
3 ¼ to 5 years	18%
5 ¼ to 10 years	31%
More than 10 years	21%
Time In Present Role:	
Up to 1 year	16%
1 to 3 years	27%
3 ¼ to 5 years	19%
5 ¼ to 10 years	22%
More than 10 years	16%
Education:	
4-Year College Degree	6%
Master's Degree	57%
Doctoral Degree	37%
Ethnicity:	
Hispanic / Latino	17%
African American	9%
Native American	3%
Asian / Pacific Islander	2%
Caucasian / White	82%

A 2. What are the roles of the mental health consultants?

Each Head Start program represents a unique combination of mental health funding sources, available consulting professional time, internal staffing choices, dispersal of classroom sites, and other critical considerations. The following provides a snapshot summary of the ways that programs have staffed their mental health services, according to information provided by program directors and mental health coordinators.

Many Head Start programs had just one mental health consultant. 34% of programs had a single mental health consultant (MHC), by far the most common answer. 12% reported 2 employed or contracted MHCs and 23% report 3, leaving just 30% of programs having more than 3. Small numbers of programs had 4 to 8 consultants, with just a few having 9 or more. The average number of MHCs was 3.2. At the time of the survey, Example Head Start reported 3.0 MHC.

On average, programs provided about 1.8 hours of contracted consultation per child, per program year. 37% of programs provided less than ½ hour of consultation per child, per year, while 26% reported more than 2 hours of consultation per child, per year. Example Head Start provided 2.99 hours of consultation per child, per year. The national average of 1.8 hours of *time per child* can also be thought of as about 241 *children per professional*, with Example Head Start reporting 568 children per mental health consultant. From another angle, contracted mental health consultants provided a total of about 373 hours of service per program year, on average (about one 25% FTE consultant for a 9-month program). Example Head Start contracted for 5100 total hours of consultation.

About one quarter of MHCs acted as the mental health service coordinator in addition to being direct service providers. Directors report that 27% of MHCs spend *more than 50%* of their time “coordinating mental health services.” 18% of programs reported a full time MHC.

Programs spent a very small fraction of their Head Start budget on mental health services. On average, programs reported spending 3.5% of their federal Head Start budgets on mental health services, including coordinator salary, screeners or assessments, trainings, and contracted hours. The information you provided indicated that Example Head Start spent about 2.0 of its Head Start budget on mental health services.

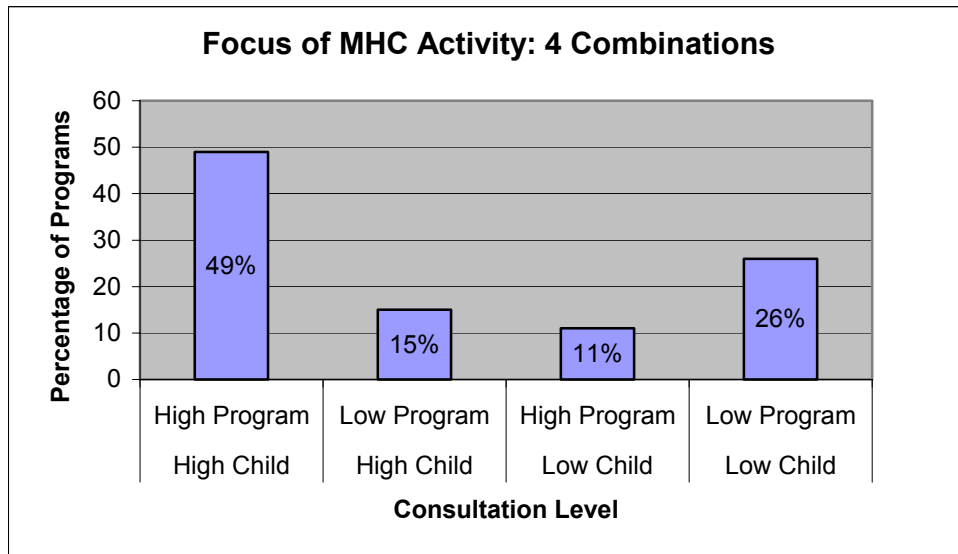
A 3. What do Mental Health Consultants do?

Consultants performed very different activities at different Head Start programs. We asked program directors to indicate the frequency with which the mental health consultant engaged in a variety of activities. For nearly every activity we found wide variability, with about one-quarter to one-third of consultants doing a particular activity “a lot” and a similar proportion performing the task “almost never.” This might be an outcome of federal management strategies that generally leave wide discretion to Head Start programs to tailor to local needs while meeting general performance standards. Again, child-level consultation refers to services provided directly to specific children, while program-level consultation involves providing support to programs more broadly, though teacher training, management support, etc. Nationally, we found that:

- **16% of consultants spent less than 10% of their time doing activities that were considered “program-level consultation,” while 26% spent over 50% of their time this way,** according to program directors. Program-level consultation refers to activities *other than* providing direct mental health services or assessments to children, such as working with teachers and family services advocates, training staff in groups or in classrooms, attending management team meetings, advising on program policy, etc.

- **Many programs emphasized both program-and child-level consultation, as shown in Chart 1.** 40 (49%) of programs had consultants who provided both frequent child-focused consultation (screening, assessment, or treatment of individual children) *and* frequent program-focused consultation (monthly or more). 12 (15%) of programs had consultants who provided frequent child-focused consultation but infrequent, rare program-focused consultation (1-2 times per year or less). 9 (11%) of programs had consultants who provided frequent program-level consultation but rare child-focused consultation, and 21 (26%) of programs had consultants who provided low levels of both types of consultation

Chart 1. Focus of Consultant Activities.



Programs had marked differences in the level of consulting activities and in consulting arrangements. These are summarized in Table 2. *Note that data about Example Head Start are not reported here in order to protect the confidentiality of individual mental health consultants.*

Table 2. Frequency of MHC Activities: Directors' Report.

MHC Activity:	% monthly or more	% 1-2 times per year or less
Classroom Observations	37%	49%
In-Depth Assessments	38%	52%
Provides Direct Therapeutic Service	48%	47%
Meets with Staff Teams	47%	28%
Provides Formal Training to Staff	24%	67%
Meets with Parents	44%	36%
Provides Support for Staff Wellness	36%	55%

A 4. What are staff perceptions of the MHC?

