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ABSTRACT

This paper describes a mental health consultation program for day care centers serving children under six years. The goals of the program are discussed together with a description of the role of the day care consultant. The steps by which the program was implemented are described in detail. The impact of the program was measured on several variables by comparing centers receiving consultation with those who did not. Measurements were taken (pre and post consultation) on the children's behavior and the expressed attitudes of the teachers. Post only measures were collected from the parents and from teachers as to their satisfaction with different aspects of the consultation process. It is concluded that mental health consultation to day care can be an effective way of furthering the prevention of behavioral disturbance in young children, although the effects are difficult to demonstrate empirically. Specific suggestions are given in three areas for professionals interested in beginning a consultation program to day care. (Author/SB)

MENTAL HEALTH CONSULTATION TO DAY CARE: PLANNING, IMPLEMENTING, AND EVALUATING [1]

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Many authors have stressed the need for preventive and early intervention programs in the field of mental health (Berlin, 1972; Bower, 1963, Caplan, 1964, & Eisenberg, 1962). Because of the lasting influence, for good or ill, of the first six years of life most authorities agree that a major effort has to be directed toward the emotional health and difficulties of the preschool child, his parents, and other care givers. There are of course a number of different avenues that preventive and early intervention efforts may take in reaching young children and their families including prenatal programs, well baby clinics, private pediatric practices, home bound infant stimulation, parent education groups and many others. Perhaps the largest societal institution serving preschool children outside of the home is day care. Previous experience had taught us that many children involved in full-time day care programs could be considered at risk. That is, they were separated from parents for long periods of time, many were from single parent families, and most were being asked to adjust to regimens that were far different from their home setting. Previous research had also pointed to the fact that behavior and adjustment difficulties if left untreated could persist for several years and lead to further

[1] The author wishes to gratefully acknowledge the efforts of Lenore Behar, Ph. D. the founder of Project Early Aid which is reported on in this paper. Dr. Behar, now the Chief of Children's Mental Health Services of the Division of Mental Health Services, North Carolina Department of Human Resources, has long been a successful advocate and supporter of the need for mental health consultation to day care.

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maladjustment and lowered performance in the later school years (Attwell, Orpet, & Meyers, 1967; Brown, 1960, & Westman, Rice, & Berman, 1967). In sum, because of the young age of the children, and the lengthy period of time spent in the institution of day care the conclusion was reached, although not a novel conclusion (Caldwell, 1967, Caldwell & Smith, 1970, Caldwell, 1972), that our efforts should be directed at improving the emotional and cognitive functioning of young children through a program of intensive mental health/educational consultation to day care workers. Several programs of consultation to day care and preschool programs have already been reported but because of space and time limitations shall not be reviewed here (Arnold, Perlman, McQueeney , & Gordon, 1973; Balter, 1973; Bikle, 1965; Brown, 1966; Eckstein, 1962; Emerson, 1965; Furman, 1966; Gibbons, 1966; Gillfillan, 1962; Mattick, 1965; Murphy, 1968; Schwartzberg & Weiner, 1966; Silverman & Wolfson, 1971; Strathy, Heinicke, & Hauer,1973; & Westman, 1964). Most of the above reports dealt with case consultation to teachers around problem children who had already been identified, or consultation to problem families, and facilitating referrals of children to diagnostic/treatment agencies. The evaluation of these programs was scanty and none employed control conditions to evaluate the effectiveness of the services.

GOALS OF THE PROGRAM

Our goals were set out to be that through the process of intensive, continuous consultation teachers could be helped to improve their knowledge of normal and abnormal child development, develop better techniques for assisting children during normal developmental crisis, be able to better communicate with parents, to be more facilitative of referrals of children in definite need, and to improve classroom techniques thus providing opportunity for learning that was

more in pace with each child's level of cognitive and emotional development. A further goal was to facilitate better staff interaction and cooperation within programs in the hope of reducing staff isolation and low esteem towards one's role as a day care worker. Our system wide goal was to increase the visability of day care in the greater community and to help call to community attention the critical needs of young children. Our thinking being that a crucial problem in day care is often the instability of the system itself due to funding problems, rapid staff turnoff, and lack of recognition of the day care worker for her crucial role in the child's life.