Staff held positive perceptions of mental health consultants, on average. On nearly all positive qualities of MHCs we asked about, the average score was above 3.0 (indicating that most people somewhat or strongly agreed that the MHC had that quality). However, more variability is apparent when we examine the difference between those who “strongly agreed” that the MHC showed a particular quality, vs. those who merely “agreed”. As Table 3 shows, the lowest scores were for the consultants’ availability, relationships with parents, cultural competence, and whether staff go to the MHC for help. Interestingly, administrators were inclined to give the MHC’s availability, experience with young children, and relationships with staff a higher rating than direct service staff. On other perceptions the staff and managers were essentially in agreement. The percentages for Example Head Start are provided at the far right for comparison.

Table 3. Staff perceptions of the MHC.

Item or Subscale (grouped items) reliability >.70 {1=strongly disagree to 4=strongly agree.}	Administrators who “strongly agreed”	Direct Service who “strongly agreed”	Your Program
1. The MHC is experienced/qualified	78%	66%	50%
2. The MHC has good relationships with staff	73%	56%	58%
3. The MHC approach is consistent with Head Start	70%	66%	67%
4. The MHC is integrated into program functioning	68%	62%	67%
5. The MHC is available when needed.	45%	38%	33%
6. Staff go to the MHC when need help	36%	43%	42%
7. The MHC is culturally competent	40%	37%	8%
8. The MHC has good relationships with parents	25%	28%	0%

B. To what extent do staff approach mental health services in ways consistent with Promising Practices?

Most Head Start staff perceived the mental health program quite positively in terms of adherence to promising practices, with two exceptions. Table 4 below shows the percent who “strongly agreed” with various statements of quality among administrative and direct service staff as well as at your program. Stronger agreement indicates more consistency with promising practices. As can be seen, most Head Start staff agreed that their mental health services are *linked to the community*, focused on *parent involvement*, *culturally competent*, and *integrated* with other Head Start components. Programs are also seen as doing a good job supporting *staff wellness*. However, scores reflect weaker perceptions of the program as *family-centered*, *prevention-oriented*, and *inclusive* of children with challenging behaviors. Half of direct staff strongly agreed programs’ mental health services are *strengths-oriented*, while only one third of administrators shared that view. The percentages for Example Head Start are provided at the far right for comparison.

Table 4. Staff perceptions of their program’s promising practices.

Item or Subscale (grouped items) reliability >.70 {1=strongly disagree to 4=strongly agree.}	Admin Strongly Agree	Direct Service Strongly Agree	Your Program
1. The program has strong links to community mental health services.	65%	59%	64%
2. The program supports staff wellness	53%	45%	50%
3. MH services focus on parent involvement	42%	57%	25%
4. MH is integrated with other HS components	42%	52%	8%
5. MH services are culturally competent	37%	48%	25%
6. MH services are family-centered	34%	39%	50%
7. MH services focus more on prevention	34%	17%	17%
8. MH services have a strengths orientation	33%	53%	50%
9. Inclusive of children with MH challenges	28%	30%	17%

C. Do Head Start staff believe that their MH services are effective, and if so, what kinds of outcomes are achieved?

About three-quarters of direct service staff and even more administrative staff felt their program’s mental health services have improved specific classroom behaviors. For example, the following percentages of administrators (directors and mental health coordinators) and direct service staff (mainly teachers and family service workers) said the mental health services at their program helped at least “somewhat” or “helped a lot” with these selected behaviors:

Programs’ mental health services helped:	Administrators Helped Somewhat or a lot	Direct Staff Helped Somewhat or a lot	Your Program
➤ Aggression toward other children	89%	72%	67%
➤ Extreme temper tantrums	79%	69%	73%
➤ Withdrawn & overly shy	80%	71%	50%
➤ Positive social interaction between children	92%	81%	75%
➤ Smooth classroom activity transitions	87%	75%	73%
➤ Age-appropriate emotional regulation	88%	77%	67%

Each table below summarizes the national responses to individual questions like the examples above, but grouped into one of three categories: positive behaviors, externalizing behaviors, or internalizing behavior. The tables below show the extent to which staff reported that the program’s mental health services either (Table 5) helped increase positive behavior; or (Table 6) helped decrease externalizing behavior, or (Table 7) helped improve internalizing behavior. As can be seen, administrators were generally more positive about the effectiveness of mental health services in terms of these outcomes, but a great majority of direct service staff also believed that MH services have helped “a lot” or “somewhat.”

Table 5. The program’s mental health services have helped increase positive behaviors.

Increased Positive	Administrative	Direct Service	Your Program
A lot:	46%	36%	17%
Somewhat:	47%	43%	58%
A little:	6%	16%	25%
Not at all:	1%	5%	0%

Table 6. The program’s mental health services have helped decrease externalizing behaviors.

Fewer Externalizing	Administrative	Direct Service	Your Program
A lot	41%	30%	17%
Somewhat	44%	44%	50%
A little	12%	20%	33%
Not at all	3%	6%	0%

Table 7. The program’s mental health services have helped improve internalizing behaviors.

Improve Internalizing	Administrative	Direct Service	Your Program
A lot	20%	23%	0%
Somewhat	54%	45%	40%
A little	24%	23%	50%
Not at all	3%	10%	10%

Results were more mixed when respondents were asked about overall program outcomes stemming from MH services. The chart below lists program outcomes often targeted by mental health consultation and other mental health services. Next to the list are the percentages from two groups of staff (Administrators and Direct Service) who said they “strongly agreed” or “somewhat agreed” with the statement. There is great agreement that staff do a good job supporting MH and that affected families are coping better because of MH services. There is mostly strong agreement that classroom staff job performance and classroom environments have improved from MH services, but direct staff consistently show less endorsement of these outcomes, compared to administrators. Fewer than 80% of staff believed that MH services reduce staff stress or are sufficient for the families’ needs. However, direct service staff felt MH services were generally sufficient, while fewer than half of administrators agree.

Program Outcome Helped By MH Services	Admin: Strongly or Somewhat	Direct: Strongly or Somewhat	Your Program
➤ Our program’s MH services have improved the classroom environments	91%	77%	58%
➤ Our MH services help families cope with challenging behaviors	85%	82%	58%
➤ Classroom staff do their jobs better because of MH consultant	85%	67%	30%
➤ Our MH services help staff feel less stress	79%	63%	42%
➤ Our program’s MH approach is sufficient to meet the needs	47%	78%	42%

The tables below summarize the national responses to individual questions like the examples above, but grouped into one of three categories: Support For Staff (Table 8), General Effectiveness (Table 9), and Staff Practices (Table 10).

Table 8. Our mental health services help support staff to do their jobs well.