THE PROGRAM AS INITIALLY BEGUN

A team of five mental health consultants (four full-time, one half time) were employed. The consultants, except one, all possessed the Masters degree and had a mean length of experience post graduate working with young children of 27 months. Eighteen day care programs in both urban and rural areas were found who indicated a willingness to participate in the program. The overall plan was that each consultant would serve four centers on a once a week basis spending a full day each week in each center. The full implementation and carrying out of the plan of consultation can not be described in sufficient detail to do it justice but five major steps are summarized below.

Step I. Defining the Consultation Relationship with the Director.

The consultant met individually with the day care director and re-affirmed that the consultation would take place weekly on the same day during the same hours. The consultant explained that the same person would work each week and that she was professionally trained and not a student. This initial discussion served to show that the consultant was consistent, could be depended on over a long period of time, and that she had a certain area of expertise which

she was willing to apply to the work of the day care center.

The consultant next explained that she was there to assist the director and teachers with their work related problems in order that they might carry out their assigned roles more effectively and efficiently. The consultant was not there to direct, supervise, or evaluate the staff but to assist where possible based on her area of expertise. The consultant would not take responsibility that particular decisions or actions were carried out. Furthermore, the relationship was a voluntary one and the consultant would not work with center personnel who were coercised into the consultation relationship. Through this explanation of the relationship, and the acceptance of the explanation by the director, the consultant defined her role as non-authoritarian and one that would help others reach their own solutions to work problems.

In order that the consultant could best carry out her assigned role she explained to the director that certain role behaviors were expected of her. These behaviors included meetings weekly and individually with both the director and the teachers as a group, observing in each classroom, and meeting with parents as needed. The consultant then requested that she meet together with the teachers.

Step II. Defining the Consultation Relationship with the Teachers.

Much of the same information that was presented to the director was explained to the teachers. The focus again was in explaining the role of the consultant as consistent, non-authoritarian, non-evaluative, but that the teachers could freely draw on the consultant's specific area of expertise to help them in the solution of their daily work problems. The consultant then shared with the teachers possible areas in which she could be of assistance. these areas included observation of problem children, planning intervention strategies to remediate problem behaviors, curriculum planning, utilization of

physical space, screening of children, stages of child development, and work with parents. The consultant explained that she could help the teachers with these areas both individually and in group meetings.

Step III. Setting a Priority of List of Needs for the Center.

An important part of the expected role of the consultant was that she would serve as a model for goal setting and decision making for the center. The consultant, through group meetings with the teachers, helped the group assemble a list of needs for the center as a whole and for each teacher's individual work with the children. The consultant assisted the teachers in reaching concensus as to priority of each need. Following this the consultant stated what she could do to fulfill the need but the teachers would have the major responsibility for effecting any decisions made. The consultant demonstrated through her behavior that her role was to facilitate the process of group centered decision making, clarify communications, and help the group assume responsibility for their own actions. At this point the needs were translated into specific actions to be taken by both consultant and teachers. The specific actions almost always involved two distinct strategies for the consultant: work with the teacher within her individual classroom, and work with the teachers as a group during the afternoon meeting time.

Step IV. Consultation with the Individual Teacher.

The first role the consultant filled with the teacher was that of a model. The consultant demonstrated how to observe children, how to integrate data from other sources to gain a more complete view of the child, how to plan interventions, and how to assess the effectiveness of interventions. The consultant also modeled behaviors in assessing the effects of the total program on the children and showed the teacher how changes could be implemented which

would benefit all children in the teacher's care. By her behaviors as a model the consultant tried to move from a problem focused approach with an individual child to how change could be effected which would profit all children in the group.

The consultant next interpreted her findings to the teacher and encouraged the teacher to attempt making changes herself. As the teacher began to implement changes the consultant's role behaviors changed to that of a reinforcer of effort on the teacher's part. As each defined need was worked on with the teacher the three parts of the consultant role were repeated; first that of a model, second, as an interpreter, and last as a reinforcer of effort by the teacher. Through this role the consultant always attempted to have teacher understand five key points in effecting change in the classroom: (1) the teacher can be a competent observer of young children, (2) many problems can be successfully dealt with in the regular classroom, (3) it is important to use information about the child's home environment to help the child rather than blame the home for school difficulties, (4) the importance of being aware of one's own feelings toward the child and his behavior, and (5) what is learned from working with a particular child can be implemented in working with all children in the teacher's care.

Step V. Consultation with Teachers as a Group.