Support For Staff	Administrative	Direct Service	Your Program
Strongly Agree:	24%	30%	8% of 12
Somewhat Agree:	67%	44%	58%
Somewhat Disagree:	8%	22%	33%
Strongly Disagree:	1%	4%	0%

Table 9. Our mental health services improve classroom and family functioning.

Effectiveness	Administrative	Direct Service	Your Program
Strongly Agree:	37%	35%	33% of 12
Somewhat Agree:	55%	47%	33%
Somewhat Disagree:	7%	15%	33%
Strongly Disagree:	1%	3%	0%

Table 10. Staff do a good job supporting children’s mental health.

Staff Practices	Administrative	Direct Service	Your Program
Strongly Agree:	61%	56%	33% of 12
Somewhat Agree:	37%	38%	67%
Somewhat Disagree:	2%	5%	0%
Strongly Disagree:	0%	7%	0%

When asked what the *most outstanding, effective* parts of their mental health services were, large numbers of program staff mentioned the following:

- **The positive qualifications and personal attributes of the MHC**
- **Availability and responsiveness of the MHC**
- **Appropriate, helpful, effective activities of the MHC**

Somewhat less frequently mentioned, but still key components of mental health services were:

- Appropriate assessment and/or timely initial follow-up
- Strength of parent outreach, family support, or parent trainings
- Strength of training for staff
- Teamwork among staff, providers, parents
- Availability of services beyond the MHC
- Strong community partnerships

When asked about the *most unsatisfactory, least effective* part of their mental health services, many staff mentioned the following. Observe that three of the four common “unsatisfactory” elements are also “excellent” elements for staff at other programs.

- **Lack of availability and non-responsiveness of the MHC** (by far the most frequent statement)
- **Inappropriate assessment and/or lack of timely initial follow-up**
- **Weakness of training for staff**
- **Families show low willingness to seek, accept, follow through on/cooperate with MH services**

Evidently the *availability and responsiveness* of the mental health consultant, as well as quality *child assessment and timely follow-up* and strong or weak *staff training* are ‘make or break’ elements of mental health programs that managers may want to focus on.

***D. Are there differences in various groups of staff, programs, or parents that influence implementation of promising practices or perceptions of program effectiveness?**

Part of the purpose of this study was to understand what characteristics influence a program’s ability to implement effective mental health services. Although these analyses are ongoing as we explore the many differences across programs, participants, and mental health service characteristics, one initial finding stands out. Our preliminary qualitative research showed that programs that had a well-integrated MHC (who was described to us as “part of the team” or “one of us” in working with families and children), also appeared to have stronger implementation of promising practices and more effective mental health services. So, for the current study, we grouped programs according to whether the program fell above or below the average score in terms of the extent to which consultants were integrated into overall program functioning.

We found that overall, integration made a statistically significant difference in a wide variety of outcomes (see Table 11, **bold** rows). Programs in which the MHC was seen as being well-integrated into program functioning perceived their programs to be more effective, and reported higher levels of promising practices. However, high integration programs did not differ from those lower in integration in terms of any number of structural variables, such as size of the program, rural/urban status, etc. Further, and importantly, programs with more integrated consulting did not have significantly more hours of consultation per child, and the influence of integrated consulting on key outcomes *remains*, even when differences in program structure, dollars spent on MHCs, and other key characteristics are controlled statistically.

These results suggest that programs would be well advised to think creatively about ways of integrating mental health consultants into broader program functioning. Ensuring that teachers feel that they can call on the consultant if needed, that the consultant is “part of the team” in helping to ensure positive child and family-well being, and that consultants provide a broad array of supports to the program are all key to having an integrated model of consultation.

* (This Section **D** presents only national data. The sample size at individual programs was too small to allow analyses of how some variables influence best practices and mental health service outcomes *within* that program, or to compare, for example, just teachers *between* programs.)

Table 11. High vs. low integration characteristics.

	Low Integration Programs	High Integration Programs	Example Head Start
1. Mental Health Program Structure			
A. Hours of consultation per child	1.57 hrs	1.95 hrs	2.99 hrs
B. % of budget spent on mental health component	3.6%	3.3%	2.0%
C. % with Salaried MHC	16%	24%**	yes
D. % with written MH mission statement	78%	85%*	36% agreed have
E. % with other sources of funding for MH services (beyond core Head Start funding)	27%	37%**	yes
F. % with in-kind commitments for MH services	62%	63%	yes
G. % with more than 25% of children needing MH services	16%	16%	no
2. MHC Consultant is: 1=strongly disagree; 2=somewhat disagree; 3=somewhat agree; 4=strongly agree			
Culturally Competent	2.7	3.5***	2.5
Positive Relationships with Parents	2.5	3.4***	2.2
Positive Relationships with Staff	3.2	3.9***	3.4
Available when Needed	2.8	3.6***	3.2
3. Staff practices are: 1=strongly disagree; 2=somewhat disagree; 3=somewhat agree; 4=strongly agree			
A. Inclusive	2.8	2.7	2.9
B. Prevention Oriented	2.3	2.7**	2.6
C. Strengths Oriented	3.2	3.6***	3.5
D. Parent Involvement Oriented	3.3	3.6***	3.2
E. Cultural Competent	3.2	3.5***	3.1
4. Child Behavior Outcomes 1=hasn't helped; 2=helped a little; 3=helped somewhat; 4=helped a lot			
A. Improve positive behavior	2.9	3.5***	2.9
B. Reduce internalizing behavior	2.6	3.2***	2.3
C. Reduce externalizing behavior	2.7	3.3***	2.7
5. Other Outcomes 1=1 week; 2=1-2 wks; 3=2-4 wks; 4=1-2 months; 5=> 2 months			
A. Time between referral and assessment	3.0	2.5***	2.5

Note: Statistical tests compared high vs. low integration programs using ANOVA for continuous dependent variables and Chi-squared for categorical dependent variables. Items in bold indicate the high integration programs were significantly differently from low integration programs. *p<.05 **p<.01 ***p<.001

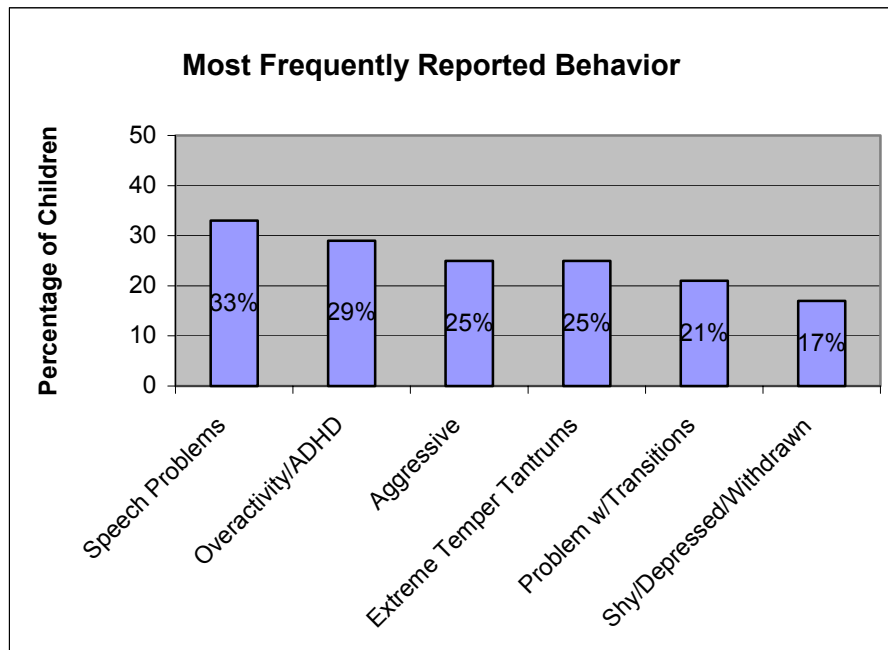
IV. PARENT SURVEY RESULTS

A. What were the characteristics of parent respondents?

The following findings are *not* descriptive of Head Start parents generally, only of caretakers of children involved in mental health services who agreed to participate in this survey. Programs were asked to approach 2-3 parents in their program whose child had been involved with mental health services in the past year. These parents had the following characteristics:

- 92% female
- 83% parents & 12% grandparents of the Head Start child
- 43% had three or more children in their care
- 49% Caucasian, 25% African American, 24% Hispanic
- 15% spoke Spanish in the home
- 17% reported a child was on medication (most frequently Ritalin)
- The most frequently reported child behavioral/emotional problems were forms of “externalizing stress,” and are detailed here in Chart 2.

Chart 2. Most Frequently Reported Behavior



B. What services did families receive?

Parent respondents were generally satisfied with the mental health services provided through their Head Start programs. These parents, or their child, had typically received a number of services related to mental health:

70% or more of parents who responded reported receiving:

- Meetings with child’s teacher (87%)
- Screening/evaluation for behavioral/emotional development (78%)
- Home visits from HS staff discussing child’s behavioral/emotional challenges (78%)
- Meeting with mental health consultant (70%)

50%-69% of parents reported receiving:

- Help from Head Start in developing a formal plan to address child’s needs (62%)
- Referral to an outside agency (60%)
- Individual counseling or therapy for the child (50%)

Fewer than one third of parents reported receiving:

- Home visit from mental health consultant (32%)
- Family counseling or therapy (31%)
- Parent therapy or counseling (25%)

C. What were parent perceptions of the MHC?

Parents were also generally satisfied with the mental health consultant as a knowledgeable, trustworthy professional.

Over 70% of parents “strongly agreed” that:

- The MHC respects their family’s cultural background (81%)
- The MHC works with HS staff to help their child’s behavior (77%)
- They trust the MHC (76%)
- The MHC meets with them at convenient times (73%)
- The MHC understands their child and his/her challenges (70%)
- Only 62% of parents “strongly agreed” that “the MHC works with me to determine needed services for my child.”

D. How do parents perceive other Head Start staff?

Over 75% of parents “strongly agreed” that:

- They felt comfortable talking with staff about their child’s behavioral challenges (87%)
- HS staff include them in making decisions about what my child needs (78%)
- HS staff communicate about their child’s positive behaviors (75%)
- HS staff try different things to see what works best for their child (75%)
- Regularly invite the parent to attend meetings to talk about their child (83%)
- HS staff respect their family’s cultural background (81%)

50%-74% of parents strongly agreed that:

- HS helps them access services for their child (70%)
- They attend meetings with staff to talk about their child (67%)
- HS staff help them deal with their child’s behavior challenges (63%)

E. How helpful were Head Start’s mental health services?

Not surprisingly, these parents and caregivers, with experience in mental health assistance from Head Start, were overwhelmingly positive in rating the helpfulness of every service listed, with about two-thirds rating any particular service (see the list on page 20) “extremely helpful” and about **85%** finding the service *more than* “a little helpful.” Just three parents thought meeting with the mental health consultant was “not at all helpful”, **70% of these parents likewise had seen a big improvement in their child’s behavior** since the services began. 24% had seen a small improvement, and just 6% had seen no improvement.

V. SUMMARY & RECOMMENDATIONS

These recommendations are not specific to your program. We hope that the information provided is useful to you in comparing your program's mental health component to other Head Start programs in the nation. We urge you to use these data to support your own program development and continuous program improvement in the area of children's mental health. Overall recommendations for programs, based on the national data, include the following.

1. Models of consultation in which the mental health professional is *integrated* into everyday program functioning appear to be more successful:

- Having an integrated mental health consultant is **more important** than having large numbers of hours of consultation per child. Integration makes a difference even for programs with fewer mental health resources.
- Integrated mental health consultants are available and responsive to staff, and provide a wide range of services, including child-directed services as well as support to the staff and managers of the program.
- Interestingly, many consultant characteristics ***did not*** appear to make a difference to program effectiveness, including level of education, organizational affiliation (e.g., school-based, private consultant, etc.), gender, and race/ethnicity (including match to program demographics).
- Programs with more integrated consultants also had stronger ***leadership*** related to mental health, including having program directors who advocated for mental health services.
- Programs with more integrated consultants were more likely to have ***written mission statements*** specific to mental health.
- Integrated consultation seems to support staff wellness: Staff from programs with more integrated models reported feeling more supported in their work.

2. Supporting staff to implement “promising practices” in early childhood mental health is important to program effectiveness:

- Programs with more staff who reported that they endorsed “promising practices” such as being prevention-oriented, strengths-based, and family-focused were more likely to report more effective mental health services.

3. Work hard to ensure staff understand the importance of inclusive practice and involving parents in supporting children's mental health:

- Staff reported significant challenges in involving parents, and may need more support in this area.
- Despite high levels of other promising practices, many staff continued to struggle in terms of balancing the needs of a few children with problem behavior with meeting the needs of the classroom as a whole.

4. Program leadership is important:

- Programs with stronger leadership specific to children's mental health were more likely to have staff who reported higher levels of “promising practices” and more effective mental health services. Strong leaders were seen as those who advocated for mental health resources, and who had a strong, clear, vision for children's mental health.