The expected role of the consultant in this phase of her work was first that of an instructor. It was believed that for the teachers to effectively bring about change for the children it was necessary that they share a common body of knowledge of child development. The consultant was expected to assess each teacher's prior degree of knowledge, plan, and present information about child development which all of the teachers could find of benefit. The consultant,

after presentation of a particular topic, helped the teachers to apply the general knowledge to their particular situation. As consultation progressed the consultant was expected to move from the more authoritarian role as group leader to a less authoritarian one in which individual teachers presented topics of interest and in which sharing of information was stressed. Again the course of work with the teachers progressed from the problem focused to the promotion of normal development of the children. The shift in role behaviors from authoritarian to non-authoritarian by the consultant helped to build group cohesiveness. Through a more cohesive group structure increased generalization of knowledge between teachers was expected. This generalization phase helped the consultant to promote center wide change.

In summary, the total role of consultant to day care program involved a variety of expected role behaviors which the consultant engaged in at distinct points of the consultation process. The different phases of consultation were designed to help the teacher solve her most immediate need, managing the behaviors of the problem child, and then to incorporate a broader program changes which would promote the adaptive behaviors of all the children in her care.

EVALUATION OF PROGRAM

A formal evaluation of the effort expended and the results obtained from consultation for the first six months of the program was made. (Show Slide I) Because of limitations in time and money only four centers of those served were selected for evaluation of service. Four control centers were selected from an adjacent area not served by the consultation program. The teachers in the treatment and control centers did not differ in terms of age and educational attainment. The children in the two groups differed slightly in mean age with the treatment group children being about two months younger on the average. There

were somewhat more black children included in the treatment group than in the control. In terms of education, occupation and income of the parents of the children it was found that the treatment group parents had a higher level of educational attainment but a lower family income than the control parents. The treatment group included more student parents as an occupational category than the control. Five hypothesis were tested in a pre-post design. 1) Would the teachers exhibit a more positive, less authoritarian attitude toward the children as the result of consultation compared to their control peers? 2) Would the treatment group children exhibit higher levels of socialized behavior? 3) Would the treatment group children show a reduction in manifestly deviant behavior as compared to controls? 4) Would there be increases in contact between parents and teachers in the treatment group compared to the controls? 5) Would there be changes in rates and patterns of referral to outside diagnostic/treatment agencies as compared to control centers?

The results from testing the treatment-control group comparisons yielded mixed results. The expected increase in positive attitudes of the teachers did not occur. (Show Slide 2) In fact, the treatment group teachers showed a slight worsening but the control group showed a significant decrement in the direction of more negative attitudes expressed. If the usual course of events is for the teacher's attitudes to become increasingly authoritarian as the year progressed perhaps the effect of the consultation is to partially counteract this trend.

The levels of positive socialized behavior was found to differ significantly between the two groups at the end of consultation. (Show Slide 3) This was indeed an encouraging finding and attempts should be made to replicate this in other programs.

The amount of manifestly deviant behavior was not found to have changed significantly although the trend of the data was in the predicted direction as the control group worsened slightly and the treatment group improved somewhat. (Show Slide 4)

The amount of contact between parents and teachers yielded significant differences between the groups with the treatment group showing more contact over time and the control group showing a considerable lessening of contact. (Show Slide 5) It may well be the effect of consultation to reverse the normal trend of parent-teacher contact.

Changes in referral rates were found; mainly in the areas of referral to pediatricians and family physicians. (Show Slide 6) These changes may merely reflect seasonal variations or may reflect increased ability on the part of day care teacher to manage minor difficulties and adjustment problems within the normal classroom setting without excessive reliance on outside resources. Hence, one could expect that referrals might become more selective and better thought through. Changes in rate of referral to mental health professionals psychiatrist, psychologist, social worker were low both pre and post and a much larger sample of children would be needed to study the trends adequately.

In addition to the treatment-control comparisons two feedback measures from the treatment group; one from teachers and one from parents were collected. The feedback measure from the teachers consisted of a 30 item questionnaire dealing with different aspects of consultation which were thought to have occurred during the six month period. The teachers were asked to first check whether each aspect of consultation had occurred or not and if it had to rank on a five point scale the degree to which the event had been helpful to them. The consultants were asked to check and rank the items in a like manner. There were

no significant disagreement between teachers and consultants as to which events had transpired but on 87 percent of the items the teachers rated their felt satisfaction higher than did the consultants. (Show Slide 7 & 8) On 70 percent of the items this difference attained statistical significance. The areas of consultation in which the consultants and teachers did not differ in what was felt to have been accomplished dealt with understanding of cultural differences between children, and identification of children with special handicaps. The areas in which the teachers felt consultation most helpful involved understanding the impact of teacher behavior upon children, the role of parents in day care, discussion of problems of children with the consultant, suggestions of working with problem children and assistance with finding special resources for children with problems.