VI. UPCOMING PROJECT ACTIVITIES: TRAINING & TECHNICAL ASSISTANCE

The final goal of this project is to develop and disseminate training and technical assistance materials to early childhood program managers. As illustrated by the timeline below, the project is now moving into its final year and will focus on creating technical assistance and training. This report is one step toward widely disseminating our findings. In return for your program's participation in this survey, you will receive copies of the training materials that are developed. Look for these materials in 2004. If you have any questions or desire more information, feel free to contact the Principal Investigator Beth Green at 503-243-2436.

Approximate Year	Major Activity
2000	Review literature, develop conceptual framework
2001	Conduct qualitative research to investigate conceptual framework & inform quantitative survey design
2002	Conduct quantitative, structured survey of national sample of Head Start agencies, their staff, and parents.
2003	Analyze survey data and develop training and TA materials
2004	Test and disseminate training and TA materials

REFERENCES FOR FURTHER READING

While awaiting this project's particular technical assistance reports, Head Start managers may want to pursue helpful ideas about mental health program design found in these publications. We have selected them for their usefulness and easy availability.

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

Donahue, P. J., Falk, B., & Provet, A. G. (2000). *Mental Health Consultation in Early Childhood*. Baltimore: Paul H. Brookes Publishing Co. (Available at booksellers.)

Simpson, J. S., Jivanjee, P., Koroloff, N., Doerfler, A., & Garcia, M. (2001). *Promising Practices in Early Childhood Mental Health* (*Systems of Care: Promising Practices in Children's Mental Health, 2000 Series*). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research: Report funded by Center for Mental Health Services, SAMHSA, US Dept. of HHS. (Available from Portland State University RRI-RTC, call 503-725-4040, or contact Maria C. Everhart (everhartm@pdx.edu) or Publications Coordinator at (rtcpubs@pdx.edu).

Yoshikawa, H., & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs*. New York: Columbia University National Center for Children in Poverty and the American Orthopsychiatric Association. (Download the report online (in 5 smaller parts) from: http://www.nccp.org/pub_mhs97.html)

APPENDIX A: SAMPLING METHOD & PARTICIPANT RECRUITMENT DETAIL

Participating agencies were recruited by sampling Head Start's Program Information Report (PIR) data. Program Information Report (PIR) data collected by Xtria for the Head Start Bureau in June 2001 was requested from Administration of Children, Youth, & Families (ACYF) and received electronically in December 2001. There were 2400 Head Start programs in the database we received from ACYF. Migrant Head Start programs complete a different annual report, and were never included in the PIR database. We then eliminated 602 programs that were exclusively Early Head Start according to PIR skip patterns. Some programs we surveyed provide both regular and Early Head Start. Next, we removed 60 Head Start programs with enrollment less than 40 for practical reasons of obtaining a sufficiently large sample of eight or more staff.

Two percent of programs were unable to be included because they reported no use of a mental health consultant in 2000-2001 school year. Just 48 of the 2400 agencies, or about 2%, reported no use of a mental health professional, an improvement over the 8% who reported no use of a mental health professional in 1992. Head Start performance standards revised November 6, 1996 specifically required agencies to "secure the services of mental health professionals on a schedule of sufficient frequency to enable" effective identification and intervention regarding a child's mental health. The standards also require "a regular schedule of on-site consultation" to assist staff and parents with program practices which respond to individual or group mental health concerns; to provide staff and parent mental wellness education (also featured in family partnership performance standards); to ensure special help to atypically developing children; and facilitate the use of other community mental health resources as needed. A psychological services component emphasizing staff and program consultation over individual screening and clinical intervention have been a part of Head Start since 1967.

Since most of the study's research questions were focused on the quality, structure, and outcomes of mental health consulting, we removed 17 of these 48 programs from our remaining list after Early Head Start and very small Head Start programs had already been eliminated. Of the initial list of 2400, 1721 programs remained after this series of exclusions.

79 program directors agreed to participate in the study. From this final list of 1721, 196 programs were randomly selected in twenty-seven stratifications, taking into account four major characteristics: ethnicity of population served, size of program, level of mental health consultation (number of hours reported), and geographic area of the nation. The directors of these 196 programs were sent an initial letter inviting their agency to participate. 156 program directors were successfully contacted by phone, email or fax, and of these, 81 agreed to participate and provided staff names for our sampling. Two programs withdrew consent after sending in a few surveys, leaving 79 programs represented in the final data. Whenever program-to-program comparisons are made, however, this report uses data from just the 72 programs who sent in at least eight surveys. Beyond general statements of "we are too busy", there were three primary reasons given by directors who declined to participate: (1) significant recent or ongoing program reorganization, including director or MH consultant vacancies; (2) participation in other burdensome research projects; or (3) in the midst of the Federal Review process each Head Start receives every third year.

Surveys were mailed directly to individuals in four different Head Start roles: Direct Service staff, Administrative staff, Mental Health Consultants (MHCs), and Parents. All three staff surveys were quite similar, allowing comparisons of responses across these three groups. There were approximately 145 items, and the survey took approximately 30-45 minutes to complete. A separate addendum was completed by directors, which collected structural information for the whole program (e.g., number of children served). Staff names were entered in a drawing for two \$250 prizes, and the winners were mailed checks in late 2002. The Direct Staff version of the survey is in Appendix C of this report. Spanish translations of surveys and cover letters were available for parents and direct service staff.

Parents were selectively approached by Head Start staff and asked to complete a survey. Because we lacked initial informed consent methods to contact parents directly, we asked the Head Start program to approach 3-5 parents who had had at least some experience with the program's mental health component and ask them if they would be willing to complete a survey. Those that agreed received a letter describing the study, filled out and signed a consent form, and signed a receipt for a small cash incentive. The parent survey contained 44 items, and took 10-20 minutes. Parents were mailed a check for \$15 after completing a survey and mailing it back to the project. 154 parents from 62 Head Start programs participated.

An overall response rate of 63% was achieved for the staff surveys. 1265 staff surveys were individually mailed to the 79 participating programs, typically including two administrators (the program director and mental health coordinator) at each program, one mental health consultant, and up to 9 teachers, 5 assistant teachers, and 3 family services staff at each program. 802 surveys (63%) were returned by the end of data collection efforts that lasted 10 months. For further details about survey respondents, see Appendix B.

APPENDIX B: DESCRIPTIVE RESPONDENT DETAILS

Program Characteristics⁺

⁺(Except where noted, this appendix describes only the 72 programs who sent in at least 8 surveys.)

Head Start programs surveyed served from 40 to 6992 children and were grouped into three categories. Below 204 children was defined as a *small* program, above 414 children was defined as a *large* program, so those in between were defined as *medium*. Please remember that we purposely did not sample any programs with fewer than 40 children.

# of Programs (%)	Size (# of children)	National %**
22 (31%)	Small	34%
19 (26%)	Medium	33%
31 (43%)	Large	33%

We considered three main categories generally describing the locations of Head Start operations. Program directors were asked whether their service area was primarily rural (small towns), primarily suburban (serving the outlying areas of a moderate or large city), or primarily urban (serving persons within a moderate or large city).

# of Programs (%)	Setting
32 (44%)	Rural
18 (25%)	Outside urban boundary, but near large metro area
22 (31%)	Urban

Ethnicity of children served by respondent programs represents national Head Start data fairly well. The 72 programs fully participating represent the nation in the racial or ethnic background of enrolled children adequately. Despite initial over-sampling and exhaustive reminder calls, small and medium programs that serve a significant proportion of African American children, as well as Native American programs operated as tribal Head Start programs, are somewhat under-represented.

# of Programs (%)	Ethnicity of enrolled families	National % of programs
23 (32%)	Predominantly White	34%
26 (36%)	Serve over 40% African American	30%
16 (22%)	Serve over 40% Hispanic	26%
4 (6%)	Over 10% Asian/Pacific Islander	5%
2 (3%)	Native American (Tribal Head Start)	5%

* In this Appendix B, **National %** means the percentage of a national list of 1721 programs this study was randomly sampling from, *after* Early Head Start programs, Head Start programs with less than 40 students enrolled, and Head Start programs with no mental health consultant reported had been eliminated from the original 2400 agencies submitting a PIR.

Direct service workers in Head Start reflect the ethnicity of parents much more than administrative or professional staff. As this table illustrates, in study respondents and typically in Head Start programs across the country, mental health consultants are overwhelmingly white even though only about half of parents are. Administrators are a better mirror of typical client ethnicity, but only direct service staff approach comparable ethnic backgrounds.

	MHC	Administrators	Direct Service	National Head Start Enrollees
African American	6%	23%	27%	38%
Asian/ Pacific Islander	6%	1%	5%	3%
Caucasian/ White	71%	60%	50%	34%
Hispanic/ Latino(a)	9%	11%	12%	31%
Native American	0%	1%	3%	4%
Multi-ethnic	8%	3%	2%	N/A
Other	0%	1%	1%	.2%

Note: this table uses data from all 802 survey respondents from 79 programs.

Respondent Head Start programs were distributed appropriately across regions of the United States. As this table illustrates, comparable percentages of participating programs were from each region as were found in the original sample from Public Information Reports. This variable, regional distribution, was the last of four characteristics we attempted to consider for a stratified random sample, so it matches the national picture least. Please note that the regional labels such as “Southern states” are approximations, as the states listed in the description show.

# of Programs (%)	National %	Region #	Description of region
13 (18%)	27%	Northeast	Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, Pennsylvania, Delaware, Maryland, Virginia, West Virginia, District of Columbia, Puerto Rico
18 (25%)	28%	South	North Carolina, South Carolina, Georgia, Florida, Louisiana, Mississippi, Alabama, Arkansas, Tennessee, Kentucky, Texas, Oklahoma, New Mexico
19 (26%)	19%	North Central	Ohio, Indiana, Illinois, Michigan, Wisconsin, Minnesota
7 (10%)	11%	Plains	Nebraska, Iowa, Missouri, Kansas, North Dakota, South Dakota, Montana, Wyoming, Colorado, Utah
15 (21%)	15%	West	California, Arizona, Nevada, Idaho, Washington, Oregon, Hawaii

Respondent Roles

74%, or 592, of the survey respondents were teachers and other staff who provide direct service to children and families. This study succeeded in its attempt to reach the opinions and perceptions of line staff working *directly* with everyday children in Head Start. This table summarizes the Head Start roles of all those who responded to the survey:

# of Respondents	% of Total	# (%) of Surveys Originally Sent	Role in Head Start
73	9%	81 (6%)	Director (Job titles Program Director, Executive Director, Assistant Director.)
67	8%	74 (6%)	Mental Health Program Coordinator or Manager
69	9%	70 (5%)	Mental Health Consultant (when different than MH coordinator)
349	43%	575 (45%)	Teacher
117	15%	281 (22%)	Assistant Teacher
126	16%	189 (15%)	Family services worker/advocate, other
154	N/A	N/A	Parents or primary caretakers of children at 62 Head Start programs

Note: this table uses data from all 802 survey respondents from 79 programs.

Over half (54%) of administrators hold a Masters Degree or more, while over 80% of *non-random* parents surveyed completed at least high school. Note again that the parents in this study were volunteers identified by the program as having experience with mental health services, so their statistics are probably *not* a reflection of the national Head Start parent population. The table here shows average levels of education among the respondents.

	Administrator		MHC		Direct Staff		Parents	
	Number	(%)	Number	(%)	Number	(%)	Number	(%)
Less than High School							22	14.3%
High School Diploma	1	.7%	0	0%	98	16.9%	93	60.4%
2 year degree/ Certificate	14	10.0%	0	0%	111	19.1%	27	17.5%
Child Dev Assoc Certificate	5	3.6%	0	0%	185	31.8%	<i>Not asked.</i>	<i>Included above.</i>
4 Year College Degree	44	31.4%	4	5.9%	162	27.9%	6	3.9%
Masters Degree	70	50.0%	39	57.4%	25	4.3%	6	3.9%
Doctoral Degree	6	4.3%	25	36.8%	0	0%	<i>Not asked.</i>	<i>Included above.</i>

Note: this table uses data from all 802 survey respondents from 79 programs.

APPENDIX C:

Head Start Mental Health Services Survey

Please answer the following questions about yourself.

1. What is your job title? _____
2. Which of the following best describes your position?

<input type="checkbox"/> Teacher ₁	<input type="checkbox"/> Program director/executive director/assistant director ₄
<input type="checkbox"/> Teacher's assistant ₂	<input type="checkbox"/> Family advocate/case manager/family services specialist ₅
<input type="checkbox"/> Manager or coordinator ₃	<input type="checkbox"/> Other staff. Please specify: _____ ₆
3. How long have you worked for this organization? _____
4. How long have you held your current position? _____
5. What is the highest education level you have obtained?

<input type="checkbox"/> High school diploma ₁	<input type="checkbox"/> 4 year college degree ₄
<input type="checkbox"/> 2 year degree/certificate ₂	<input type="checkbox"/> Master's degree ₅
<input type="checkbox"/> Child Dev. Assoc. Certificate ₃	<input type="checkbox"/> Doctoral degree (Ph.D., etc.) ₆
6. How would you describe your race/ethnicity? (Check all that apply.)