Feedback from parents was secured through a mailed questionnarie. The questionnarie attempted to assess the parents awareness of the consultation program, the manner in which they became aware, and the areas in which the program rendered service. (Show Slide 9, 10 & 11) It is worth noting the pivotal role played by the day care center director in informing parents of the program and the lack of effectiveness of imparting information to parents through our media coverage.

DISCUSSION

What have we learned that others may apply in carrying out mental health consultation to day care? It is the author's definite belief based both on informal and formal feedback from recipients that the day care consultant can be an effective agent of change although the effect is far from immediate and is difficult to demonstrate empirically. I shall now put forward some suggestions in three areas.

PLANNING

A consultation program which assumes day care is a uniform system and that an overall consultation format will serve the needs of many different centers is going to meet with much frustration and will have to redo many programmatic goals thus resulting in false starts, blind alleys and wasted staff time. Our experience has taught us that the heterogeneity of day care cannot be overestimated. Secondly, do not overlook the obvious in planning. Many centers simply cannot respond to mental health consultation as we typically conceptualize it. Centers which are in continual threat of not finding sufficient funds to purchase food for the children are not going to be much interested in learning new teaching techniques or principles of behavior management. Do plan to employ consultants who do not feel threatened to take on a variety of helping roles beyond that of expert in child development or classroom technique. The child care system must be stabilized before much long range work can be done. Consultants who had actual preschool teaching experience in addition to their mental health training were more easily accepted in the centers than those who had not had theexperience.

Part of effective planning is assessing needs. In addition to assessing the need of day care workers and directors for consultation an equal period of time should be spent assessing the needs of parents for consultation to <u>their</u> day care center. Parents usually form a strong identification with all portions of their child's environment and the assessment of this identification should not be over looked.

IMPLEMENTING

We have found that trying to launch a program of consultation can best be done through holding workshops for teachers and parents before the day care

programs are approached directly to ask if they would like to take part in the consultation program. The workshop format allows the teacher or parent to meet the staff, gain some knowledge, and learn about the consultation program without having to make a definite commitment to something about which they know little.

During the first stages of consultation it is very easy to assume that the director speaks for the center as a whole as to the perceived needs and the type and quantity of mental health input needed. Much care has to be taken to work out specific steps directly with the teachers and yet not circumvent or undermine the relationship between the director and the teachers.

As consultation progresses it is sometimes apparent that the consultant is being thrust into an administrator-decision-maker role. This may come about either covertly or overtly. Assuming a vertical relationship with the consultees has to be studiously avoided and if found to be occurring needs to be brought quickly into the the open and clarified. Attempts to place the consultant in a decision making role probably occurs more frequently in day care because of the severe stress the system is under and workers are often prone to turn to outside authority for instant solutions for extremely complex problems.

EVALUATING

Ongoing consultation programs often collect data for other purposes which can be profitably used for the first stages of evaluation if it can be systematically analyzed. This sources of data are often overlooked and if they can be used for multiple purposes may prevent the development of redundent data collection procedures.

In our study, we relied heavily on global paper and pencil measures of change. While these measures are fairly efficient in terms of staff time they are indirect measures. Direct behavioral observations either in person

or through video tape of teacher-child interactions would probably be a better (more sensitive) measure of change. There are several reliable behavior observation schedules available for use with preschool children.

Another good source of evaluation data can come from in depth interviews of consultees by independent judges. This type of data would provide an indepth study of complex variables which are often oversimplified by paper and pencil measures. Also, we did not attempt any systematic follow-up so it was not possible to know whether gains made were sustained over any appreciable period of time. Any attempt to follow-up at six month or yearly intervals would add a needed dimension to evaluation of program effectiveness.

In this short period of time today we have only been able to touch upon and highlight the many aspects of planning, implementing, and evaluating mental health consultation programs to day care. I hope in the discussion period to follow that some of these facets can be gone into in more detail.

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