<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic/Latino(a)
<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Native American
<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Other. Please specify: _____
7. What is your gender? Male ₁ Female ₀

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

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

In our program, it is important...

 - ___ to help children develop language and problem-solving skills.
 - ___ to help children build strong friendships and learn to share.
 - ___ to help children master concepts needed for reading and arithmetic.
 - ___ to help children develop skill and independence in caring for themselves.
 - ___ to help children develop physical coordination.
 - ___ to help children develop a healthy self-esteem and positive self-concept.
9. Does your program have a *written* philosophy or approach (beyond the performance standards) about how to provide children's mental health services? This could include a policy or vision statement, set of "guiding principles" or other written documentation about how to approach children's mental health issues.
 Yes ₁ No ₀
10. Does your program have an *unwritten*, but commonly understood, philosophy or approach about how to best provide children's mental health services.
 Yes ₁ No ₀

IMPORTANT!

- ◆ If you answered “No” to BOTH questions 9 and 10, GO TO question 28.
- ◆ If you answered “Yes,” to either 9 or 10, continue with question 11.

11. Which of the following led to the development of your program’s mental health approach? Check all that apply.

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

Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
I learned about this approach:					
12.	By reading about it in a training manual.	1	2	3	4
13.	Because it was part of my initial training when I was hired.	1	2	3	4
14.	Through informal conversations or meetings with staff.	1	2	3	4
15.	Through our program’s regular pre-service/in-service training.	1	2	3	4
16.	Through informal conversations or meetings with the mental health consultant.	1	2	3	4
17.	By observing or watching other staff.	1	2	3	4
18.	Just by being part of the program.	1	2	3	4
19.	I understood this approach before I started working with this program.	1	2	3	4
The following groups understand and share the program’s approach to mental health services:					
20.	Administrators/managers/coordinators/management team	1	2	3	4
21.	Classroom teachers	1	2	3	4
22.	Assistant teachers	1	2	3	4
23.	Family advocates/family services staff	1	2	3	4
24.	Support staff (secretaries, bus drivers, cooks, etc.)	1	2	3	4
25.	Head Start parents	1	2	3	4
26.	Mental health consultants	1	2	3	4

Questions 28–63 ask about your program’s mental health consultant(s) (MHC). If you work with more than one consultant, please think about their overall characteristics and how the consultants, on average, work with you and your program. (See next page.)

Instructions: Please indicate the frequency with which your mental health consultant(s) engage in each of the following activities, <i>to the best of your knowledge</i> . If you work with more than one MHC, think about what they do, overall, in general.		Rarely or Never	1-2 Times per Year	Every other Month	Monthly	Weekly or More
28.	The MHC(s) conducts group (classroom) screenings and observations.	1	2	3	4	5
29.	The MHC(s) conducts individual screenings of children.	1	2	3	4	5
30.	The MHC(s) conducts more in-depth assessments of children after they have been screened.	1	2	3	4	5
31.	The MHC(s) does planning for children with special needs (e.g., IEPs).	1	2	3	4	5
32.	The MHC(s) makes referrals for children or families to community services.	1	2	3	4	5
33.	The MHC(s) attends management team meetings.	1	2	3	4	5
34.	The MHC(s) meets with staff teams to discuss children or families.	1	2	3	4	5
35.	The MHC(s) provides direct therapeutic/counseling service to families and children.	1	2	3	4	5
36.	The MHC(s) provides formal training to teachers.	1	2	3	4	5
37.	The MHC(s) talks and meets with parents.	1	2	3	4	5
38.	The MHC(s) provides support to staff for their own well-being.	1	2	3	4	5
	Other activities of the MHC(s). Please specify:					
39.	a.	1	2	3	4	5
40.	b.	1	2	3	4	5
41.	c.	1	2	3	4	5

Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. If you work with more than one MHC, think about what they do, overall, in general. Answer these questions to the best of your knowledge.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
42.	The MHC(s) has experience working with the HS population.	1	2	3	4
43.	I have a good relationship with the MHC(s).	1	2	3	4
44.	The MHC(s) works as a partner with staff to meet children's MH needs.	1	2	3	4
45.	The MHC(s) seems like another member of the HS staff, not like an outsider.	1	2	3	4
46.	The MHC(s) understands how mental health can be addressed through all program components.	1	2	3	4
47.	The MHC(s) has good relationships with parents.	1	2	3	4
48.	The MHC(s) works closely with parents to define services to meet children's needs.	1	2	3	4
49.	Most of the parents in the program know the MHC(s) by name.	1	2	3	4
50.	Staff regularly go to the MHC(s) when they need help with particular children or families.	1	2	3	4
51.	The MHC(s) expresses an awareness of his or her own cultural norms and expectations, and how these might differ from the cultural experiences of Head Start children and their families.	1	2	3	4
52.	The MHC(s) is able to work effectively with non-English speaking families.	1	2	3	4
53.	The MHC(s) is an essential part of our program.	1	2	3	4

Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. If you work with more than one MHC, think about what they do, overall, in general. Answer these questions to the best of your knowledge.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
54.	The MHC(s) has experience working with young children.	1	2	3	4
55.	The MHC(s) respects staff's perspectives on children's issues.	1	2	3	4
56.	The MHC(s) is "part of the team" trying to help families.	1	2	3	4
57.	The MHC(s) provides services in a way consistent with the HS philosophy.	1	2	3	4
58.	Parents trust the MHC(s).	1	2	3	4
59.	Parents of children with special needs know the MHC(s) by name.	1	2	3	4
60.	The MHC(s) is available when I need him/her.	1	2	3	4
61.	The MHC(s) talks with staff about the ways in which understandings of mental health and related concepts (self-esteem, discipline, etc.) may differ for children based on culture.	1	2	3	4
62.	When talking with families about their children, the MHC (s) demonstrates an awareness of each family's unique cultural characteristics and preferences.	1	2	3	4
63.	Dollars spent on mental health consultation would be better spent on other areas of the program.	1	2	3	4

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

Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. Although different staff may think or behave differently, consider how program staff overall, in general, behave. Think about the program staff that you know.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
64.	Program leadership has a clear vision of how children's mental health issues are related to all program components.	1	2	3	4
65.	Program leadership (e.g., managers, directors, coordinators) supports staff to learn more about children's mental health needs and how to address them.	1	2	3	4
66.	Program leadership advocates and tries to obtain more resources for children's mental health services.	1	2	3	4
67.	Staff in our program disagree on what mental health services should be provided to which children.	1	2	3	4
68.	Our mental health services and approach are well-integrated into all program components.	1	2	3	4
69.	Staff would like to see therapeutic classrooms for all children with behavioral health challenges.	1	2	3	4
70.	Our program's mental health services focus more on children with special needs than on preventing mental health problems.	1	2	3	4
71.	Families in our program who need therapeutic/counseling services have problems accessing these through community-based programs.	1	2	3	4
72.	Staff believe that the best way to meet children's mental health needs is to identify what is "right" with the child, not what is "wrong."	1	2	3	4
73.	Parents of children with special needs regularly attend staffings or service planning meetings.	1	2	3	4
74.	This Head Start program has effective ways of involving parents in the management of problem behaviors.	1	2	3	4

	Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. Although different staff may think or behave differently, consider how program staff overall, in general, behave. Think about the program staff that you know.	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
75.	When a child has a mental health issue, staff actively involve the child's family in meeting this child's needs.	1	2	3	4
76.	Staff work actively to identify and facilitate services for adult mental health issues.	1	2	3	4
77.	When talking with families about children's mental health issues, staff demonstrate an awareness of each family's unique cultural characteristics and preferences.	1	2	3	4
78.	Our Head Start program uses curricula that provide images of and attention to children and families from a variety of cultural backgrounds.	1	2	3	4
79.	Our Head Start program offers effective trainings on racial/ethnic, social/economic, religious and other cultural differences among children and families.	1	2	3	4
80.	Our program's approach to mental health focuses extensively on classroom curriculum.	1	2	3	4
81.	Staff in this program see mental health as part of everything they do.	1	2	3	4
82.	Staff believe that children with significant behavioral challenges are best served by programs other than Head Start.	1	2	3	4
83.	When a few children have significant behavioral challenges, staff find it difficult to spend time with any of the other children in the classroom.	1	2	3	4
84.	Our program has a strong partnership with at least one community-based mental health provider.	1	2	3	4
85.	Staff are able to build on family and child strengths even when the family is facing significant challenges (e.g., substance abuse, mental illness, homelessness, etc.).	1	2	3	4
86.	Parents of children with special needs are invited to attend staffings or service planning meetings.	1	2	3	4
87.	Staff feel comfortable talking with parents about their children's mental health needs or issues.	1	2	3	4
88.	This HS program has a mechanism for communicating positive behaviors or events to parents.	1	2	3	4
89.	Staff believe that family participation is essential to improving a child's well-being.	1	2	3	4
90.	Staff have an awareness of how their own cultural norms and expectations may differ from the cultural experiences of Head Start children and their families.	1	2	3	4
91.	Our program has staff who feel comfortable talking to non-English speaking families about mental health issues in their own language.	1	2	3	4
92.	In their interactions with children and families, staff regularly demonstrate an appreciation for cultural norms and expectations different from their own.	1	2	3	4
93.	Our program's approach to mental health includes a strong focus on staff wellness.	1	2	3	4
94.	Our program's approach to mental health focuses exclusively on how to manage children's behavior in the classroom.	1	2	3	4
95.	I have a good understanding of "best practices" in children's mental health.	1	2	3	4
96.	I have a clear understanding of my role in supporting children's mental health in our program.	1	2	3	4
97.	Our program provides me with the training and professional support I need to do my job most effectively.	1	2	3	4
98.	This program recognizes the good work that I do on behalf of children and families.	1	2	3	4
99.	Transitions are smoother in my classroom (or classrooms I know about) because of our mental health services.	1	2	3	4
100.	Our mental health services help all children in our program.	1	2	3	4
101.	Staff have a hard time knowing what to do to help children with challenging behaviors.	1	2	3	4
102.	Classroom staff do their jobs better because of our mental health consultant.	1	2	3	4

Instructions: Please answer these questions by circling 1 if you <i>strongly</i> agree with the statement, 2 if you <i>somewhat</i> agree with the statement, 3 if you <i>somewhat</i> disagree with the statement, and 4 if you <i>strongly</i> disagree with the statement. Although different staff may think or behave differently, consider how program staff overall, in general, behave. Think about the program staff that you know.		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
103.	Our program's mental health services and approach are sufficient to meet the needs of children and families.	1	2	3	4
104.	This HS program has a plan for dealing with children who may have a situational crisis.	1	2	3	4
105.	I consistently use best practices in children's mental health in my work.	1	2	3	4
106.	I feel I do a good job in supporting children's mental health within our program context.	1	2	3	4
107.	Our program provides me with the emotional and personal support I need to do my job most effectively.	1	2	3	4
108.	Our program's mental health services have improved the quality of our classroom environments.	1	2	3	4
109.	Our mental health services help children with challenging behaviors.	1	2	3	4
110.	Our mental health services help families know how to cope with children's challenging behaviors.	1	2	3	4
111.	Our mental health services and approach help staff to feel less stress.	1	2	3	4
112.	Our mental health services and approach are in need of improvement.	1	2	3	4

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

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

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

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

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

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

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

119. Medication only _____

120. Medication plus therapeutic services _____

121. Other mental health services _____

Please describe: _____

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

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

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

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

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

126. Medication only _____

127. Medication plus therapeutic services _____

128. Other services _____ Please describe: _____

Instructions: To what extent do you think your mental health services, including prevention and classroom activities, as well as direct mental health services, have helped each of the following? Circle 1 if it has helped a lot, 2 if it has helped somewhat, 3 if it has helped a little, and 4 if it hasn't helped.		Helped a lot	Helped somewhat	Helped a little	Hasn't Helped
129.	Aggression towards other children	1	2	3	4
130.	Aggression towards adults	1	2	3	4
131.	Self-destructive behavior	1	2	3	4
132.	Extreme temper tantrums	1	2	3	4
133.	Withdrawn/overly shy behavior	1	2	3	4
134.	Extreme moodiness	1	2	3	4
135.	Child depression	1	2	3	4
136.	Speech/language problems	1	2	3	4
137.	Problems concentrating	1	2	3	4
138.	Positive social interactions between children	1	2	3	4
139.	Smooth transitions between activities	1	2	3	4
140.	Prosocial behavior (e.g., helping, sharing)	1	3	4	4
141.	Age-appropriate emotional regulation	1	2	3	4
142.	Non-violent problem solving	1	3	3	4

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

- 1 week ₁ 1–2 wks ₂ 2–4 wks ₃ 1–2 months ₄ More than 2 months ₅

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

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

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

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